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Teaching Psychodynamic Psychotherapy to Medical Students

Papers from the American Psychoanalytic Association

Eric R. Marcus, M.D., Guest Editor

At the American Psychoanalytic Association meeting in December 1998, there was a Presidential Symposium entitled "Psychoanalysis and American Medical Education for the Millennium: Teaching and Practice-Building Opportunities." The speakers included national leaders in psychoanalysis, psychiatry, and medical education. The talks covered the range of relevant topics, from the new economic organization of medical education, to teaching programs and needs, to research and medical education. The following papers are from that symposium.

As a group, they describe the landscape of American medical education at the turn of our century. They describe the new need for psychodynamic teaching in a variety of teaching venues. This need offers great opportunity to psychodynamic psychiatry, to psychoanalysis, and to individual practitioners. Psychodynamic science and art can once again make an important contribution to medical education and receive in return a new energy for its own growth and development.

Medical schools are becoming a rich, creative, cross-fertilizing, interdisciplinary mix as the basic and human sciences extend their reach and begin to overlap. Cognitive science has discovered affect processing and seeks sophisticated information about human emotional systems. We psychodynamic psychiatrists and psychoanalysts are the experts.

These papers describe the multiple opportunities for us in American medical education.

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Opportunities for Psychoanalysis in American Medical Education

An Overview

Herbert Pardes, M.D.

The field of psychoanalysis and psychodynamic psychiatry correctly perceives itself to be increasingly marginal in American medical education. This does not mean, however, that the marginalization is good for American medical education; nor does it mean that faculty trained in these areas are not needed and wanted. The time may be right for a reconciliation that would benefit psychoanalysis, psychodynamic psychiatry, and American medical education.

CHANGING ECONOMICS OF MEDICAL EDUCATION

The past 10 years have seen tidal changes in the logistical base of American medical education. With the training of more researchers, scientists are increasingly competitive with each other and medical schools are more competitive with each other for research dollars. Although increases in the research budgets of NIH and NIMH are expected for the near future, tight competition for research dollars will remain. The falling reimbursement rates from managed care and Medicare mean that clinical and education income is under substantial strain. The medical schools therefore have suffered a one-two punch at the economic base of their enterprise. This means that full-time faculty in research or clinical work are spending more and more of their academic time on research or

clinical work that is directly economically productive. They are hard pressed for time to teach.

At the same time, medical education has shifted dramatically in its task and its curricular content. It has had to incorporate an increasingly diverse set of topics while integrating basic science teachings and expanding the breadth of clinical education experiences. It has become more focused on understanding the major sources of morbidity and mortality and targeting those sources, either in illness-specific ways (hypertension) or in clusters of related high-morbidity illness groups (cardiovascular disease). One of the most frequent of these clusters is depression, because this psychiatric illness is a major public health issue. In all of these illness categories, more attention is being given to chronic care and primary, secondary, and tertiary prevention—and that means helping patients with lifestyle and behavior changes.

In addition, the growth of general medicine as a subspecialty, an increase in public awareness about doctors, and the public health need for patient cooperation and compliance in medical care have brought the psychological factors in the doctor-patient relationship back into central focus in medical education. We teach the doctor-patient relationship and medical interviewing. These courses are supplemented by courses in the ethics and values of a patient-centered humanistic medical care.

In order to teach these subjects well and to give the students the practical ability to use the information and to build necessary interpersonal skills, medical schools have changed teaching methods to emphasize more small-group teaching and one-to-one clinical mentoring.

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Such teaching requires a smaller student-faculty teaching ratio than does lecturing or ward rounds.

We thus see the entire logistical base of medical education shifting in terms of income, available faculty time, and need for teachers. This means that medical schools are crying out for donated, voluntary faculty teaching time. Particularly needed are voluntary faculty who have skills in the psychological aspects of medical care and can teach doctor-patient relationships and the potential for behavior changes based on those relationships in the practice of long-term care. The need for teaching of this kind provides the potential entree for the psychodynamic psychiatrist and psychoanalyst. Those of us with this training are uniquely poised to become the mentors and general medical educators of the twenty-first century. Psychoanalysts and psychodynamic psychiatrists could fill the role of psychodynamic experts on the doctor-patient relationship, life-cycle development, and the clinical process teaching that the new medical pedagogy is embracing.

BARRIERS WITHIN PSYCHOANALYSIS TO THE NEW MEDICAL PEDAGOGY

In order to join the new medical pedagogy, however, psychoanalysts and psychodynamic psychiatrists must understand the changes in the goals and venues of medical teaching that have been based on the changes in economics of medical education. Psychoanalysts and psychodynamic psychiatrists must understand that the teaching opportunities are enormous but that they are unremunerated. Faculty must be willing to donate a part of their time. Psychoanalysts and psychodynamic psychiatrists must also understand that the need is for psychodynamics applicable to medical care and not for pure psychoanalysis and its metapsychology. Medical students need to know about feelings and emotional adaptations, not about the development of the libido. They need to know about normal development and not just about pathology and neurogenesis. Psychoanalysts must therefore be prepared to teach clinical process and not just psychoanalytic process, clinical values and not just psychoanalytic values. Psychoanalysts and psychodynamic teachers must join their general medical colleagues in teaching warm therapeutic relationships with patients rather than psychoanalytic blank-screen relationships. All the subtleties of transference and countertransference can still be seen and understood in this more relational context because the transference reactions are

great in the medically ill.

Because of the research mission of medical schools, the modern medical school psychoanalytic teacher will have to teach analysis in *relationship* to biology and not in *opposition* to biology. Nothing will peripheralize the profession more than to ignore the dramatic leap forward in understanding brain function and psychiatric illnesses that the Decade of the Brain has brought us. With modern neuroimaging, genetics, immunology, and informatics, one can anticipate more rapid progress in the new century. Psychoanalysts as clinicians have much to teach about sophisticated clinical phenomena that cry out for sophisticated research. But in order to expand the research mission, they must embrace research, not oppose it.

PAYOFFS

The payoff to medical education of increasing involvement by analysts and psychodynamic psychiatrists is an increase within medical education in understanding the patient-centered skills and values that are required for clinical excellence. It will mean a richer and deeper education for students as they enter the psychologically complex realm of clinical care. It will mean increasing opportunities for sophisticated teaching and for the kind of faculty development that inspires teachers and drives teaching programs. It will offer the opportunity for sophisticated clinical research on these relationship issues and their impact on medical care.

As medicine shifts more and more to the treatment of chronic illness and as these chronic illnesses more and more require chronic medication and lifestyle changes, the issue of cooperation by patients with these regimens comes to the forefront of medical concern. These issues are psychological issues. Little is known about how to bring about dramatic lifestyle changes required for the control of atherosclerosis, hypertension, and diabetes, to mention three of the most frequently morbid chronic illnesses. We know for sure that scaring people and providing them merely with facts doesn't work. Because these issues often involve different specialties, the potential for interdisciplinary teaching, patient care, and research is very great and is probably the challenge and the opportunity of the next century.

The payoff to psychoanalysis can be in the increasing medical respect and interest with which medical students and residents regard psychoanalysis. This may pay off in increasing numbers of candidates and of patient referrals as the relevance of psychoanalysis is seen. An addi-

tional, badly needed payoff to psychoanalysis can come in integrating modern medical research methodology with the understanding of clinical work within psychoanalysis. Initial, broad-based outcome studies are actually quite positive for psychodynamic treatments. Many studies have shown that the more intensive the therapy and the longer it continues, the better the results. What is lacking is research sophisticated enough to provide an understanding of specificity about psychoanalysis and psychodynamic psychotherapy as a method and its specific application to specific illnesses. Medical schools may have research methodologies that can help.

CONCLUSION

If psychoanalysts do not fill this medical education vacuum, it will soon be filled by others. A multitude of cognitive and behavioral approaches exist and a large number of practitioners are available to teach them. But analysts and psychodynamic psychiatrists should remember that we all have one primary goal: the best of patient care accompanied by the best in medical education.

Teaching Psychodynamic Psychiatry During Medical School and Residency

Specific Skills and Beyond

Allan Tasman, M.D.

Some years ago, during a workshop that focused on the integration of psychotherapeutic and psychopharmacologic treatment, a young woman patient was presented who had problems with both severe manic-depressive illness and borderline personality disorder. She was extremely sensitive to medications, but even during times of stability of her manic-depressive illness, management was difficult. Following a presentation of a videotaped psychotherapy hour of a resident and the patient, a residency director in the audience raised his hand and said, "I don't know why you showed this videotape. This woman has manic-depressive illness and needs medication, and that's that." Although this may seem a caricature of the emphasis on biological psychiatry in the last several decades, the question was asked by an experienced residency director who had been in his position for many years. Too many clinicians believe that good psychopharmacology practice requires only knowledge of dosages, side effects, drug interactions, and indications for the medication. To me, however, the essence of good psychopharmacologic management is how one responds when a patient comes into the office and says, "Dr. Tasman, you know that medication you prescribed. Well, I'm not going to take it any more." Dealing with issues of resistance and treatment compliance, even in a busy medication clinic, an emergency room, or an inpatient unit, requires psychotherapeutic skill and knowledge.

THE PRESENT NEED

The economic forces transforming the clinical practice of psychiatry over the past several decades have seriously

affected academic medical centers as well.¹ Shifts in delivery systems, decreases in public funds available to support academic medical centers, and a disproportionately severe effect within psychiatry of the wave of managed care have all put increasing pressure on psychiatry faculty to generate funds necessary to support their positions. This has meant less time available for teaching, even from committed clinician educators. Further, the explosion in neuroscience research and available grant funds to support such work have led to an emphasis on faculty who have the potential for garnering research funds and a relative deemphasis on those who rely primarily on clinical service to provide salary support. These forces led to a mass exodus of psychoanalysts from departments of psychiatry in the 1970s and the 1980s. Feeling devalued and underappreciated, psychoanalysts reacted with anger and hurt, leading to a situation in which many departments of psychiatry today have little access to those psychiatrists most expert in teaching psychodynamic principles and techniques. Further, the explosion in the knowledge base in psychiatry in the last several decades has led to intense competition for curriculum time, producing a situation in which there is decreasing curriculum and supervisory time devoted to psychotherapy training at the same time that there are few faculty available to teach it. Moreover, the competition for what psychotherapy training time is available is

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now intensified with the growth of newer and more research-tested psychotherapy techniques such as cognitive-behavioral and interpersonal psychotherapy.

Even with delivery system changes, the clinical vignette at the start of this paper illustrates that it is still essential for psychiatrists to have the knowledge and skills base necessary for psychological understanding and intervention. This is true even when the primary treatment modality is psychopharmacologic. These needs are present not only in the outpatient clinic, where research is beginning to show the superiority of combined medication and psychotherapy treatment (especially in seriously ill patients),² but in every clinical setting.

Twenty-five years ago it was still not uncommon for psychoanalysts to be directors of every clinical service and of both medical student and residency education programs. There was no question, in that environment, that residents would be exposed to a psychodynamic way of understanding no matter what patient they were seeing or in what setting. However, at present, teaching the knowledge and skills necessary to conduct psychodynamic psychotherapy occupies little curriculum time. Further, few data exist regarding adequacy of psychotherapy training, which is necessary to plan appropriate training experiences. It is known, however, that residents feel increasingly unskilled when it comes to psychoanalytic psychotherapy. In discussions with residents around the country, the one issue heard more than any other is a wish for a more adequate psychodynamic psychotherapy training program.

Most residency programs at present still claim to focus most of their psychotherapy training on a psychodynamic model of understanding and intervention, although this focus has significantly decreased in medical student education.³ However, what is defined as psychodynamic psychotherapy differs widely. A study conducted 12 years ago³ revealed that approximately 80 percent of residency programs reported that psychodynamic psychotherapy was the primary model of psychotherapy training used; however, there was very little experience offered in treating patients for any length of time. The total percentage of cases that were carried for longer than a year was less than 10 percent in that study. Is this adequate or not? We have insufficient data on which to base a conclusion. Further, with the growth of cognitive-behavioral therapy and interpersonal psychotherapy (IPT) in the last decade, it is clear that a repeat survey would no longer reveal the same emphasis on psychodynamic psychotherapy.

The issue of psychotherapy training, though, also raises other questions. Many would argue that benefits well beyond learning the specifics of psychotherapeutic treatment come from learning about psychodynamic concepts and psychodynamic psychotherapy.

THE BENEFITS

A paper published in the *American Journal of Psychiatry* in 1990⁴ argued that there were at least 10 major reasons for continuing to teach psychodynamic psychotherapy. Three of these related directly to the acquisition of skills necessary to deliver psychodynamic psychotherapy to patients, but seven others were related to the acquisition of skills, knowledge, and experiences important to other aspects of psychiatric and medical practice.

The 1990 publication described these seven issues:

1. The concepts of psychodynamic psychotherapy are intimately related to the psychological and social concepts of all doctor-patient relationships. The psychotherapeutically competent psychiatrist should be able to *provide more effective consultation* to medical colleagues and be able to *manage his or her own non-psychotherapy doctor-patient relationships more effectively*.
2. Psychotherapy training also provides the resident with experiences that *enhance learning about and management of other dyadic relationships within psychiatry*, such as in supervision, consultation, and mental health administration.
3. Psychotherapy training *enhances basic interviewing expertise* by providing the resident with an opportunity to observe longitudinally the course of psychopathological and normal mental phenomena present in an initial interview. This experience makes it possible for the resident to recognize emerging mental phenomena earlier, more accurately, and more confidently.
4. Psychotherapy training *provides the resident with an in-depth and longitudinal view of both conscious and unconscious mental functioning*, which may be normal or pathological and which are related to the effort to change thinking, feeling, and behavior. Such an effort requires an ongoing relationship between therapist and patient and involves the inevitable obstacles, resistances, strengths, and opportunities related to such an effort. Understanding these phenomena is essential to treatment planning and management of virtually all psychiatric disorders.

5. Psychotherapy allows the observation of complex pathological and normal mental functioning over time. In so doing, it complements the observation of similar mechanisms in inpatient, consultation, and emergency room settings. Furthermore, it provides access to the primary materials that form a basis of general psychodynamic theory. As such, psychotherapy training *enhances the learning of psychodynamics as a basic science within psychiatry*.
6. Many ethical difficulties result from psychiatrists' problems in managing their feelings and reactions to patients. With its emphasis on the complex dyadic emotional interplay between psychiatrist and patient, psychodynamic psychotherapy training *enhances psychiatrists' ability to anticipate, analyze, and avoid ethical dilemmas and transgressions*.
7. Finally, practicing psychotherapy forces the psychiatrist-in-training to observe, analyze, and attempt to understand an extremely complex interactive phenomenon. This *enforces intellectual rigor and discipline* in observing behavior, developing hypotheses, and analyzing theories and data.

Even if we are uncertain about the role that conducting psychotherapy will play in psychiatrists' activities in the future, the above issue highlights the importance of psychodynamically informed residency education. There is little evidence that all this other learning that occurs during psychotherapy training can as easily be learned in other ways, especially in undergraduate medical student education.

Many fear that we are in danger of training a generation of psychiatrists and physicians who lack basic psychotherapeutic skills or a framework for understanding mental functioning from a psychodynamic perspective. With the neuroscience knowledge explosion continuing, and with the financial pressures on academic departments of psychiatry unlikely to diminish, there is little likelihood of a major influx of full-time psychoanalysts into academic departments of psychiatry any time in the near future. However, this state of affairs intersects with pressures from residents for more psychotherapy training and with the medical education emphasis on primary care training, especially psychoanalytic or psychodynamic psychotherapy training. This conjunction of limited faculty resources with new pressures for training provides an opportunity unparalleled in recent years for psychoanalysts, and others able to teach psychodynamic knowledge and practice, to reengage in psychiatry

teaching programs from the first-year medical student level on up.

Even in the heyday of academic psychoanalysis, much of the teaching and clinical supervision provided to residents was made available by volunteer faculty in private practice. The severe financial pressures under which most analysts practice today are well known, but it is clear that this is a time that there must be a recommitment to reengagement in psychiatry residency training lest the entire body of psychoanalytic knowledge and skills be lost to the discipline of psychiatry. Historically, analysts provided clinical supervision of outpatient work, often in their own offices. At present, though, there are opportunities to teach within the academic medical center on any clinical service and at every level. This is especially true with the rise of preclinical introduction to clinical medicine courses, which are often co-coordinated by psychiatry and which have a major emphasis on teaching students about the doctor-patient relationship. Even an hour or two a week spent making rounds on a consultation service, an inpatient unit, or working in an emergency department supervising residents or teaching students can help provide early imprinting of a psychodynamic way of thinking in younger psychiatric colleagues. It is well known from educational research that early imprinting of frameworks for making sense of information often has the most dramatic effect on the way data are perceived, interpreted, and integrated over time.

Thus, it is important that psychoanalysts move beyond reactions to the perceived rejection by academic psychiatry over the last several decades and offer to reengage even at the earliest levels of training. Interestingly, the same financial pressures that drove analysts out of academia now make department chairs receptive to and welcoming of offers to teach or supervise from volunteer faculty in nearly every clinical setting. To ensure that the psychiatrists of the future have the requisite psychodynamic knowledge and skills base, psychoanalysts must take advantage of the unparalleled set of opportunities available within psychiatry teaching programs.

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Psychodynamic Social Science and Medical Education

Eric R. Marcus, M.D.

Psychoanalysis and psychodynamics can offer medical education an understanding of unconscious emotional developmental processes. This knowledge can not only guide teachers and mentors in individual teaching tasks, but also enable us to understand medical students' growth and development in the professionalization process. Understanding how students become professionalized can help us understand the effect of medical education on the process. This can then perhaps help us influence medical pedagogy so that our courses and our teaching approaches benevolently steer the professionalization process in directions we value.

Medical education is an emotional developmental process and not just a process of information transfer. You don't only learn facts; you become a doctor. Becoming a doctor describes a state of being, a state of feeling about ourselves that suggests a set of self-representations whose organization and content we call professional identity. We are in the infancy of trying to understand the processes at work in the organization of professional identity.

Clearly, major aspects of this identity formation occur in medical school. Many of us psychodynamic educators have hypothesized, on the basis of personal experience and observation, that pedagogy in medical school is affecting professional identity through processes of identification in students. If this is true, *how* we teach is also *what* we teach and may be more important than content teaching. From the medical students' point of view, medical school experiences are at least as important in professional identity formation as the facts they are taught.

What are the developmental vicissitudes of this unconscious professionalization process? How does peda-

gogy in medical school affect unconscious professionalization? Should we change medical pedagogy, and if so, how? Freud said he hoped psychoanalysis would influence pedagogy but added that whether the result would be for better or worse he could not say!

PSYCHODYNAMIC RESEARCH DATA

The problem in exploring this issue is how to get data that reveal unconscious, developmental psychodynamic processes. I have chosen to study this issue by collecting dreams students have had where the manifest content is about medical school. The collection in this study was from medical students at one major academic medical school. The dream collection was done over several contiguous years. The study population was a convenience sample of volunteers who submitted their dreams for remuneration of \$10.00 per dream. None was undergoing psychiatric treatment. The submissions were anonymous and gave only the manifest content of the dream, the sex of the dreamer, and the year of medical school or residency training in which the dream occurred. The dream collection covers all years of training from medical school year 1 through the last year of residency. The dreams are not dreamt by a collection of dreamers who dream over the years but are from volunteer cohorts in each year. The collection is from the different years of training simultaneously collected. I purposely did not want the same cohort progressing through all the years,

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because I was less interested in the individual developmental process than in the group's, and I believed that the individual variants would more easily be washed out by collecting different individuals from the training sequence. In this way, I hoped to accentuate the themes of each year rather than the themes of the individual dreamer.

The dreams were studied in two ways. The first way was to read them serially to see if a sequential unconscious fantasy was thereby revealed. The second was to analyze the dream symbols according to categories of character, setting, action, specific medical school day residue, and affect. Each dream was cross-catalogued according to these categories, and the entire collection of about 400 dreams was placed on computer disk along with the categories. This spreadsheet approach to the tracking of the dream symbols enabled simple statistical measures to be done for each dream symbol as it changed year by year. The statistics produced served as a rough approximate gauge of accuracy of the hypothesized unconscious fantasy, as well as suggesting aspects of that fantasy.

RESULTS

The research result most pertinent for this paper is the vicissitudes of empathy and emotional involvement with patients, because this is a crucial area in which psychodynamically trained medical school teachers can contribute. Achieving an appropriate level of empathy is one of the major psychological tasks of medical training. The major finding in the dream material is the sequence of close identification with patients in the early years of medical training followed immediately by a flooding of that identification due to the intense, traumatic emotional experience of feeling so much like desperately ill patients, or even the cadaver, that the student is in danger of experiencing what is happening to the patient or the cadaver as happening to themselves. This flooding, reflected in traumatic nightmares of identification, is delivered by medical school training experiences in the form of abrupt, overwhelming experiences for which there is no emotional preparation. It results in a series of counteridentifications against patient experience and in favor of identifications with faculty. It is the psychodynamic explanation for why students in the first year of medical school can interview a patient and show great understanding of the patient's emotional experience although having little knowledge of biological illness, whereas in

the fourth year of medical school they can interview patients with great understanding of biological illness but little understanding of the patient's emotions.¹ The ability to empathize with patients in the student's object representations rather than identify with patients in the student's self-representation is a psychological ability that only becomes solidified and relatively resilient in later years of residency training.

APPLICATION OF THIS FINDING TO MEDICAL PEDAGOGY

Can we use this basic finding to consider whether medical school education can decrease its traumatic impact on students and solidify an empathic ability earlier in medical training? Can this grow out of more benign medical school experience as well as be the result of direct, didactic teaching in the area of empathy? There are data to show that factual information does not change student attitudes.² It might therefore be worth trying the experiential model.

Over the last several years, I was given administrative and pedagogical responsibility for all the non-basic science courses at the College of Physicians and Surgeons at Columbia University. I tried to use this dream study to fashion an integrated sequence of courses in the doctor-patient relationship, ethics and values, clinical epidemiology, human nutrition, human sexuality, life cycle development, pathophysiology correlation clinics, medical interviewing, physical examination of the patient, and psychiatry.

The courses are conceived as a sequence for teaching, illustrating, and demonstrating skills in the doctor-patient relationship, applied to patients undergoing illness in the context of the life cycle and in the context of the life cycle of the physician. The central early medical student fantasy of one doctor, one patient, one responsibility, one goal, one illness, one fact, one intervention, one cure is acknowledged and elaborated, but it is also made more complex by reference to the viewpoints of other disciplines and to the complexity of the doctor-patient relationship.

Caring and empathy are taught directly through medical interviewing courses and in discussions on the psychology of medical care. Specific skills and attitudes are modeled, as well as taught, within the confines of the student's knowledge base. In the first year, when knowledge about biological illness processes is small and skills in specific medical history taking are weak but listening

attitude is high, students are taught to elicit patients' life histories, of which the illness is only a part. Students are shown the power of listening to stories and of telling the story back to the patient. A sequence in the humanities on narrative structures is a selective available to students in the second year that elaborates this skill.

Teaching is done with live patients from day one, liberating the student from the psychology of having the cadaver as the first "patient" experience.

In the organization of our courses, we are trying to change the focus of medical education from data stuffing and data sponging, with its underlying fantasy that it is possible to learn an infinite data set, to a focus on processes both within people and within data sets. The clinical approach is taught as above all a collection of observational skills about operational processes and principles. We try to decrease the emphasis on competitive fact grabbing and grade grubbing and emphasize student doctors' unique roles in an individual's life because of their power to connect with the individual, not because of their competitive ability to get a better grade within their group of peers.

We try to help them understand that their fantasy of the "fact that they don't know" killing someone and the "fact that they do know" saving someone is a greatly exaggerated fantasy. The reality is that the better emotional contact you have with someone, the greater the bond of trust, the more pertinent clinical facts will be given to you by the patient, and the better chance you will have of seeing the integrative illness processes and of judging the appropriate intervention. It isn't the facts only, it's the relationship of the facts: the process.

We hope that in this way we can make an impact on the learning environment so that students will feel better taken care of by us as a faculty and by their peers, and that this sense of being cared for will enable a better attitude of care taking. We try to influence the content of student identifications by not flooding them with patient experience and by providing a benevolent role model in faculty rather than seeming distant, judgmental, and unemotional. We attempt to teach in a cross-disciplinary way that shows the integration of knowledge as well as its dissection. We illustrate the integration of life histories and illness histories. We try to ameliorate the dissection experience by having an elective in life drawing where students can look at, experience, and try to render on the page the living anatomy of function, of form, and of aesthetic. We find students better able to tolerate integrative experiences involving the dynamic living and

healthy rather than the sick and the dead.

In order to encourage an integrative experience of medical school, encompassing both the intellectual and the emotional, we give the students a journal consisting of a hard-cover blank book with a seal of the school and the year of their class. They are encouraged to write about their experiences in medical school, both of patients and of themselves.

These journals, the course content, and their patient care experiences are discussed in weekly small-group teaching with clinical mentors. The clinicians are volunteers whose backgrounds are in clinical practice, in public health, and in teaching. They are a devoted group of practicing doctors from all specialties. They are empathic mentors who help the students integrate and digest data, cooperate and help each other, and learn basic clinical skills and the relevance of basic science facts to those clinical skills. The emphasis is on processes of learning, processes of interpersonal contact, and the organization, relevance, and application of knowledge in the clinical setting.³ At all times, patience, interest, concern, validation, and encouragement are demonstrated by the mentors. Sometimes this mentoring concern involves tactfully but fearlessly dealing with the more aggressive students. These moments are some of the crucial educational moments both for the individual whose behavior is inappropriate and for the small group as a whole.

LESSONS LEARNED

We think we are learning the importance of faculty concern about patients and patient care, students and student care, curriculum, and student learning environments. We are appreciating the need for faculty development directed toward an increasingly psychologically sophisticated view of pedagogy. We help each other with this development through faculty meetings, faculty discussions, and faculty reading. We share teaching techniques, try out each other's pedagogical methods, develop our own styles, see what works and what doesn't, and try to shape the course to our growing experience with the course. We are more and more convinced that active learning—the teaching of specific skills and attitudes through the modeling and mentoring function of the small group leader—is empowering students both intellectually and emotionally.

We take great care not to traumatize students by flooding them with data or by flooding them with clinical experiences that they don't have a chance to prepare

themselves for and discuss afterward. We try never to show off or to humiliate a student, even when we have to defuse a student's grandiose certainty that he or she knows it all.

Our outcome data are outstanding. Student satisfaction with these courses has risen from very dissatisfied to outstandingly satisfied. The faculty involved with the course have appreciated the organized focus on the clinical approach and on clinical values. The third-year clerkship teachers feel that students enter the clerkship at a higher level of sophistication about people and about the clinical task and do better interviews, physical exams,

and case formulations. Nevertheless, the long-range staying power of these benevolent experiences and their capacity to influence the longer range developmental course during clerkship, senior subinternship, internship, and residency training remain to be tested.

If these changes are effective and durable, it will demonstrate the usefulness of the psychodynamic approach to the social science of medical pedagogy that focuses on the unconscious professionalization process. This field of study is another of the rewards available to the psychoanalytically informed medical school faculty member.

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Psychoanalysts Teaching Medical Students

How to Succeed

Janis L. Cutler, M.D.

Teaching in medicine generally follows the old adage “See one, do one, teach one.” Providing medical school faculty with instruction in teaching methods has traditionally not been a priority.¹ This lack of training may contribute at times to faculty’s reluctance to teach medical students. Medical students are a potentially large and enthusiastic, but also perhaps intimidating, audience for psychoanalytic teachers, who may already feel that they are on the fringes of the medical school community. This discussion is intended to allow psychoanalysts to feel prepared and equipped for medical student teaching.

Much can be learned from educators within and outside of academic medicine as to effective teaching methods.¹⁻³ This presentation will focus in particular on issues relevant to the teaching of psychiatry by psychoanalysts. Recommendations are based on the author’s extensive experience lecturing and running seminars, as well as years of supervising other faculty members’ teaching. That supervision has included direct observation of lectures and seminars as well as monitoring of students’ responses. The degree to which faculty can improve in their ability to reach and to educate medical students by sometimes quite simple modifications in teaching methods has been particularly impressive.

CHALLENGES

Awareness of the potential to improve one’s teaching raises one of the challenges of teaching in general and of psychoanalysts teaching medical students in particular: as teachers, we must be able to tolerate the narcissistic injury of not necessarily being loved and admired by all of our students. Medical students can be a particularly

tough audience. Certainly not all of them plan to be psychiatrists, let alone psychoanalysts. Probably many of them will be skeptical as to concepts that seem like second nature to us. Perhaps at least a few students will be quietly, if not overtly, hostile. An understandable faculty reaction to such a reserved reception might be to meet arrogance and hostility with more of the same. Here is where our analytic training with regard to neutrality, timing, and tact can be extremely useful. The most productive approach for psychoanalysts teaching medical students is to be equipped with an understanding of the students’ resistance and to be prepared with appropriate tools to work with and maneuver around that resistance. In addition, it is crucial to keep in mind that it is virtually impossible to please an entire class of medical students.

Medical students may assume that psychoanalysts have nothing to offer them that is of clinical relevance. Case presentations and patient videotapes effectively demonstrate clinical relevance. Concepts should be explained in simple, understandable language. Jargon should be avoided, as should abstract metapsychology. The most energetic and charismatic teachers, favorites among psychoanalytic candidates and psychiatric residents, will lose medical students as soon as they launch into a theoretical discussion of part objects and partial identifications. Sometimes efforts to make material understandable and relevant can turn into simplifying it and avoiding nuance, but that does not need to be the case. Complicated concepts and subtle distinctions can

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be presented as long as the instructor is clear and the material has clinical relevance. The challenge of this approach is that it forces us to think through our definitions carefully and have a clear understanding of what we are trying to convey.

Medical students tend to be exquisitely sensitive to any hint that psychoanalysts are being critical, judgmental, or blaming of patients. Much of their concern arises from their own tendency to identify themselves with patients, particularly during the first two years of medical school, as well as from their ego ideals, which often restrict their fantasies of themselves as future physicians to caretakers with infinite patience and sensitivity. Students will need to struggle with seemingly unacceptable feelings toward patients that they will inevitably experience during their training. But until they have accepted those feelings within themselves and have modified their unrealistic expectations of physicians, faculty would be well advised to avoid being unnecessarily self-revealing regarding hostile or sexual feelings toward patients. Instead, psychoanalysts should make clear their empathy for patients and their suffering when describing phenomenology and psychodynamics. For example, one teacher described an inpatient unit's staff as becoming infuriated with a passive-aggressive, somatizing patient. The lecturer's complacency with the staff's response, and with her own frustration with the patient, left the students furious with her. The same material would have been better received if the psychoanalyst had indicated that she had struggled with these angry feelings and had made clear that she did not feel that it was appropriate to act upon them. Teaching medical students sometimes requires that we spell out rules of conduct that may seem so obvious to us that we don't realize that they need to be mentioned.

STRUCTURE AND STYLE

The technical analytic concepts of timing and tact in making interpretations are particularly applicable in medical student teaching. The choices of topics should be based on a "surface-to-depth" hierarchy. Thus, for example, students should be made aware of the existence of unconscious conflicts and defenses, whereas primitive sexual and aggressive fantasies, if they are mentioned at all, should not be addressed early on. Analytic teachers must realize that students are constantly wondering how clinical and theoretical material applies to themselves. The medical student's tendency to self-diagnose whatever dis-

ease is being covered extends to the presence of personality disorders as well as less well-defined psychopathology. Students' defenses and possible vulnerability to narcissistic injury should be respected.

Attention should also be paid to the teaching environment in choosing topics and the depth at which to cover material. As a rule, the larger the group, the more emotional regression will be observed. Anxious laughter inevitably accompanies the presentation of anxiety-provoking material during large group lectures, as opposed to a more contained reception of the same material in a small seminar or in individual supervision. The seeming comfortable anonymity of a larger group appears to contribute to the immaturity of the group's common psychology. A useful approach to raise the level of maturity is to break the lecturer-audience barrier by introducing interaction into the relationship. Requesting questions is one obvious approach. Eliciting students' observations or responses to a question from the lecturer is even more effective at reducing anonymity and can be done even in large lecture halls. Classes of up to approximately twenty students can develop effective rapport and collaboration when teachers actively involve the students in clinical case problem-solving as a group.

Seemingly superficial elements of presentation can make a tremendous difference in medical student teaching. Students respond very positively to the appearance of spontaneity in faculty. Reading from a prepared text is a common presentation style at the postgraduate level, particularly among psychoanalysts. It is unacceptable for medical students, however, who will tune out a lecture that is read to them regardless of the quality of the material. Lectures can certainly be well rehearsed, but faculty should quell their performance anxiety with the realization that students will forgive a human lecturer who is stumbling over words much more readily than a robotic speaker who delivers a perfect reading. Techniques that can contribute to the perception of a relaxed and connected lecturer include moving away from the podium and around the stage, using the blackboard, and varying one's line of vision so that eye contact is periodically made with the entire auditorium or classroom. Some faculty take spontaneity and casualness to an unacceptable extreme by, for example, chewing gum while conducting a seminar or being seated while giving a lecture. The effect of such behavior is to diminish respect for the teacher and for the material.

Humor is a helpful but sometimes overused tool for connecting with a medical student audience. Gentle hu-

mor with regard to anxiety-provoking topics can be particularly effective. But, while one or two cartoon slides or relevant jokes can break the ice, a dozen or more cartoons or elaborate funny stories during one lecture might result in trivializing the seriousness with which the material is received. Similarly, popular movies can be a tempting teaching device but should be used sparingly. Putting entertainment ahead of substance should be avoided.

In addition, it is important to be aware of one's personal strengths and weaknesses as a teacher. Just as a particular phrasing of an interpretation might come naturally for one analyst and seem extremely awkward for another, the same lecture style does not work for everyone. A reserved person is only going to appear awkward if he or she tries to emulate a more charismatic and flamboyantly dramatic presentation style, but may be extremely well received when making good use of a naturally dry sense of humor.

An awareness of group dynamics is important in conducting class discussions. Efforts should be made to have all students involved. Faculty sometimes are reluctant to insist on all students' participation, not realizing that students who exclude themselves from the group frequently harbor resentment at the instructor for allowing more outspoken students to monopolize the discussion. In the spirit of encouraging full participation, faculty should guard against being dismissive or critical of any student's comments. Students should be encouraged to feel that there are no "stupid" questions. Faculty should continuously try to develop the art of identifying the wisdom in a seemingly obscure student observation.

It can sometimes be tempting to avoid engaging argumentative or otherwise difficult students by allowing them to be scapegoated by the group. Such an approach is ultimately doomed to failure, however, since it undermines the group's respect for the teacher as a mature and

fair caretaker. Potentially disruptive students should be treated respectfully and confronted individually with firm limits when necessary. Similarly, individual faculty may be tempted to be dismissive or critical of other faculty in a misdirected effort to boost their own standing. Students perceptively detect such defensive splitting and devaluation, which usually undermines the entire faculty's reputation. Faculty's feigned or genuine ignorance as to what has been presented in related areas of the curriculum is a variation on this theme of faculty competition that should be avoided as well.

OPPORTUNITIES

Psychoanalysts should welcome any opportunities to teach medical students and should not limit themselves to specifically psychoanalytic topics. General psychiatry courses and interviewing seminars offer the chance to demonstrate that psychoanalysts are skilled clinicians and sophisticated interviewers, as well as smart, funny, and relatively normal people. Furthermore, the relevance of psychoanalytic concepts to medicine as well as psychiatry can be easily conveyed in those settings. Everyday patient care issues such as noncompliance allow demonstration of basic analytic assumptions such as the existence of the unconscious and the influence of the past on the present.

Teaching medical students offers psychoanalysts the challenge of using their clinical tools of empathy and timing and a knowledge of human psychology and psychodynamics to help students be most receptive to what they have to offer. In return, psychoanalysts will be engaged by energetic, curious, and fresh minds. In addition, psychoanalysts who teach medical students will have the gratification of knowing that they have helped to develop a new generation of informed and open-minded physicians and psychiatrists, as well as future psychoanalysts.

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How to Think Like an Analyst 101

A Model for Teaching Psychotherapy to Medical Students

Deborah L. Cabaniss, M.D.

I went to medical school determined to be a family practitioner. Then, during my third-year psychiatry clerkship, I met doctors who knew more about talking to patients than any doctors I had ever met. They could anticipate what people were going to say, they talked to people about things no one else would (such as thoughts, fears, fantasies, and dreams), and it seemed to me that they could help people simply by talking to them. One teacher, sensing my interest, recommended to me that I read Charles Brenner's *Elementary Textbook of Psychoanalysis*. I read it every night until 1:00 A.M. I gradually realized that I could train myself to be like these doctors—to effect change in people not with scalpel or pill but simply by talking to them. I was sold.

Did I know that these doctors were psychoanalysts? Sort of. Did I understand anything about psychoanalytic theory? Certainly not. But the idea of the unconscious and its role in human behavior had captivated me, and that was enough. I would have time to learn the rest.

That, I think, is the essential role for psychoanalysts in medical education, and I think it is one of the most important roles psychoanalysts can play. The physician without a sense of the unconscious has difficulty understanding patients, whether the physician is a psychiatrist or an orthopedic surgeon, and only psychoanalysts and psychoanalytically informed psychiatrists can offer that sense of the unconscious to students at this formative

stage of their medical careers.

Yet analysts do not seem to want to teach medical students, for many reasons. It goes without saying that this type of teaching often goes unnoticed by groups like analytic institutes and departments of psychiatry and that it is not particularly valued. Psychoanalysts frequently feel that they are not even welcome in medical schools and that there is no role for them. The traditional teaching role for the analyst—supervision—has no place in the medical school curriculum. But even more, I think that psychoanalysts fear that they will take the time off from their offices, losing income and earning no wage, to travel to the medical schools only to be met with blank looks, overt hostility, or, worse yet, disinterest. However, in five years of teaching third-year medical students, week after week, that has almost never been my experience. And my task is to teach a weekly seminar on a topic of which medical students frequently have no experience and which they often think is irrelevant to their medical training: psychotherapy.

My goal is simple. I want to give my students some idea of what psychoanalytically trained psychiatrists do in their offices and, in doing so, interest them in the unconscious and the power of psychoanalysis and psychoanalytically oriented psychotherapy. Every five weeks I get a new group of approximately eight medical students with whom I meet weekly for a one-hour seminar. Some groups have some students who want to become psychiatrists. Some groups consist solely of future urologists. In my experience, the future urologists are often as interested as the future psychiatrists. Are they interested the minute they walk in the door? Not usually. Are they often

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hostile to psychotherapy and psychoanalysis in general? You bet. But psychoanalysts should be able to handle resistance, and here is the approach that has worked for me.

STARTING POINTS

I start with the premise that you can talk about anything with medical students as long as you do not make them anxious and give them some reason to think that there is a point to learning it. It is more of a process than a content issue. In order to do this, I first assume that it is going to be the unusual student who either knows anything about psychoanalysis and psychotherapy or is eager to learn much about it. Second, I appreciate that learning about the unconscious can be incredibly anxiety-provoking. These students are in the middle of one of the most stressful, regressive, potentially symptom-producing experiences of their lives, and they are at risk of becoming more alienated from the topic if it makes them anxious. Third, I recognize that these students, like the rest of the population, have spent their lives being inundated by all kinds of ideas about psychoanalysis and psychotherapy, from movies they have seen or stories their friends have heard about crazy psychiatrists. It is likely that they come into their psychiatry clerkships with more preconceived notions about psychiatry and psychoanalysis than about any other aspect of medicine. And those notions often are not positive. And lastly, I realize that they are incredibly busy and overtired, so I do not have them read anything. After all, I do not expect them to actually learn anything about the topic. I only want them to try to think like analysts. My feeling is that once someone has started to think like an analyst, it is so interesting that there is no need to think any other way again.

My curriculum is simple. In my first hour with the students, I tell them that there is no reading but that the tradeoff is that they must come and that they must be on time. I tell them that the goal of the course is to help them understand what goes on during a psychotherapy session in an outpatient psychiatrist's office, but that this is a very difficult thing to do since they cannot come with me to watch me work the way they could go with a surgeon to watch operations. To this end, I tell them that what I am going to be doing is reading them process notes from sessions that I have conducted with my patients to try to give them a glimpse of what I do. I then tell them something about myself, including the part about my not knowing that I wanted to be a psychiatrist, let alone a

psychoanalyst, until I was sitting precisely where they are sitting now.

Then I ask them to introduce themselves and to give me one line about what they think about psychotherapy. My manifest reason for doing this is to gauge the interest level of a particular group; however, my real reason for doing this is that it lets everyone say what they otherwise would have kept in and talked about as they walked away from the class. Things like, "This is bullshit—why do we have to learn about this in medical school?" As long as I tell them that I want to hear it, as long as I laugh with them, let them identify with my own fairly negative thoughts about psychoanalysis as a junior medical student, give them examples of things that medical students sometimes say, and tell them that I absolutely do not want to hear about their own therapy experiences, they *talk*. They talk, they laugh, and they say the funniest things. Things like, "Everything I know about psychotherapy I learned from Bob Newhart. And why did he invite his patients to his house?" And, "I think that psychotherapy is elitist and only for rich white people." And, "Do they still do that?"

In my experience, if these things are not said, you could stand on your head and tap dance and no one would pay much attention. The more negative their comments, the more positive feedback I give them. Great, I say, this is great, there is no reason for you to know much more about this topic than you do. And I do address certain concerns like the length of treatment and the financial aspects of treatment in as straightforward and nondefensive way as I can.

THE SEMINAR: MODELING PSYCHOTHERAPY

I spend the rest of the first session teaching about the different types of psychotherapy and the indications for each, with an emphasis on ego function. My intention is to demonstrate that the decision to recommend a psychoanalytically oriented psychotherapy or a psychoanalysis is a very deliberate one and that this type of treatment is only appropriate for a specific group of patients who have particular types of difficulties and adequate ego function to tolerate the treatment. I think that the students find this very reassuring, since I am modeling that psychoanalysts, like the other doctors they have met, make careful diagnoses and prescribe specific treatments. Then, psychotherapy ceases to be something fuzzy and inchoate; it is no longer just counseling or talk-

ing to people, and it gains in stature as it takes on specificity.

The rest of the seminar is spent in reading process notes from psychotherapy sessions—and, for the particularly interested classes, psychoanalytic sessions. I choose my sessions carefully, opting for those that are somewhat self-contained. These are usually sessions in which something “happens,” such as a session in which the patient realizes something by virtue of the process. I always use at least one session with a dream and one or two sessions that illustrate new understanding through interpretation of the transference. I do not hesitate to use words like *transference* and *free association* as long as I define them carefully and demonstrate that there is no other way to get to unconscious material.

I present the patient briefly, describing the patient as he or she originally presented to me. The chief complaints I use are typical ones such as “I’m feeling sad but I don’t know why” and “I can’t seem to have a long-term relationship.” I ask the students to think about what might be leading to the problem, insisting that they first think about possible organic problems, substance abuse, and other major Axis I disorders. Again, this models that the psychiatrist/psychoanalyst is grounded in biological psychiatry, that he or she would not inappropriately treat someone only with psychotherapy who also needed medication or some other type of treatment, and that analytic treatment may be combined with other treatment modalities. Once the diagnosis is made, we talk about the indications for psychotherapy and whether a psychoanalytic approach is appropriate.

We then proceed with the sessions. I read and stop and read and stop, asking the students what they might say before I tell them what I have said. Again and again these bright students are, by the end of the seminar, able to produce terrific interpretations. Their eyes widen as they see how the patient who had no idea why he was

sad or who kept repeating a maladaptive behavior begins to realize that some fear or fantasy was guiding his behavior. I frequently use a session in which an obsessional patient who has tremendous difficulty with intimacy fears she has offended me but doesn’t know why. I let them delight in catching her parapraxes as she trips over herself insisting that she is not in fact angry with me and continues to inadvertently insult me. By the end of the session, the students are laughing and insisting: “But she is angry, she *IS*!” And in fact, by session’s end, the patient also has a glimmer of her own anger. The students discover it for themselves, and I praise them and tell them how much they know that they didn’t even know they knew. And it’s true!

WHY TEACH MEDICAL STUDENTS ABOUT PSYCHOTHERAPY?

Not all of these students will become psychiatrists or psychoanalysts; in fact, few will. But they will all be physicians who will have to deal with their patients’ behavior—such as noncompliance and negative transferences. I give them plenty of examples of the ways in which understanding such concepts as transference will aid them whether they become surgeons, pediatricians, or psychiatrists. And, of course, they are the referral base of the future—the clinicians who, if well informed, will be able to recommend this important treatment to their patients who need it. I am a voluntary faculty member, so teaching medical students means taking time away from my private office hours. But I feel that in addition to teaching residents and analytic candidates, it is my responsibility to offer these medical students my expertise, so that we can train more psychologically minded physicians, earn the respect of future clinicians, and maybe even recruit one or two. And the great part is that it is one of the most fun and rewarding things I do.

A Psychoanalyst in a Medical School's Student Health Psychiatric Service

Burton Lerner, M.D.

Psychoanalysis, a general psychology, was initially shepherded by medicine and for a period of time found an important place both in medicine and in the culture. My development as an analyst began within this milieu. We are all aware that the situation has changed: the place of psychoanalysis in medicine has diminished, and Freud-bashing continues.

Then why do I say this is in many ways an ideal time for a psychoanalyst to be situated within a medical school–medical center? Because psychoanalysis has always been concerned with a broader frame of reference than that of the treatment of symptoms that brought the first patients to its clinicians' doors. Psychoanalysis is a general developmental psychology, especially focused on the formative stages and the ways in which these stages are expressed and repeated throughout the life span.^{1,2}

My career, professional identity, and practice as a psychoanalyst have been intimately linked to my work in the Student Health Service at the Columbia University Health Sciences Campus. As director of the Student Health Psychiatric Service, I have been involved in developing, shaping, and running the program and in delivering direct clinical service to our student patients as well as supervising the clinical work of our staff.

My convictions about the power of psychoanalytic insights have guided me in both my administrative and clinical activities. The opportunity to see evidence of the value and validity of applied analytic concepts in this setting has strengthened my identity as a psychoanalyst and has provided a most fundamental gratification for me throughout my career.

POPULATION AND STRUCTURE OF THE SERVICE

The nature of the student population is an important factor in the work. Medical students are at a nodal point in their own development.³ As young adults, they are involved in learning how to take care of their patients. At the same time, many are uncertain and conflicted about their own capacity to take care of themselves. Taking on what is in effect parental responsibility for their patients is out of phase with what they have achieved in their own development.⁴ The experience of entering into the world of illness, frailty, abandonment, and death renews the students' contact with their OWN childhood catastrophes and their limited capacity to master these issues.

Therefore, students are threatened with regression, which obstructs their adaptive capacities. On the other hand, they are also provided opportunities to confront earlier developmental positions with a now stronger ego, resulting in more durable and adequate solutions to childhood predicaments. For us, there is the opportunity to help our students deal not only with the symptoms of conflict, so that they *feel* better, but also with the content of conflict, so they can *get* better.

I have found the psychoanalytic model of development to be a valuable tool in understanding, conceptualizing, and treating the developmental conflicts that fuel the student patient's distress. Our students are at the cutting edge of learning about technological interventions

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that improve human life. But they often share the cultural attitudes that, in Jonathan Lear's words, "hope to ignore complexities, depth and darkness of human life."⁵ At the same time, the specific nature of the medical students' experiences necessitates exploration of these often ward-off areas of concern. A psychoanalytic perspective is a powerful tool in this therapeutic investigation.

I have tried to structure the Student Health Psychiatric Service so that it facilitates the clinician's opportunity to help patients understand what is going on inside themselves, to make it possible for them to become better observers of themselves, to enable them to think about how they think. Perhaps the most fundamental condition necessary for this undertaking is the requirement for the confidentiality of treatment. In the small and tight medical school community, with frequent observations and evaluations, student concern about exposure and loss of confidentiality is very high.⁶

Human development takes place through small increments over time. The clinical structure affords the opportunity for the continuity of treatment during the entire four-year period of the individual's tenure as a student. The depth of immersion, as determined by the frequency of visits, can be shaped so as to provide the opportunity for intensive psychotherapy, including psychoanalysis.

EDUCATING, ADVISING, AND CONSULTING

The dual functions of administrator and clinician provide opportunities to interact with other physicians and nurses, not only in the Student Health Service but also in the larger arena of the medical school. I have served as advisor and consultant to individuals within the faculty and administration on a range of issues. These contacts provide an opportunity to establish a network within which to approach administrative and clinical problems from an analytically informed perspective.

One example focused on the question of patient responsibility for missed sessions. A student had complained to the director of the Student Health Service about being charged for a missed session. The student's view that emerged in a discussion with him was that charging for a missed visit was unphysicianly. I now had an opportunity to inform a nonanalyst, the student, about how we might view this matter differently. For me, the manner in which an individual thinks about the responsibility for time and money in an object relationship is

often a sensitive and good indicator of the level of an individual's development and therefore provides important data in doing psychotherapy.

Another example is teaching aspects of development. As clinicians informed by a psychoanalytic developmental psychology, we understand the close link between how one is taken care of and how one learns to take care of oneself and, finally, others. Such identifications with teachers and clinicians in their caretaking functions provide an important basis for development, and they are a critical aspect of the medical student's experience in the process of becoming a physician. This conceptualization has been an important thread in discussions I have had with the dean of students over many years, one that has contributed to her thinking about the process of becoming a physician.

As director of the Student Health Psychiatric Service and as a clinician with a psychoanalytic point of view, I have served as consultant on grant applications and have participated in interdisciplinary conferences. My professional network has extended to the Mental Health Service on the main university campus. The opportunity to provide analytically oriented supervision to staff members and to participate as discussant in conferences has been a very important contributing factor supporting my identity as an analyst. As I will note below, it also provides opportunities for practice building. And the network extends further, to the world of student health services in the American College Health Association.

I cannot express too strongly the value of the network that begins with the Student Health Service, extends to the medical school, to other divisions on the Health Science Campus, and to the larger university and beyond. As teacher, consultant, and clinician, I get tremendous gratification from sharing my conviction about the power of psychoanalytic ideas in therapy, teaching, curriculum building, parenting, and just plain living.

At the Health Sciences Campus, the role of teacher-consultant-supervisor can find focused expression. In my hiring I have established a community of clinicians, often analytic candidates or graduate analysts, within which treatment of patients rests on a shared respect for the value of a psychoanalytic frame of reference. Collaborative research is possible in this setting. For example, a study is currently being conducted on the use of psychoactive medication on our service. In this study of patterns of utilization of psychoactive medication, we look at such issues as transference, resistance, and the therapeutic alliance.

CLINICAL PRACTICE

Perhaps the most critical experience supportive of my personal growth and development as an analyst is in my experience as clinician. Treatment available in the Student Health Psychiatric Service is subject to time constraints, which are modified when indications for more extensive psychotherapy are present. Clinical services include short-term and longer term dynamic therapy, which can be extended and deepened so that intensive analytic psychotherapy, even on occasion formal analysis, has been conducted as the treatment of choice. It is not uncommon to find that when treatment continues across the four-year period of medical school, a process of conversion to an analytic mode is part of the work.

Analysis is essentially a developmental psychology where basic concepts contribute to the diagnosis and treatment of our students. Because the treatment can be maintained during a significant portion of the medical school experience, it supports and enhances the maintenance of ego functions, basic trust, object constancy, and stable identifications.

An important aspect of analytically informed therapy is the development of student awareness of motivational conflict. As Kris noted, psychoanalysis is, after all, nothing but human behavior considered from the viewpoint of conflict. The clinical opportunities in brief and longer term therapy in the Student Health Psychiatric Service offer the chance to use these analytic tools.

PRIVATE PRACTICE

A critical factor in maintaining my identity as an analyst resides in the opportunity to practice analysis—in my private office. I feel that all the other experiences supportive of my career and professional identity rest importantly on the opportunity to practice analysis.

So what are the practice implications? Ethical considerations preclude students from entering my private practice while enrolled at school. But it isn't unusual for referrals to arise from recommendations by students, sometimes during their own treatment, or sometimes after—even years after. It is also not unusual for former student patients, now house officers or attending physicians, to return for additional therapy. And it is not unusual for the process to lead to psychoanalysis.

All the other contacts in the network of connections within the medical school community become the source of referrals from time to time. These opportunities also contribute to my ability to refer patients to colleagues. At any particular moment a significant segment of my private practice is directly or indirectly linked to the complex network established in the Student Health Service setting.

In all of these ways, I have enjoyed my experiences in medical student mental health and feel the different aspects of this setting are synergistic and helpful to my patients, to the school, and to me as an analyst.

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Teaching Psychodynamic Psychiatry to Students on General Medical Rotations

Miriam Tasini, M.D.

Medical students' and physicians' training is oriented toward rapid retrieval of information and the development of those clinical skills needed to make immediate interventions. Medical students' education in the area of psychiatry is usually limited to a six- to eight-week rotation, where they are most often exposed to a view of mental function as a simple epiphenomenon of the activity of neurotransmitters.

To obtain a detailed psychosocial history that might give medical students some understanding of emotional reactions to illness is not part of their educational process. The biopsychosocial approach is given only lip service. A detailed psychosocial history is not regarded as important or necessary to understanding the illness of a person. Providing a meaningful experience of learning psychodynamic principles requires understanding the attitudes with which the medical students and residents come to their psychiatric rotation.

In this paper I will describe a method that has proven successful in integrating psychoanalytic concepts into the psychiatric education of medical students and internal medicine trainees. The method is evaluation of a medical case by the use of a simple psychoanalytic tripartite structural model and its resulting psychodynamics. The description of these pedagogic tools may appear simplistic to the psychologically sophisticated reader. Psychologically sophisticated minds, however, are not the intended audience of the method; students and medical residents are. In

my experience, these methods have successfully started a process that allows the students to view mental functioning in a new, psychodynamic light.

INTRODUCING KEY CONCEPTS

Clinical material and visual aids (some of which are reproduced as Figures 1–10) are the means by which the following concepts are introduced to the students:

- Existence of a structure of the mind.
- Components of that structure of the mind.
- Unconscious mentation.
- Individual variations.
- Developmental influences on these variations.
- Clinical evaluation of these variables.
- Effects on treatment decisions and outcome.

The tripartite model of ego, id, and superego, although questioned in psychoanalytic circles in recent years,¹ remains highly useful in this setting. It allows development of a framework in which mental illness can be seen as analogous to physical illness.

An introduction provides historical background about Freud, his postulation of a lawful mind, and the existence of unconscious mental components.² Freud began his career as a neurobiologist, citing Helmholtz as one of the major influences in his intellectual development.³ Present-day students can still relate to Charcot's ideas about conversion and grasp Freud's realization that these may be reversible conditions that are attributable to some mechanism other than a degenerative process. It is then fruitful to introduce the students to the hypothesis of unconscious mentation as an aid to explaining and

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filling the gaps in the patient's subjectively reported observations.

This elementary psychoanalytic model of the mind⁴ (with modifications) is used as the basis of understanding of unconscious and conscious mental functions and the relationships between them (Figure 1).

This model of the mind, shaped for the students we are addressing, is based on the idea that humans are born with biological needs that initially must be met by a caretaker if the infant is to survive. These biological needs, sometimes called *instinctual drives* or simply *drives*, exert pressure for immediate satisfaction. Parental and environmental capacities and deliberate restrictions prohibit the satisfaction of these needs. Uncontrolled expression of needs a little later in development leads to disapproval and loss of parental love, resulting in painful experiences. These experiences are eventually integrated into the structure of the mind as conscience, designated by Freud as *superego*, which develops to accommodate to reality as well as to social prohibitions. Humans develop conscious and unconscious strategies, which are called *defenses*, to deal with conflict between needs, the limitations of realities, and the impositions of authority. These strategies reside within the structure of the mind that we refer to as *ego*. It is essential to convey that the ego is not a concrete structure, but a theoretical concept that allows an understanding of many spectra of behavior. A useful analogy is to describe ego activity as like that of a traffic controller at a busy airport terminal who evaluates departure priorities according to weather condition, traffic congestion, and safety. First and foremost, the ego has to judge reality

so as to balance the need for gratification against the need for delay of gratification of basic wishes (Figures 2 and 3). It is essential to demonstrate that these conceptual ideas are applicable to the understanding of clinical problems.

It is usually necessary to repeat for psychoanalytic audiences (or readers) that the purpose of this pedagogic method is not to teach psychoanalytic theory to students of psychoanalysis, but rather to demonstrate to medical students and medical residents that their ability to take proper physicianly care of their patients is enhanced by their having a framework to understand the developmental and emotional personality factors that influence the onset, course, and outcome of illness. Just as in other applications of psychoanalytic understanding outside of the psychoanalytic situation proper, we are not trying to teach psychoanalysis, but trying to help other clinicians to do their work in a better and more satisfying way.

We can now consider case material, in which the gradations and variations of these forces can be seen to influence the clinical picture. The cases are sometimes presented by the student and sometimes demonstrated by myself using projected slides (some of which are reproduced as figures in this article). Case presentations are selected to allow the exploration of underlying psychopathology and elucidation of the pertinent mental functions.

The case material that follows represents a common clinical problem that can be an outcome of either non-compliance and impulsiveness or of strict morality and inflexibility: both cases illustrate failure of the ego to balance gratification, reality, and moral prohibitions in an adaptive manner.

A 47-year-old man was brought into the hospital with ascites secondary to liver failure. He had been abusing alcohol for 20 years and had never complied with any treatment for this difficulty. He was aware of the life-threatening condition and

FIGURE 1. Visual aid introducing concepts of conscious and unconscious mental functions.

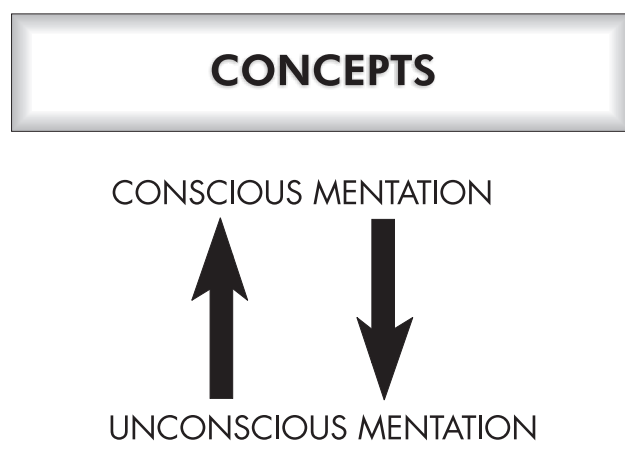
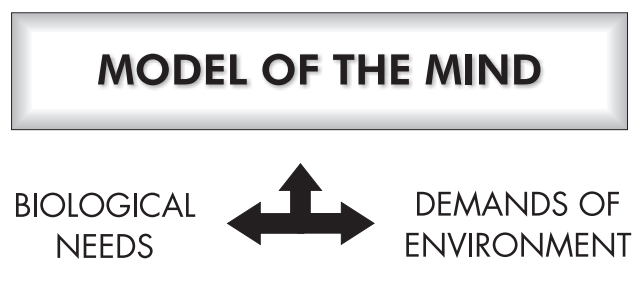


FIGURE 2. Visual aid: model of the mind.



initially agreed to undergo a detoxification. He left the hospital against medical advice 4 days later and continued to drink.

A 35-year-old man was brought to the emergency room after he was found barely arousable at the gasoline station that he had owned for the past 6 months. He and his wife had invested all their savings to purchase the business. He had been working 7 days a week. His anxiety about failure continued and became so intolerable that he was unable to sleep and decided to take some "sleeping medications."

The students easily understand the juxtaposition of the impulsive, self-destructive patient and the overly diligent, depressive patient. The contrast leads to discussion of the problems that they as physicians might encounter in treating the self-destructive patient. This allows introduction of the transference/countertransference paradigm (although these terms are never used) through the observation that it is often easier to care for patients who love us, admire us, and resemble us than it is to deal with patients who are less similar to us and are more demanding of immediate satisfaction.

The students are asked for examples of patients whom they find difficult to tolerate. This arouses anxiety, but the students also rapidly develop some sense of a pattern to the difficulty, and the attendant revelation may arouse a degree of interest in self-exploration. Bringing into conjunction the rather straightforward concepts of psychopathology and personal reactions to it may help the students alter their views of patients as bad or hateful and allow a more clinically useful (empathic) approach.⁵ Modification of the physician's sense of being in a struggle with a patient, so that the patient is now seen as an impaired person with limited resources for dealing with

the stresses of illness, does bring some immediate reward in the experience of administering clinical care.

Once the stage is set in this way, it becomes possible to begin to explore the spectrum of human psychopathologies and gain a sense of their complicated etiologies. The student can begin to realize that there are developmental/genetic contributions to symptoms as well as biological/genetic predispositions. The goal is to convey to the students that although biological endowment provides the substrate for mental development, environmental influences, mostly in early childhood but also throughout a lifetime, have roles in producing a wide spectrum of behaviors (Figure 4).

MAKING THE CASE FOR PSYCHOSOCIAL HISTORY TAKING

Most students have had some exposure to child development, but they are not always aware to what extent the resiliency of the human mind is tied to experiences in early childhood. A brief discussion about the nature of parent-child relationships can convey the idea that parents are seen as omnipotent, having the power to give and withdraw love, to punish, or to reward. A child soon learns to adapt to parents' expectations and uses the parent as a model. Having stable, predictable, available, and dependable parents in early childhood allows development of the ability to balance restraint against immediate satisfaction, whereas exposure to a chaotic environment during early childhood interferes with the development of a stable and resilient personality.

The concept that life experience matters because it shapes reactions to current life situations can then be

FIGURE 3. Visual aid: concepts.

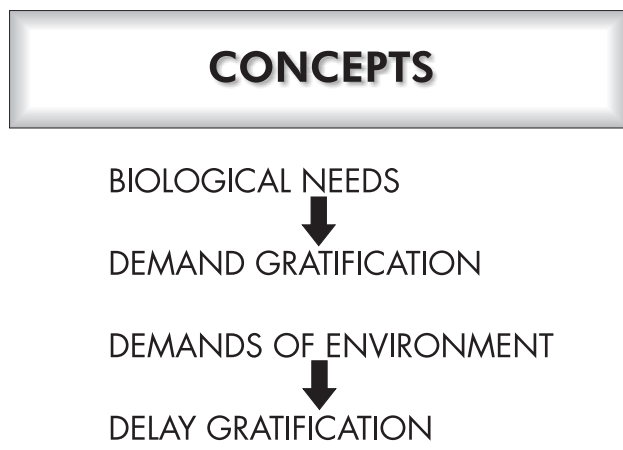
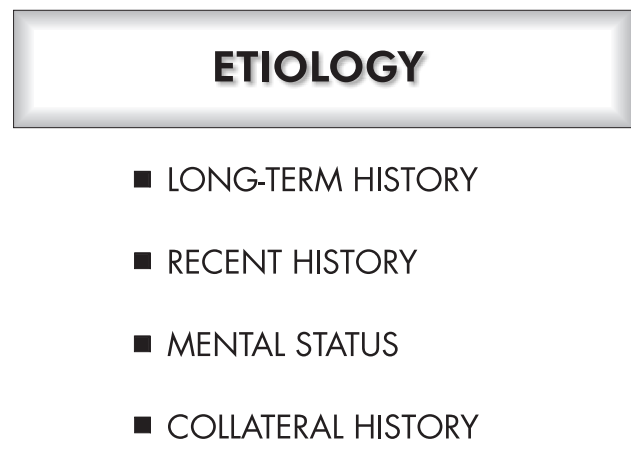


FIGURE 4. Visual aid: etiology.



used to introduce the necessity for longitudinal history taking as an element in diagnosis and the formulation of treatment plans. We return to case illustrations at this point.

A psychiatrist was called to evaluate two 50-year-old men who were agitated and exhibiting evidence of visual hallucinations. Both were intoxicated on admission and have been given the diagnosis of delirium tremens.

I then ask the students, "What else do we need to know?"

Patient A had a history of alcohol abuse for many years and had failed numerous treatment trials. Life history revealed that his mother died when he was three. He was raised in foster homes. He never finished high school. He had had many jobs, all for brief periods of time. He had been married twice but had lost contact with his three children. He lives alone (Figure 5).

The wife of Patient B reported that he lost a job he had held for many years when the company that employed him went out of business. He became despondent because he was unable to find employment. His wife supported the fam-

FIGURE 5. Visual aid: history.

HISTORY OF PATIENT A

- YOUNGEST OF SIX
 - MOTHER DIED WHEN HE WAS THREE
 - RAISED IN FOSTER HOMES
 - DROPPED OUT OF HIGH SCHOOL
 - TWO FAILED MARRIAGES
 - THREE CHILDREN
 - NO CONTACT WITH FAMILY
 - TRANSIENT RELATIONSHIPS
 - WORKS SPORADICALLY
 - HAS HAD MANY JOBS
-

ily financially. He started drinking. He was born in a small town where his parents owned a hardware store. He graduated from high school and married his high school sweetheart. They raised three children and had never been in financial difficulty in the past (Figure 6).

Patient A signed out of the hospital against medical advice. Patient B responded to the offer of detoxification and a therapy program. He has been sober for the past 2 years.

As the cases are presented, it becomes clear that although these patients had similar symptoms, their illnesses, treatment, and prognosis were not the same. The student has to learn to understand that the only way one can adequately diagnose, predict, and treat is by including a longitudinal past history in the evaluation.

The concept of ego strength is useful in implementing the historical information obtained. There is no definitive test to measure ego strength; however, a very brief structured history provides valuable information for making such an estimate. It is called an "emergency room five-minute five-point ego function evaluation." The five points are 1) relationship with family of origin, 2) graduation from high school, 3) length of friendships, 4) stability of employment, and 5) present relationships. It needs to be repeatedly clarified, in addition, that there is a wide spectrum of variables and that understanding is essential in patient care management.

FIGURE 6. Visual aid: history.

HISTORY OF PATIENT B

- HISTORY OF ALCOHOL USE FOR ONE YEAR
 - NO PRIOR HOSPITALIZATIONS
 - NO HISTORY OF PSYCHIATRIC CARE
 - OLDEST OF THREE
 - MOTHER A PART-TIME SCHOOL TEACHER
 - FATHER OWNED A HARDWARE STORE
 - FINISHED HIGH SCHOOL
-

ILLUSTRATING APPLICATIONS TO DIAGNOSIS AND TREATMENT

Emphasis in the pedagogic method can now be shifted to the provision of quality medical care, using the now demonstrated value of obtaining a longitudinal history. The point made is that quality clinical care requires a broad approach to diagnosis and treatment. Careful recognition of symptoms, which was the basis for the development of the DSM system, is important as an initial, reliable diagnostic approach. However, diagnosis cannot be based solely on symptoms in any medical condition, including mental illness. It is helpful to demonstrate this by a very specific analogy to a medical condition; for example, a low hematocrit indicates a symptom called anemia, but one does not usually give a transfusion without trying to determine what might be the cause of the blood loss.

Presentation of the following three case examples further highlights the problems entailed in making a diagnosis on the basis of a symptom checklist.

A psychiatrist was called to see (at different times) three different men who had required an amputation shortly after admission to the hospital 2 weeks earlier. All three presented with symptoms of anorexia, psychomotor retardation, insomnia, hopelessness, and preoccupation with thoughts about death. Thus, all three meet the DSM-IV criteria for major depressive disorder (Figure 7). Unfortunately, when asked about treatment at this juncture, most students come up with a series of psychopharmacologic agents. Additional data reveal that two of the men have had a trial of antidepressants

FIGURE 7. Visual aid: differential diagnosis. S/P=status post.

DIFFERENTIAL DIAGNOSIS

- 54-YEAR-OLD MAN S/P AMPUTATION
ANOREXIA, INSOMNIA, HOPELESSNESS
- 54-YEAR-OLD MAN S/P AMPUTATION
FATIGUE, ANOREXIA, HOPELESSNESS
- 54-YEAR-OLD MAN S/P AMPUTATION
FATIGUE, ANOREXIA, HOPELESSNESS,
WORTHLESSNESS

without any symptom relief. The different histories obtained provide a more accurate diagnostic picture and possible alternative treatment strategies:

Patient C was in a vehicular accident, was injured, lost his leg, and his wife was killed (Figure 8). Patient D carries a diagnosis of sarcoma that required the amputation (Figure 9). Patient E is a diabetic who has had numerous depressive episodes in the past and does not comply with the treatment of his diabetes (Figure 10). Patient C, the accident victim, is a mechanic who coached Little League on weekends; Patient D is a physician who is aware that the poorly differentiated tumor is unlikely to respond to treatment.

The use of case material from hospitalized, medically ill patients is of special interest to medical students, most of whom will not have careers in psychiatry. Understanding that grief reactions may occur not only as result of a loss of a loved one, but also as a response to other losses, is crucial. Medically ill patients suffer loss of health, loss of ability to function, loss of body parts, loss of sexual enjoyment. All of that may lead to the development of symptoms of depression. Treatment with antidepressant drugs without psychotherapy may be ineffective in such cases.

The purpose of the educational process described in this presentation is to convey the idea that responses to treatment and management of illness in adults are closely correlated with preexisting ego strength. Throughout the life cycle, ego adaptation capacity and personality affect the reactions to illness. Illness affects the nature of emo-

FIGURE 8. Visual aid: history.

HISTORY OF PATIENT C

- VEHICULAR ACCIDENT 1 MONTH AGO
- WIFE KILLED
- PATIENT LOST LEG
- DIAGNOSIS:
 - POSTTRAUMATIC STRESS DISORDER
 - GRIEF REACTION

FIGURE 9. Visual aid: history.

HISTORY OF PATIENT D

- PATIENT TOLD HE HAS METASTASIS
- EXPECTS TO DIE IN 6 MONTHS
- DIAGNOSIS:
 - ADJUSTMENT REACTION

tional and mental responses. Diabetes is an example of a disease that may arise at any time from childhood to senescence, leading to physical as well as mental alterations of the affected individuals. Childhood onset leads to dependence on parents and health care providers that may prevent normal maturation and separation from the family. The recurrent episodes of illness and dietary restrictions may lead toward a tendency to somatization and hypochondriasis. Onset in adolescence interferes with normal social activities, causes body image distortions, and may interfere with normal sexual development. In adulthood, dietary restrictions and medical treatments require constant vigilance. At all times, anticipation of development of life-threatening conditions produces anxiety. The individual variation in defense mechanisms results in a wide spectrum of reaction to this as well as any other chronic illness.

SUMMARY

This article describes certain methods of teaching, intended for the instruction of medical students and medical residents. The material is based on psychoanalytic principles. The purpose is to provide a conceptual and,

FIGURE 10. Visual aid: history.

HISTORY OF PATIENT E

- DIABETES
- 3 SUICIDE ATTEMPTS IN THE PAST
- MULTIPLE PSYCHIATRIC TREATMENTS
- DIAGNOSIS:
 - DEPRESSION

in some degree, affective framework to enable medical students to

1. Learn a simplified model of the mind in order to understand the role of the mind in determining the reaction of patients to their illnesses and to their physicians.
2. Identify a psychiatric disorder.
3. Differentiate normal reactions to medical illness from psychiatric illnesses.
4. Accept the existence of a vast scope of human behavior beyond the known roles of neurotransmitters.

The method is based on a simplified psychoanalytic model of the mind, centered around the concept of ego strength. As such, methodologically it is an example of applied psychoanalysis.

There are other teaching methods to accomplish the goals of psychodynamics teaching. The approach illustrated here is only one, but it illustrates general principles that may be useful in designing from our method.

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The Psychoanalyst in the Academic Community

Steven T. Levy, M.D.

The relationship between psychoanalysis and medical academia, while generally amicable and cordial, has always had what one might call an edge. Controversy and competition are routine parts of both science and the academy and are to be expected. Nonetheless, there is also affection; it is merely a matter of seeing and feeling it. We analysts know about the binding quality of aggression within relationships, and we should recognize it in the sometimes testy nature of our ongoing interactions with adjacent disciplines, organizations, and colleagues.

A PSYCHOANALYTIC PERSPECTIVE WITHIN THE ACADEMY

What qualities must an analyst possess intellectually and characterologically in order to live and thrive within the often contentious and competitive world of medical academia?

1. The analyst must have a deep conviction about certain points relative to both psychoanalysis and medicine:
 - Our understanding of human beings brings with it an obligation to the science and practice of medicine. This in-depth knowledge of human beings, which analysts possess to a greater degree than members of most scientific disciplines, constitutes a *basic science* of the relational aspects of healing, of

human response to illness, pain, and suffering, and of numerous psychiatric disorders. It is important in this regard to define “basic” as concerned with what is underlying and integral, as much as with the surface and the microparticular.

- Our obligation to medicine is also a by-product of our many decades of participating in and benefiting from the riches of American academic medical institutions, especially departments of psychiatry. Although psychoanalysis no longer plays the leading role in academic psychiatry that it once did, any wholesale abandonment of psychiatry threatens to impoverish the latter as well as cut psychoanalysis off from influence on established modes of care of the mentally ill and from the next generation of psychiatric practitioners.
 - This obligation to medicine is the opposite of our current preoccupation with analytic case finding, which is more than a little self-serving and does a disservice to our profession and science. Psychoanalysis as a general psychology is relevant to medicine and medical education beyond issues concerning analyzable patients.
 - Our identities as analysts and as physicians are not contradictory. Nor does being an analyst-physician and an analyst-psychiatrist promote psychoanalysis as a subspecialty rather than as an independent discipline.
2. Psychoanalysts should never forget that resistance to dynamic ideas is not personal, however personally it may be manifested in any given instance. There should be a connection between an analyst’s capacities for understanding resistance (especially in its

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aggressive and belittling manifestations) in the analytic setting and in institutional manifestations emanating from deans, department chairs, and nonanalytic colleagues.

3. Understanding group and institutional dynamics is pleasurable and interesting and can actually be one of the work rewards for analysts within psychiatric and other medical settings. Appreciating this aspect of the work is perhaps more problematic for analysts who are steeped in private practice with single individuals. We need more rigorous training of all analysts in group and organizational dynamics, and such training might help with some of our own intraprofessional problems as well.
4. Analysts have protean interests that may include skills of great value to medical institutions. For example, analysts can be helpful to such institutions by assisting in crisis management; providing consultative expertise; helping in delicate, contentious negotiations; informing small and large group process; assisting institutional planning; providing dynamic insight into intergenerational succession of power and its problems; or maintaining awareness of abuse issues, ethics concerns, or problems with aging and otherwise impaired professionals. Whether or not one regards such work as a use of genuine analytic knowledge is a matter of attitude as much as of substance, although it is often denigrated by some analysts as nonanalytic.
5. Analysts must possess a peculiar combination of pride and humility in order to work successfully in academic medical settings. Historically, we have been better at the former than at the latter. We must always remember that we do not hold a patent on concern for patients and that despite our area of expertise we cannot be contemptuous of our psychiatric and other medical colleagues whose interactions with patients are of a different sort. At the same time, we must be "in their faces" about their limitations as well as our own. For example, we have much to offer in relation to medicine's reliance on "potions." Problems with compliance issues, placebo ("suggestive") effects, and the presumed magical effects of medications, as well as their imbeddedness in the doctor-patient relationship, are all areas where our expertise can be of value to our physician colleagues.

Psychoanalysis can also contribute to understanding the threat from for-profit medicine and managed care to

the personal satisfaction and integrity necessary for a physician's professional and personal well-being. Likewise, the impact of the billion-dollar pharmaceutical industry on the humanistic qualities of medical practice as well as on academic freedom and values is a subject to which analysts should address themselves in alliance with the medical academic community. It is important also to be aware of our limitations, which include our envy of technology and modern bioscience (which is why analysts don't show slides), our irrational negativity about data-based research, and our attitude about the limited effectiveness of many of our clinical interventions.

ENGAGEMENT

Analysts must learn to be "out there," available for dialogue, confrontation, and collaboration. This is difficult for many analysts who are used to a more private and subdued type of professional activity. We must overcome negative attitudes about drama, hyperbole, and self-revelation in order to be effective within the academic community.

Analysts must learn to appreciate that our own envy and insecurity are often manifested as aloofness and grandiosity in relation to medical academia. We are well aware that our place within the scientific community is in no way assured. Nonetheless, this is not a good reason to denigrate our own vital contribution to the training of physicians and other medical academic activities.

Many analysts shrink from this environment because of a too-narrow view of what constitutes scholarship within an academic setting. There are opportunities for scholarship in medicine beyond bench research. These include the writing of textbooks, educational experimentation, novel curriculum development, innovative evaluation methodology, and the development of new and better teaching and learning techniques, in addition to writing about clinical work.

Analysts can also make important organizational contributions to medical academia. Participation on admissions committees, search committees, harassment committees, ethics programs, clinical interviewing courses, and in advisory roles are all possible for psychoanalysts interested in making a contribution to academic medicine.

A BROADER VIEW

Many of these possibilities point to a question regarding the nature of psychoanalytic institutes: whether

they should emphasize practitioner training (limiting the scope of institute curricula) or broader educational goals (introducing multiple tasks for a variety of career paths within psychoanalysis). The trend toward broader involvement is evident in debates about the extent to which “applied” psychoanalysis is a core subject or a peripheral one. It is worth remembering in this regard that Freud had large plans for psychoanalysis within

society and was cautious about an overemphasis on psychoanalytic therapeutics. Current circumstances bear out his foresight. We would be wise as a profession and as a discipline to not limit ourselves to those arenas that, while immediately congenial and economically rewarding, deprive psychoanalysis and medical academia of many things that each has to offer the other.

Emotional Control Theory and the Concept of Defense

A Teaching Document

Mardi Horowitz, M.D.
Hansjoerg Znoj, Ph.D.

Defensiveness in intrapsychic and interpersonal activities is a generally accepted concept among psychodynamic theorists, but a theoretically grounded classification of emotional control processes is needed. As a result of intensive case-by-case clinical and empirical studies, such a system was assembled. The system is organized by three major categories of processes that can regulate emotions. These are sets of mental operations that control 1) content of thought and communications, 2) form of thought and communications, and 3) person schemas that organize beliefs and interpersonal expressions. Each category of defensive control processes is linked to observable outcomes at intrapsychic and interpersonal levels. This classification system can be used to formulate how patterns of avoidance and distortion are formed.

(The Journal of Psychotherapy Practice and Research 1999; 8:213-224)

Defensive control of emotion is a classic psychodynamic concept and an element of case formulations. For decades, medical students and psychiatric residents have had to pass tests showing an ability to define traditional psychoanalytic defense mechanisms. Yet the concept is not fully accepted in nondynamic approaches, and defensive styles were not accepted, after controversy, as a part of the multiaxial diagnostic system in DSM-III¹ and DSM-IV.²

One problem has been the theory of classification of defenses. A related problem has been the degree of reliability and validity of empirical variables related to the traditional definitions of defense mechanisms. A third problem has been divergence in schools of psychotherapy. The time is at hand for an integration and a revision of the theory of classification of defenses based on empirical evidence. This paper summarizes such a revision, and some of the evidence. It is intended as a teaching document.

BACKGROUND

Sigmund Freud and other early psychoanalysts developed names and definitions for defense mechanisms.

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Anna Freud³ offered an organization of her father's observations, yet inconsistencies of categorization remained.⁴⁻¹⁰ Some defense mechanisms were defined as simple units of mental processing and mental outcomes, as in *repression* of a single, specific wish. Other defense mechanisms were complex combinations of mental and social operations, as in *identification with the aggressor*. What is needed now is a better theory of classification, one that clearly relates processes to observable outcomes.

The earlier defense classification system evolved in the context of a psychoanalytic motivational theory that emphasized drives: the ego formed defenses to mediate between id urges and superego injunctions.¹¹ Subsequent theory from cognitive sciences revised this view, replacing it with an information-processing approach. This modern view allows a shared theoretical language across disciplines and a redefinition of emotional control processes.¹²⁻¹⁴

Theory

The context for control of emotion is usually the processing of a difficult, emotionally challenging topic. An example is processing a piece of bad news from a stressor event, one that requires revision of prior knowledge, cognitive map, or schema. When a person gets bad news, it may be discordant with existing mental models.

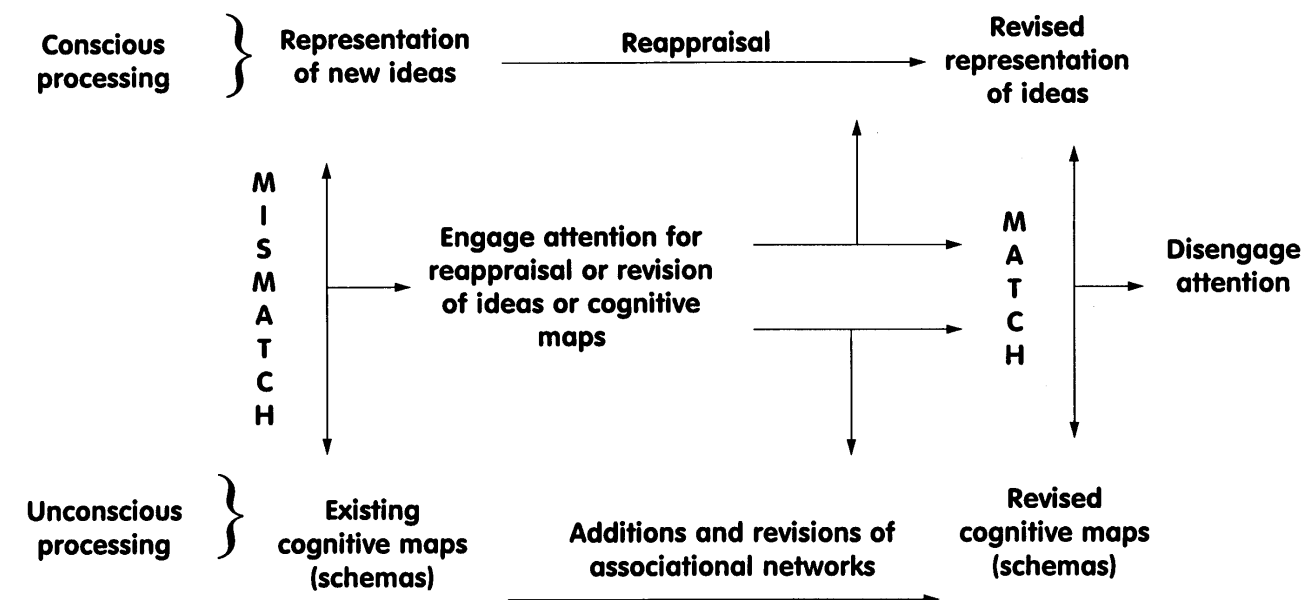
Such a mismatch between event interpretations and cognitive maps will activate negative emotions. These emotions in part function as motives to focus attention, fixing it on the problem of how to reconcile the incongruities between the bad news and existing schemas. With reconciliation, the person can reduce emotional alarms and shift attention to another topic.

Information processing helps the person shift from a state of mismatch to one of match, as illustrated in Figure 1. Figure 2 adds the element of emotion to the cognitive model of Figure 1. In addition to current emotional evocation, information processing evokes *anticipation* of where emotion might lead. One possibility is anticipation of entry into a dreaded state of mind with intense, out-of-control negative emotions. To avoid current or anticipated excessive emotional arousal, the person then increases control processes to regulate the flow of information by selective inhibitions and facilitations. This is a contemporary model of signal affects, like Freud's early formulation of signal anxiety.^{3,11} The following case example provides an illustration.

Case Example

Steve, a first-year surgical resident, was at a crucial level of training that would dictate his future career, and his goal was to become a great surgeon. The attending surgeon who had

FIGURE 1. A model of ideational processing.



observed him told Steve that he had not met the required standards of judgment and skill for advancement in the residency training program. The new information—that he had only mediocre skills in a key area—was sharply discordant with Steve's goal. This mismatch threatened to produce intense shame. He anticipated entering a state of excessive humiliation and suicidal preoccupation.

Steve had had states of shame and despair in the past. He anticipated a repetition of such dreaded moods, and to avoid them he activated defensive control processes that inhibited his conscious contemplation of the recent deflating news, as illustrated in Figure 3.

Steve's defensive avoidance could be variously categorized. One way is to use the classic psychoanalytic terminology of defense mechanisms.^{3,6,15-17} If his inattention to the topic of his insufficient surgical skills was a conscious choice, then his acts would be called *suppression*. If it was an unconsciously chosen inhibition of an important topic, then it would be called *repression*. The defensive control processes classification to be presented¹⁶⁻²⁰ uses one simple term, *topic inhibition*, to identify the basic process without getting into the difficult inference of the role of reflective consciousness in information processing.

Through topic inhibition, Steve affected the *content* of his attention. He could also have affected the *form* of his attention as well as its mental content. Instead of having a distressing visual fantasy of failing to receive his certificate of completion when other residents received theirs at the year-end ceremony, he could inhibit imagery. By being aware only of words predicting such a future, and not imagining the scene visually, he might reduce shame. Instead of an undermodulated state, Steve might maintain a well-modulated

state while anticipating a tolerable degree of embarrassment.

By a third type of control, Steve could alter *person schemas*. He could change the relative activity of his various possible roles of self and his relationship models. Steve could inhibit conceptualizing himself as a degraded man and instead facilitate concepts of himself as a competent man performing well in an alternative career. Figure 4 illustrates how deciding to be an anesthesiologist shifted his state from a degraded to a competent self schema. Steve could also alter role schemas of his attending surgeon, by shifting from viewing him as an admired and competent mentor to viewing him as an incompetent judge.

Person Schemas Theory

Contemporary cognitive theory employs the concept of *parallel processing*. That is, multiple appraisals and revisions of information on the same topic can occur at the same time in different information-construction channels. Schemas (cognitive maps) can organize the construction of informational sets in each parallel processor. Supraordinate schemas help in fitting together the output of several processing channels. The fittings and choices may tend to accentuate one schema from the medley, leading to the working model that organizes a current state of mind.²¹⁻²⁴

Organizing schemas influence the changing strengths of associational linkages among these networks of patterned meanings. The most complex of these or-

FIGURE 2. A model of emotional information processing.

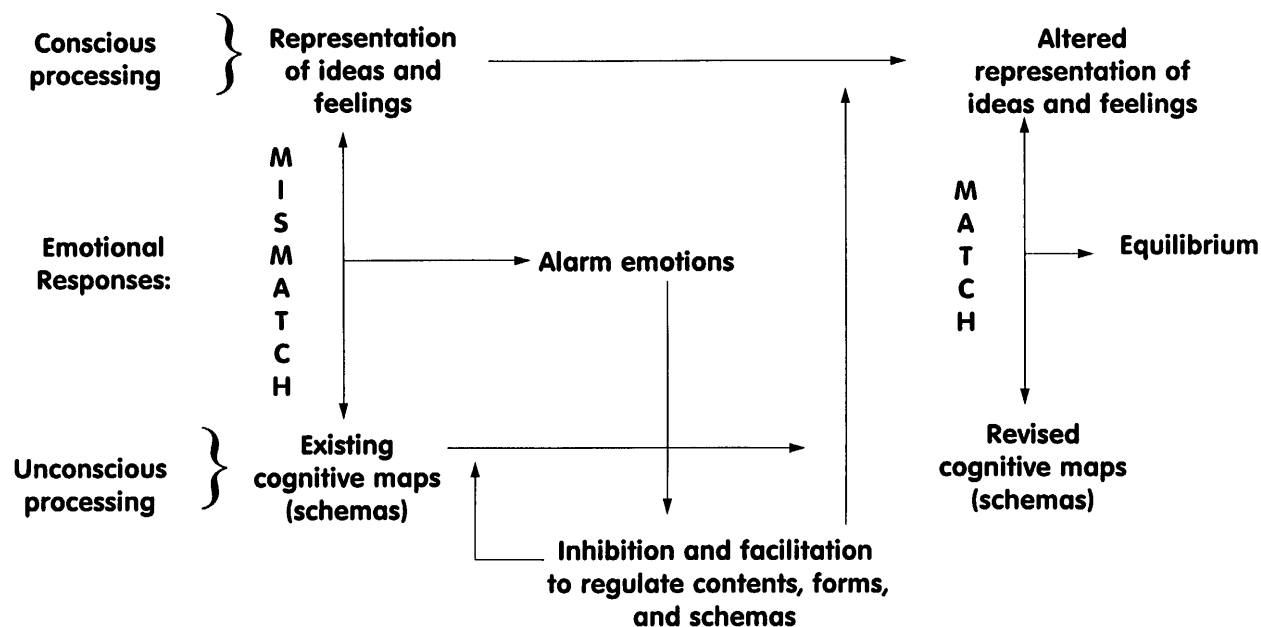


FIGURE 3. A model of Steve's inhibition of distressing emotional content.

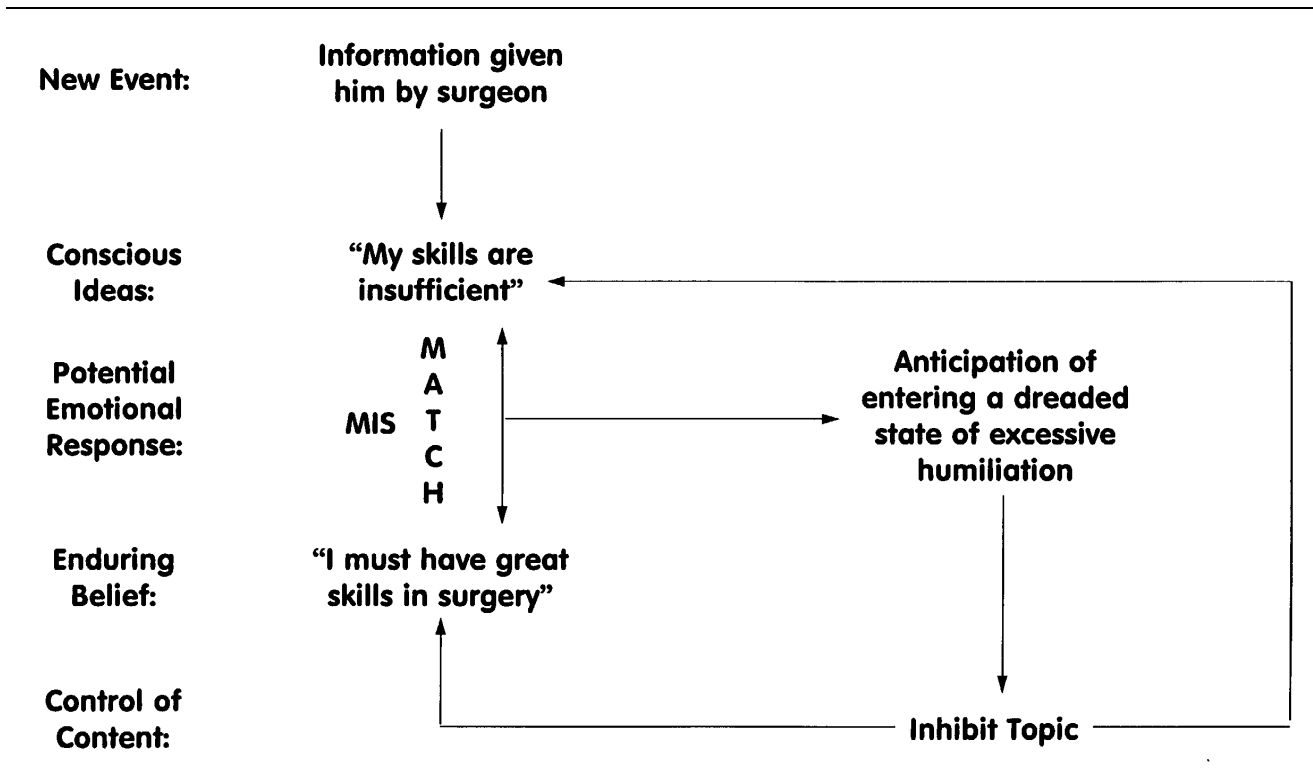
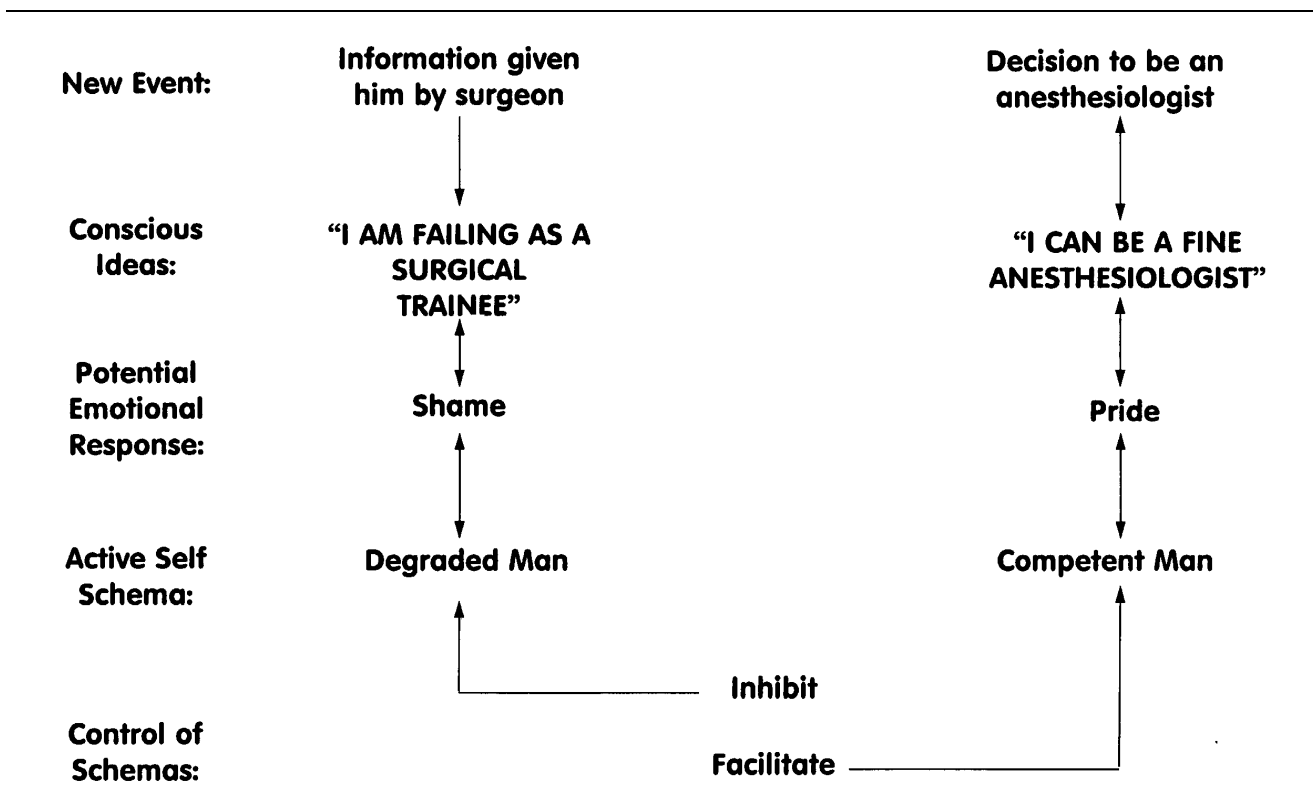


FIGURE 4. A model of Steve's inhibition and facilitation of self schemas.



ganizing schemas are probably the schemas of self and others (*person schemas*). Like other cognitive maps, person schemas revise, smooth, integrate, and package information.²⁵⁻²⁷ Current motives are guided to suitable targets by plans and scripts for actions. Person schemas include transactional sequences that lead to anticipated consequences, as well as roles and values used in assigning blame and praise. Control processes are guided by anticipation of such outcomes as success, failure, esteem, or degradation; that is, anticipation involves both desired and dreaded states of mind. In this way, defensive control processes are placed within a *motivational matrix*.¹⁸⁻²¹

A CLASSIFICATION OF DEFENSIVE CONTROLS: PROCESSES AND OUTCOMES

Three larger categories organize this classification. Some controls *shift the content*. Other control processes *alter the form*. Still other defensive control processes can *shift person schemas*. These three sets will be discussed in that order. For each set, control process outcomes will be described at two levels of observation: *reflective awareness* (which can be assessed by self-reports) and *communication* (which can be judged by clinical raters).

Controlling Contents

Contents of expressions can be selected by control processes that can alter 1) topics, 2) concepts, 3) the designation of importance of concepts, or 4) the threshold for disengaging attention from a topic.

1. *Altering Topics*: Potential topics may be inhibited or facilitated relative to one another, leading to a shift in attention from one topic to another.²⁸ Adaptively, shifting focus away from an unresolved topic can reduce emotion and ward off entry into a dreaded state of mind. Maladaptively, extended forgetting, disavowal, or denial can lead to a failure in coping.

2. *Altering Concepts*: Concepts are potential ideas and feelings to be used in contemplating a topic. These elements are activated from memory because of the strength of connections in complex networks of associational linkages. Priming can determine priorities for what concept is likely to be "next" in the expression or representation of a chain of concepts. Altering the next concept can change emotion.

A tightly linked chain of ideas is likely to be clear.

Leaps and flights in linking concepts together can lead either to confusing chains or to new combinations that provide stunning and creative insights. Altering concepts can lead to both adaptive and maladaptive consequences.

3. *Altering the Importance of a Chain of Concepts to the Self*: A chain of ideas may appear to lead to a solution to a problem. Another chain can be formed that also appears to solve the problem. Reflective conscious awareness can compare the alternatives, and each chain is then weighed for relative probabilities of real success.

The significance of a chain can be exaggerated or minimized relative to an alternative. This shift in weights can lead to rational evaluations or irrational sliding of meanings. Distorted attitudes may be formed or important possibilities can be ignored.

4. *Altering Threshold for Disengagement*: Some patients in psychotherapy declare a topic concluded when the therapist believes it is not. The problematic topic, with its emotional conflicts, is interrupted. The habitual tendency noted is one of moving away from hard decisions. Personal dilemmas remain unresolved because of these short circuits.

Outcomes of Control Processes: Either by self-reports (from introspection) or by direct observation (e.g., of recorded communications), clinicians study the outcomes of defensive controls and infer the underlying processes. Most outcomes result from the combination of several control processes, but it is clarifying to give an example of a prime outcome for each category of process. These examples are provided in Table 1 as outcomes assessed on the basis of introspection-based self-reports, and in Table 2 as outcomes that observers can judge.

In our research in developing this classification, we examined how independent judges rated psychotherapy transcripts for different kinds of elaboration and dyselaboration of emotional ideas. The subcategories of dyselaboration in the manual used by judges followed the "Maladaptive Outcome" column of Table 2. The judgments of the raters were reliable, and the averaged category frequencies showed increased defensive-level outcomes during discourse on the patient's most conflictual and unresolved topics.^{29,30} In single-case studies, we found the results from this classification to be clearer than analyses of some portions of the data that were based on classical psychoanalytic defense mechanism categories.³¹

Controlling the Form of Conscious Thought

Emotion can be controlled by altering forms of thought. Several such processes include altering 1) mode of representation, 2) time span, 3) logic level, 4) level of action planning, and 5) arousal level.

1. *Altering Mode of Representation:* People can shift the relative dominance of words, images, and somatic enactions in thought. People can have different states in which there is high or low translation of meaning between modes. Isolation of meaning in one mode, especially in the lexical mode, can reduce emotion, whereas increasing imagery may increase emotion. If vivid images occur without translation of the images into lexical meanings, the focal conscious experiences may seem like perceiving rather than recollecting. This can result in a sense of reliving a past experience, rather than having a memory or fantasy contemplation.

2. *Altering Time Span:* Time spans for contemplation can be set by intentions to limit an associational search

for knowledge. Time spans can be set to encompass long or short periods or toward recollecting and imagining past or future. The remote or recent past, as well as the near or distant future, can be specifically focused on in setting an attentional frame. Emotional arousal can be limited by focusing attention tightly away from a time when bad things happened and might happen again.

Focusing consciousness on the very recent past and the very near future can help the person plan immediate action without being swamped by emotions about dire but distant futures. For example, when receiving news of a laboratory test that shows the presence of an unexpected cancer, a person can think of whom to tell right now, rather than think about what it will be like to have the disease exacerbate in the future. People can also reduce emotion by focusing on the remote past or by reliving a memory or fantasy in order to ignore current threats. At other times, threatened by the possibility of recalling traumatic memories, they keep the time frame of attention set for only right now and for what detailed actions they should perform next to keep themselves busy.

TABLE 1. Outcomes of control processes affecting the contents of awareness

Control Processes	Defensive Outcomes		
	Adaptive	Maladaptive	Failure of Regulation
Altering topics	Alternates useful periods of contemplating and not contemplating a stressful topic (dosing); rational balances between internal and external sources of information.	Does not examine important topics insightfully or make needed decisions because of forgetting, disavowal, or denial.	Intrusion of an emotionally overwhelming topic.
Altering concepts	Shows useful contemplation of implications and possible solutions to problems; selective inattention to vexing or distressing concepts in order to gain restoration from distressing level of emotion or loss of morale when problems seem insoluble; useful balancing of emotion by switches between reciprocally inhibiting concepts; establishment of a rational order of concepts.	Avoids key concepts; amplifies irrelevant details; moves from the emotional heart of a topic to its periphery in a way that leaves cause and effect sequences distorted or obscured.	Disjointed and confused thought.
Altering the importance of a chain of concepts to the self	Can weigh alternatives and accept the best solution to a problem; acceptance of realistic estimates.	Shows irrational exaggeration or minimization; excessive "sweet lemons" or "sour grapes" valuations; rationalization of irrational solutions.	Dazed sensation, sense of emptiness, or chaotic shifts in attitudes.
Altering threshold for disengagement	Acts when a good solution has been reached; accepts for the self a new reality; makes an effort to practice new ways of thinking and acting; is able to override outmoded unconscious ways of thinking; is able to tolerate high levels of negative emotion without derailing a topic.	Terminates contemplation of a topic prematurely; blocks reviews of memories or anticipation of threatening events; selects the emotionally easy but unrealistic choice; no choices are made on how to integrate contradictions.	Uncontrolled impulsive conclusions.

3. *Altering Logic Level:* People can influence the rules of thought; they can shift from having tight, narrow rules for logically linking associations to making broad, creative, and even illogical associations. Some people blunt emotion caused by broad awareness by emphasis on plans that involve careful logic. Others who are distressed by a focus on planning may instead have a broad and glorious fantasy.

4. *Altering Level of Action Planning:* In restful repose, a person may have a mental set for contemplation without bodily action. On a basketball court, that person's mental set may intend swift reactive movements without the distraction of contemplation. In playing ball, action is at lightning speed; in playing chess, action is restrained until a move is fully thought through. Control processes can alter such setpoints for degree of thought and degree of concomitant motor activity. Defensively, a person can act too impulsively instead of thinking or, like Hamlet, ruminate to avoid taking action.

5. *Altering Arousal Level:* People seek stimuli, take drugs, meditate, or choose calming or arousing activities. Giddiness, avoidant sleeping, or sexual promiscuity are

sometimes used to avoid serious issues. Both thrills and lethargies can reduce emotional threat.

Outcomes of Control Processes: The introspective outcomes of these defensive processes that control form are summarized in Table 3. The outcomes observable in interpersonal communications, such as records of evaluation or therapy sessions, are summarized in Table 4.

Controlling Person Schemas

Emotions can be changed by shifts in how self and others are viewed. People can change an internal working model of an actual social transaction by altering 1) self schema, 2) the schema for the other person, 3) role relationship models, 4) value schemas, and 5) executive-agency schemas.

1. *Altering Schemas of Self:* Control of schemas of self can lead to shifts in roles and procedures for role-related behaviors. It can directly and indirectly alter the emotions that color a state of mind. By shifting roles within a repertoire, people can reduce the intensity of an unwanted emotion. One example is shifting to the role of

TABLE 2. Outcomes of control processes affecting the contents of interpersonal communications

Control Processes	Defensive Outcomes		
	Adaptive	Maladaptive	Failures of Regulation
Altering topics	Expresses a potentially stressful topic to another person to the degree that both can tolerate the emotion or conflict evoked, with a balanced focus on self and other.	Shows unbalanced focus; is disruptively attentive only to self, or too attuned to other to be sufficiently attentive to topics of importance to self; does not present stressful topics; selects obscuring or misleading alternative topics.	Sudden plunges into and out of expression of emotionally overwhelming topics.
Altering concepts	Communicates key facts and emotions; contemplates implications and possible solutions to problems; is alert to cues of others.	Shows conceptual reluctance; misleads others who are potentially helpful; gives misinformation; generalizes when specifics are indicated; avoids expressing a concept that might prove useful in solving problems; switches back and forth regarding the facts; interrupts or overrides others to prevent clarification or useful give and take; refuses to follow useful cues or leads provided by others.	Fragmented and hard-to-follow talk.
Altering the importance of a chain of concepts to self	Carefully appraises alternatives; maintains and/or makes clear changes in values, commitments, and shared meanings; makes appropriate jokes.	Vacillates when it is essential to take a stance; engages in facile face-saving at the expense of reasonable shared estimates of the truth; rationalizes the irrational; makes inappropriate jokes.	Disruptive or chaotic shifts in attitudes.
Altering threshold for disengagement	Shares the decision-making process; makes decisions when in the best position to do so; selects the best topics and shows links between topics.	Avoids desirable actions to prevent inner tensions; acts in an impairing manner to get a tense situation over with prematurely.	Uncontrolled impulsive speech or other actions.

indignant accuser from the role of weak victim. Getting angry provides escape from a dreaded state of fear.

2. *Altering the Schema for the Other Person:* In a similar manner, a person can shift the roles of others. Altering

the role of the other person leads to different emotional interpretations, expectations, and plans. An individual may at first view the other person as a highly desirable companion and shudder at an anticipated rejection. A defensive shift in role for the other may change this

TABLE 3. Outcomes of control processes affecting the form of thought

Control Processes	Defensive Outcomes		Failure of Regulation
	Adaptive	Maladaptive	
Altering mode of representation	Selective representation in all modes; lexical clarity; restorative imagery; somatic preparation.	Excessive numbing by avoiding images; avoiding understanding images in words; prolonged escapist use of imagery or bodily enactments.	Intrusive and excessively vivid images (flashbacks, pseudohallucinations, hallucinations); enactive expression of raw emotions.
Altering time span	Looking at only one step at a time to make urgently needed plans and/or to avoid being emotionally overwhelmed by long-term implications; relating an event to an entire life span to avoid being overwhelmed by long-term implications.	Denying urgency of a threat; disavowing long-range implications to self; focusing on past or future to avoid the need to make present decisions and take necessary actions.	Chaotic sense of time.
Altering logic level	Balance between rational planning and restorative or creative fantasy.	Excessive preoccupation with small logical steps and details or with fantasy.	Confusion; prolonged inability to emerge from fantasy.
Altering level of action planning	Making restorative changes between activity and thought; taking prompt action at appropriate signs of opportunity; using useful restraint.	Preoccupation with thinking to avoid important perceptions; preoccupation with perception to avoid necessary thinking; excessive action to avoid thought; excessive thought to avoid action; paralysis of action in favor of endless rumination.	Impulsive action and/or thought; no action.
Altering arousal level	Balanced arousal and rest cycles.	Excessive hypervigilance and compulsive worry or avoidant sleeping, reverie, and lethargy.	Frenzied or exhausted states of mind.

TABLE 4. Outcomes of control processes affecting the form of interpersonal communications

Control Processes	Defensive Outcomes		Failure of Regulation
	Adaptive	Maladaptive	
Altering mode of representation	Coherent mixes of verbalization, facial signals, apt imagery metaphors, and bodily gestural movements.	Disruptive use of odd metaphors; flat verbiage; discordant prosodics across words, voice, face, and body.	Jumbles different expressive media; impulsive enaction of emotional signals.
Altering time span	In discussion, shows coherent framing of time as to past, present, future, or imaginary perspectives.	Disruptive or confusing shifts in temporal perspective.	Chaotic timing of actions.
Altering logic level	Balance between rational planning (reflexive analyses) and restorative or creative fantasy (brainstorming); restorative humor or banter.	Disruptive or confusing shifts between analytic reasoning and fantasy; avoidant humor, joking, or banter.	Inability to follow a thread of meaning.
Altering level of action planning	Appropriate and shared choices of when to talk and when to act; taking turns in a dialogue.	Avoidant disruption of turn-taking in a dialogue; avoidant chatting when acting is indicated; restless action to avoid thinking and feeling.	Impulsively excessive actions.
Altering arousal level	Appropriate lulls, silences, excitements, and turn-takings; useful cycles of activity and inactivity in complementary actions.	Excessive speed or slowing of dialogue or actions.	Unavailable to shared communication because of excessive excitement or blunting.

emotional arousal. The other is viewed as ordinary, unworthy of intense pursuit. The anxious affects over feared rejection are quieted.

3. *Altering Role Relationship Models:* Role relationship models are an internal map for social transactions. In an important affiliation, a series of role relationship models develops. Of these different role relationship models, some may be desired, some feared, and others used as a compromise to avert dreaded states. When a wish/fear dilemma links desired to dreaded views of a relationship, the person can shift to a state organized by such compromise role relationship models.³²

The compromise avoids the threat of the dreaded consequences of the desire. For example, a person may have an urge to flirt with a new acquaintance but fears the other would find the self deplorable. Anxious states of mind could occur: will the self be rejected? A compromise state of mind can be organized by a different role relationship model, one in which the self is self-sufficient and the other is viewed as only slightly interesting. The dilemma between excitement of intimacy and feared pain of rejection is reduced by a shift into the compromise view. The defensive shift says, in effect, "Oh, I was just conversing to pass time with you until I go on to something more interesting." Unfortu-

nately, the compromise seldom promotes real satisfaction.

4. *Altering Value Schemas:* An important conscious activity is judging actions. People use alternative sets of values to make these critical analyses. Different value schemas may be given different priorities in different states.

When they are in danger of blame, when emotions of shame and guilt threaten to demolish self-esteem, people can control distress by shifting values. For example, a patient lied to his best friend, saying he was not flirting with the friend's girlfriend. This lie made him feel guilty because telling the truth is of value. He then shifted to asserting that "love is war" and that in war deceit is part of "good strategy." Similar rationalizations occurred in his business. As business agent, he sold a product containing pollutants because he was "just following orders" and was "loyal to the corporation." In other states, he was furious about firms that committed such practices.

5. *Altering Executive-Agency Schemas:* The executive agent is the person believed to be in charge of forming plans and instigating action. In different states of mind, an individual may vary in how a sense of executive agency influences decisions. In everyday life, the execu-

TABLE 5. Outcomes of control processes affecting person schemas that organize conscious experience

Control Processes	Defensive Outcomes		Failure of Regulation
	Adaptive	Maladaptive	
Altering self schema	Improved understanding of situation; enriched sense of identity.	Excessively grand or inferior beliefs about self; taking on a bad self-schema to avoid identity diffusion; alternating "personalities."	Identity diffusion, states of depersonalization.
Altering schema of other person	Enriched understanding of the intentions, motives, and predictable patterns of other.	Disregard of nature of other to preserve fantasy or personal stereotypes; changing the object of a feeling, wish, source of threat from a more pertinent to a less pertinent one (displacement).	Severe misunderstanding of other people.
Altering role relationship models	Resilient change in internal working model of a current situation; useful learning by identification, mourning, transferences.	Role reversals inappropriate to the situation; switching working models into all-good or all-bad views of the relationship; changing the agent or source of an activity, wish, or feeling from self to other or other to self (role-reversal, projection).	Annihilation anxiety or panic on separations; states of derealization.
Altering value schemas (critic role)	Sagacious monitoring and judging of self and others, and of the future critique of present choices; maintains useful vows and commitments; emancipatory self-reflections.	Unrealistic devaluation or idealization of self and/or others; switching values so rapidly that doubt paralyzes thought or action, or good intentions are not maintained.	Inability to evaluate moral consequences.
Altering executive-agency schema	Restorative sense of being a part of something beyond self; generating responsibility for others.	Excessive surrender of best interests of self; excessive self-centeredness.	States of alienation.

tive agent may be the “I” in a sense of identity. This executive agent may be shifted to something other than “I.” There are other leaders, the “we” of a family, friendship, work group.

Sometimes seeing “I” as an executive agent feels too impoverished, and one’s mood deflates. The schema for who is executive may be shifted to an idealized other or larger group. De Gaulle said, “I am France.” Self-abnegation or a sense of merger with cosmic powers may occur. That can have adaptive or maladaptive consequences; morale may be restored as grand agents are assumed to be in charge, or grandiose delusions may be formed.

Outcomes of Control Processes: These person-schematic control processes are linked to outcomes in conscious experience in Table 5 and to outcomes in interpersonal transactions in Table 6.

RESEARCH FINDINGS AND CLINICAL APPLICATIONS

Empirical Studies

The classification presented in Tables 1–6 evolved through research efforts and discussions to develop a shared cognitive-psychodynamic language. These efforts began with careful case studies of patients in psychotherapy for stress response syndromes.^{18,21,33–35} Later, quantitative investigations of reliability and validity of the categories occurred.^{36,37} Because multiple observers can study and rate recordings, both quantitative and qualitative studies of interpersonal manifestations are likely to allow for tests of consensus and predictions. Judges did reliably score signs of defensive control, and these did locate the most conflictual topics in psychotherapy.³⁰ Defensive organizations inferred as configurations of sche-

TABLE 6. Outcomes of control processes affecting the person schemas that organize interpersonal transactions

Control Processes	Defensive Outcomes		Failure of Regulation
	Adaptive	Maladaptive	
Altering self schema	Increased competence and resilience within a situation; improved fit of behavior to the situation.	Jarring shift in “personality”; acting in a too-superior or too-inferior way; using others as if they were part of or extension of the self.	Intentional signals are confusing.
Altering schema of other person	Increased understanding of the intentions, motives, and predictable patterns of other (empathy); “reading” of another during an interaction.	Reacting according to an erroneous schema of the other; provoking the other to conform to an inappropriate internal schema; short-circuiting to an inappropriate all-good or all-bad view of other; changing the target of a feeling, wish, or fear from the most pertinent one to a less pertinent one (displacement).	Chaotic views about what to expect of another in a situation.
Altering role relationship models	Useful trials of a new pattern for a situation.	Disguising or undoing an intended script sequence by running an alternative, compromise, or opposite one (undoing, passive-aggression); shimmering alternations of contradictory patterns; pretense of roles that are not felt authentically; preservation of an inappropriate script rather than acting flexibly as situation unfolds; switching working models into all-good or all-bad views of the relationship; changing the agent or source of an activity, wish, or feeling from self to other or other to self.	Inability to use relationships with others to stabilize a sense of identity.
Altering value schemas (critic role)	Pointing out the following of or deflections from values, rules, and commitments to self and others in order to give rewards or improve deflections from values, rules, and future situation.	Irrational assumption of other’s values to avoid a social tension; inhibition of spontaneity by excessive monitoring; attributing blame outward irrationally to protect self-esteem.	Impulsive, punitive, revenge behaviors (on self or others).
Altering executive-agency schema	Acting responsibly to care for others and to care for self as situations demand.	Unrealistic abnegation of self; suddenly selfish or autistic acts that disrupt relationships.	Inability to care for others responsibly.

TABLE 7. Defensive control processes

Content	<p>Shifting attention: Avoids conscious thought, discourse, or action on important unresolved topics by shifting attention to another topic; the shifts may be deliberate (suppression) or may involve less conscious automatic choices (repression, dissociation, disavowal, or denial).</p> <p>Juggling concepts about a topic: Shifts too often among ideas or emotional valences of ideas, thus preventing a potentially affect-related deepening train of thought; irrelevant details may be amplified. Vital links between ideas and feelings, and between cause and effect, may be obscured.</p> <p>Sliding meanings and values: Adjusts conceptual weighting by minimizing or exaggerating intentions or emotional salience; the resulting appraisal errors and rationalizations may preserve self-esteem or reduce affect ("sweet lemons" or "sour grapes").</p> <p>Premature disengaging from topics: Declares important topics or actions "finished" before reaching closure despite awareness of unresolved dilemmas and contradictions, effectively blocking potentially emotional review of important memories or anticipation of likely future events (e.g., interpersonal tensions).</p>
Form	<p>Blocking apt modes of representation: Ineffectively represents ideas and feelings about a topic, engaging in either verbal intellectualizations or preoccupying fantasies. Both can lead to failure to engage in effective action planning. Discourse may lack imagery, metaphors, and clarity, or else may be excessively metaphoric with poor translation of visual images into clear, concrete, meaningful ideas. Both can reduce reactive emotions.</p> <p>Shifting time span: Shifts from most pertinent to alternative less relevant temporal contexts (e.g., distant past, recent past, here-and-now, immediate future, distant future) in a manner that avoids or reduces emotionality (e.g., shifts past memories apparently to avoid confrontation with current relationship difficulties or future jeopardy).</p> <p>Using poor ideational linkage strategies: Employs intellectualized analysis of generalities when reflective contemplation or recollection of personalized issues and emotional memories is more appropriate; conversely, may use creatively wide-ranging associations when careful adaptive planning is more appropriate. The results may be isolated from identity and emotional responses.</p> <p>Engaging inappropriate arousal levels: Shifts to inappropriate level of arousal specifically when addressing a problematic topic; becomes dull, listless, or sleepy or else becomes too excited to do effective contemplation.</p>
Person schemas	<p>Shifting self/other roles: Abruptly shifts to alternate views of self and other or switches attributes of self and others (e.g., projection, role reversal, displacement, compensatory grandiosity), avoiding dreaded states of fear, shame, rage, and guilt.</p> <p>Rigidly stabilizing compromise roles: Rigidly assumes compromise roles and views of self and others, apparently avoiding desired ones that may have associations with dreaded ones (e.g., wish/fear dilemmas); consequences include avoiding threatening situations and dysphoric emotion, but also include withdrawal, numbing, excessive self-preoccupations, and lack of satisfaction.</p> <p>Altering valuation schemas: Shifts to an alternate set of values for appraising self or other, with idealizing or devaluating consequences (e.g., unrealistically attributing blame to another, unrealistically criticizing oneself).</p>

mas were reliable as scored by independent raters,³⁸ and independent formulation teams, blind to each other's inferences, arrived at similar configurations for the same case material.^{39,40} Additional empirical checks on this classification included separate studies of observer and self-report measures based on this classification system. Subjects reported on their own habitual control processes with highly significant levels of test-retest reliability over time, and observers agreed to a significant degree in independent rating of videotapes²¹ (Horowitz and Znoj, unpublished data).

Clinical Utility

Tables 1–6 presented the details of this classification of emotional control processes and are useful for detailed

theory and research. A simplification is desirable for clinical teaching and practice, and the focus there should be on what is important to help a patient change. Accordingly, a list of common maladaptive avoidances and distortions appears as Table 7. From such a list, the clinician can develop techniques for modification of the maladaptive defensiveness.

The levels of observation listed in the tables lead to inferences about how ideational and interpersonal avoidances and distortions occur. Psychotherapists can then show a patient how to confront emotional and conflictual topics more directly.

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Projective Identification, Self-Disclosure, and the Patient's View of the Object

The Need for Flexibility

Robert T. Waska, M.S., MFCC

Certain patients, through projective identification and splitting mechanisms, test the boundaries of the analytic situation. These patients are usually experiencing overwhelming paranoid-schizoid anxieties and view the object as ruthless and persecutory. Using a Kleinian perspective, the author advocates greater analytic flexibility with these difficult patients who seem unable to use the standard analytic environment. The concept of self-disclosure is examined, and the author discusses certain technical situations where self-disclosure may be helpful.

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Jacobs¹ writes,

Our technique calls for restraint, neutrality, abstinence. But with some patients this leads to resistance. In such instances we may need a different approach to engage these patients. Some patients need more of us. (p. 247)

Some patients seem to need a modified method of interpretation at particular junctures in the treatment. Others demand a flexible approach throughout the analysis. These are usually patients who have acute paranoid fantasies of being attacked, rejected, and abandoned.

PROJECTIVE IDENTIFICATION

Melanie Klein proposed the term *projective identification* in 1946.² She described an intrapsychic phenomenon by which certain parts of the ego were put into parts of the object, for defensive and protective reasons. Since then, Kleinians have elaborated on her concept and made it a cornerstone of Kleinian theory and technique.

Ogden³ summarized these developments:

Projective identification . . . is a psychological process that is simultaneously a type of defense, a mode

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of communication, a primitive form of object relationship, and a pathway for psychological change. As a defense, projective identification serves to create a sense of psychological distance from unwanted (often frightening) aspects of the self; as a mode of communication, projective identification is a process by which feelings congruent with one's own are induced in another person, thereby creating a sense of being understood by or of being "at one with" the other person. As a type of object relationship, projective identification constitutes a way of being with and relating to a partially separate object; and finally, as a pathway for psychological change, projective identification is a process by which feelings like those that one is struggling with, are psychologically processed by another person and made available for re-internalization in an altered form.

Each of these functions of projective identification evolves in the context of the infant's early attempts to perceive, organize, and manage his internal and external experience and to communicate with his environment. (p. 362)

Rosenfeld⁴ felt projective identification was more than just defense:

One has to realize that projective identification is not just one single process but includes many different types of projective identification. There are also processes which are similar to projective identification but not identical with it and it now seems important to differentiate and understand these processes in greater detail.

In a previous paper . . . , I suggested first of all that it was important to differentiate between projective identification used for communication and projective identification used for defensive purposes such as ridding the self of unwanted parts of the self. I also described a third very important form of projective identification which is frequently observed in the transference relationship of the psychotic patient which seems to be based on a very early infantile type of object relationship. In this form of projective identification one observes that the patient believes that he has forced himself omnipotently into the analyst and this results in a fusion or confusion with the analyst and anxieties relating to the loss of his self. Here the projection of omnipotent or deluded parts of the self into the analyst often predominates. (p. 263)

EASING ANXIETY WHEN WORKING WITH THE TRANSFERENCE

With some patients, making direct and specific interpretations of the transference and of projective identification

(PI) mechanisms is what helps ease their anxiety. This is the avenue I try first because it usually works. If the usual approach to dealing therapeutically and analytically with a patient doesn't seem to help, and I have explored the reasons why, I may try a modified contact.

Concerning the importance of working with the transference, Strachey⁵ writes,

Instead of having to deal as best we may with conflicts of the remote past, which are concerned with dead circumstances and mummified personalities, and whose outcome is already determined, we find ourselves involved in an actual and immediate situation, in which we and the patient are the principal characters. (p. 133)

Whether the analytic situation is flexible or standard, one hopes that it is an exploration of the transference/countertransference dynamics, since this is where the patient's unconscious fantasies and anxieties manifest.

With more territorial individuals who see the world as divided into puppets and string pullers, a more cautious stance can prove helpful. First, I make comments about the PI mechanisms they use with external objects in day-to-day life. Next, I interpret the interpersonal context of PI, between patient and therapist. I may stay at this level for a long time. In fact, it may be as far as some patients can go. Making genetic PI interpretations also seems helpful if this type of patient becomes anxious. It certainly is a retreat from the transference and an avoidance of the here-and-now relationship, but usually these are cases where nothing else works. Finally, after laying groundwork with interpretations of their PI efforts with external objects and of the interpersonal context of the transference, I proceed to more standard interpretations of the intrapsychic nature of PI within the here-and-now transference. This flexible approach is a way of warming up to the mutative moment in which the interpretation directly refers to the object of the patient's fantasy, the therapist.

Again, I only mention this warming-up approach to working with PI as a method I have had to use as a deviation from or modification to more usual interpretive techniques. A few very difficult patients have benefited from it. I would stress the need for the therapist's careful examination of the countertransference, to avoid using this modified approach to act out the patient's PI fantasies.

Both patient and therapist need to free-associate during the session. The patient is encouraged to speak his

mind in totality. Then, the therapist must quietly examine the contents of her own mind for information that applies to the situation and judge what would be useful in verbal intervention. I often find my emotional response to a patient takes the form of a conscious mental picture or story concerning some type of one- or two-person conflict. I then find a way to put that countertransference image into words, if the analytic moment seems right. My interpretation is formulated on the current relational and internal interplay between therapist and patient.

Strachey⁵ has summed up the vital points in making interpretations. He writes,

A mutative interpretation can only be applied to an id impulse which is actually in a state of cathexis . . . interpretations must always be directed to the "point of urgency." At any given moment some particular id impulse will be in activity; this is the impulse that is susceptible of mutative interpretation at that time, and no other one . . . but as Melanie Klein has pointed out, it is a most precious quality in an analyst to be able at any moment to pick out the point of urgency . . . a mutative interpretation must be specific: that is to say, detailed and concrete. (p. 149)

Some patients are so gripped by paranoid fantasies that they hear almost any interpretation as an attack, even when it is detailed and concrete. Some have such sadistic superegos that they take any interpretation as a cruel judgment. These patients are difficult to maintain in treatment because interpretations that normally soothe actually make things worse. The therapist is caught, with the patient, in a vicious cycle. What works best with some of these cases is to interpret that cycle.

However, interpreting the source and intent of the projection can push patients into being more defensive and regressed. Making an interpretation about *other* aspects of their PI fantasies can allow them to explore their thoughts and emotions without feeling as pressured to re-own their unwanted affects and thoughts. Knowing enough about the patient's fantasies and anxieties to position the interpretation where the patient will best receive it is important. Malcolm⁶ has done interesting work in this area. Some patients can take in the information if I say, "I am really stuck right now. I feel I can't say much without making it worse." This would be the use of self-disclosure in the service of the patient's ego. Essentially, I would be disclosing my feelings as the stuck and cornered aspect of their ego, which has become lodged within my psyche through PI.

THE ISSUE OF SELF-DISCLOSURE

Self-disclosure has many proponents and many detractors. Recent discussions have been numerous.⁷⁻¹⁴ *Psychoanalytic Inquiry*¹⁵ devoted an entire number of the journal to this issue, and an article in *Contemporary Psychoanalysis* brought together several discussants.¹⁶ Many other papers, panels, and workshops have occurred in the last few years.

However, the issues are far from being resolved. Most of the literature available tends to be from analysts within the intersubjective, interpersonal, or self psychology schools. There is a marked absence of material from the Kleinian school on disclosure. I hope to fill some part of this void with a few thoughts on the use or misuse of disclosure.

Weigert¹⁷ writes,

The unconscious of the analyst is a receiving organ. His countertransference, lifted into consciousness, becomes an important source of information in the analytic process. Any rigidity, any automatization of attitude or procedure can become a defense against intuitive insight and block the passage from the unconscious to the conscious processes of the analyst. It is therefore important that the spontaneity of the psychoanalyst not be muffled by the rigidity of his technique. (p. 703)

This captures the essence of being flexible and receptive to patients and whatever they bring to the analytic relationship. Countertransference is often the best tool to detect PI within the transference. It is also the vehicle through which self-disclosure usually emerges. However, there is no particular reason to share one's own thoughts and feelings about matters outside of the immediate clinical situation.

I feel self-disclosure is rarely necessary, but when it is, it is for very specific technical reasons. Rather than as a supportive gesture based on ideas of relational connection or intersubjective interaction, self-disclosure is best used as a clinical tool of interpretation that specifically targets patients' fantasies about their objects. The actual disclosure is a revealing of particular countertransference thoughts and affects that have been generated by the patient's PI mechanisms. So self-disclosure and analytic flexibility, as I am defining them, are not shifts away from analytic treatment to supportive therapy. They are more a therapeutic stretching of certain analytic postures to accommodate moments of extreme difficulty in the pa-

tient-therapist dyad. Therefore, this approach differs from Pine's ideas¹⁸ on using supportive techniques to supplement the standard interpretive approach.

In other words, clinical judgment may deem that the best interpretation to be made in the moment is a description of how the patient's projections affect the patient's object. This is also an exploration of the intricacies of patients' defensive relationships to their objects rather than a direct interpretation of the leading anxiety that pushes them to engage in their defensive maneuvers.

Clinical judgment helps the analyst match and balance interpretations to the patient's level of psychic urgency at any given moment. These interpretative decisions are made by evaluating the affect, physical gestures and sensations, and associations in both analyst and patient. Neutrality and abstinence are necessary and helpful procedures, yet there are times when they can be loosened. For example, some patients with paranoid character structure will debate over why coming in once a week isn't just as good as coming in twice a week. Similarly, they might argue that they can achieve the same degree of health from coming in three times a week as from four times a week. With some of these patients, trying to explain the rationale behind our clinical recommendation would be an acting out by the therapist of "I will prove to you why you must be here" as well as an avoidance of the transference. This is usually in tune with these patients' tug-of-war PI fantasy.

With other patients, giving them "the facts" can be helpful in paving the road to future interpretations. It can temporarily help them to trust the relationship enough to stay rather than flee. It also helps them feel that they have some power or say in a relationship that may seem dangerous or confrontational. Providing a matter-of-fact response can help them proceed with their material. At the same time, offering our clinical rationale when asked can be used for the wrong reason: as a coercive weapon to circumvent resistance. Therefore, clinical judgment is crucial.

Again, flexible approaches are helpful only for select cases. Using a flexible approach, including self-disclosure, should be a carefully thought-out detour from standard technique that is used for specialized reasons.

Clinical Material

One patient, Frances, was mired in obsessive fantasies about power, control, and justice. She used manic defenses to be always correct and better than her analyst. Any interpretations

I made, she had already thought of. This was to prevent the breakdown of her omnipotence and to avoid the loss of her fragile, idealized object. We could have no differences. Part of her anxiety was about my keeping secrets. Frances felt I might have knowledge about her or her problems that I didn't share. This was unacceptable because it showed we were separate and different. It also made her feel inferior and humiliated.

During one period of her analysis, Frances became convinced that I had an opinion about her condition that I wasn't sharing. She demanded to know. Her insistence to have what she "had a right to know" escalated over several hours. It began to take on an obsessional and paranoid quality. She would not rest until I handed over the secret. Frances felt that I had a piece of her, and she was ready to fight for it to prevent a collapse of her integrity and feeling of power. After one rather grueling hour, with her becoming highly agitated and demanding, I felt cornered, controlled, and on the verge of being rejected. In other words, I was sure she was about to quit her treatment unless I gave in and "surrendered the goods."

Between these sessions, I found myself thinking and worrying about our relationship. It occurred to me that I was feeling as she often had growing up. She had felt bullied and controlled by an alcoholic father and a manipulative mother. Frances had wanted to obsessively confess all her shortcomings to her mother, since any aggressive or sexual feeling made her dangerous and sinful. By confessing to her mother, she regained her feeling of being better than her family. Omnipotence or loss were her choices. Using my countertransference and my knowledge of her background steadied me.

When Frances arrived for the next hour, she refused to use the couch and demanded that I tell her what I thought of her. She was anxious and agitated. She said she was on the verge of quitting. Frances was an obsessive neurotic, mostly organizing her mental life within the depressive position.^{19,20} However, she easily regressed into paranoid-schizoid² persecutory fantasies. Therefore, I felt it important to be very sure of what unconscious state she was in that day before making my interpretation. If she were mostly managing her inner world from the paranoid-schizoid perspective, I felt it would be unwise to make a transference interpretation about her thoughts and feelings toward me. This usually makes such a patient increasingly defensive and prone to a paranoid flight. In such a situation, I find it more clinically helpful to interpret the ego's vision of the object. This might include some self-disclosure. Therefore, I was ready to tell Frances that I was feeling confused and cornered, as if things would go sour if I did not "come up with the goods." I was ready to share my thoughts with her about how she was doing. Nevertheless, I felt nervous about what she needed and how everything suddenly seemed to have so much weight, as if everything could rise or fall based on what I said.

When I began to tell Frances that I was willing to talk with her about her worries and to try and help her out with what she needed, she calmed down. She visibly regrouped and began to relate to me from much more of a depressive stance. I was less of a dominating dictator in her eyes. When

I acquiesced somewhat to her fantasy about our tug-of-war, she felt less gripped by severe anxieties. When I saw that she had reintegrated somewhat, I decided to make a more standard PI interpretation concerning the transference.

I said, "You want me to tell you what I think of you. You grew up with a father whom you wanted to be close to and to get inside and understand. You wanted to look up to him and be close to him. You craved to know how he felt about you. Instead, you had a father who was angry and drunk most of the time. You felt blocked from knowing him and from knowing if he cared about you. Then he killed himself and you felt you would never be able to get inside him and know. Now, you are letting yourself be more vulnerable with me and are starting to want to know about me. You want to know how I feel about you, but you are worried I am blocking you as well. This makes you furious and sad and you want to try and push your way in. That conflict of wanting to be inside of me and feeling shut out is happening more and more lately. You are hoping I will see that and help you out."

This was a more oedipal-based interpretation that directly addressed her urges and fears. She listened intently and immediately seemed to relax. After a long silence, she began associating to memories of her childhood and her desires to be close to her father. Frances also told me she wanted to find out more about me but felt unsure if I would be nice or if I would be mean and withhold things. Based on my assessment of her intrapsychic structure, her unconscious fantasies and anxieties, and my own countertransferences, I was able to make sense out of her PI mechanisms and offer an appropriate interpretation.

These deviations from regular technique only apply to some patients who are very defensive and paranoid. These are the patients who are unusually rigid, controlling, and scared of others.

One paranoid, psychotic patient was so anxious about not getting a handshake from me at the end of each hour that she alternated between shouting at me for being a cold, mean bastard and begging me for some sign of compassion and love. She was so locked into her fantasy of me as a teasing, distant father whom she needed desperately and immediately that asking her to discuss it was like pouring gasoline on a fire. We were at a stalemate. I shook her hand at the end of the hour. Not surprisingly, she complained that it was a miserable, cold gesture and she wanted a "real handshake." Overall, what did happen was that we became less stuck.

Gratification is nevertheless a tricky matter. Some patients will become insatiable and others will pose the question, "If you fed me that time, why not all the other times?" I think it is inaccurate to automatically assume a person with ego defects needs gratifying support. This woman could not and would not continue unless I gave

in to her demand and her need. Some patients do indeed create an ego emptiness from excessive PI. It is an emptying of the self into the object. Also, through excessive and destructive PI and splitting, the ego can become fragmented and disintegrated. As with all patients, deficits, conflicts, demands, and needs are always found together, never apart. A patient can demand immediate satisfaction, pushing and manipulating the therapist into various levels of acting out. This is always a danger and must be noticed, explored, and analyzed. However, it is a situation that can't always be avoided.

Another psychotic patient came to me to stop smoking. His symptom, inability to stop smoking, was a fragile oral compromise that helped him keep from becoming floridly psychotic. When in the first meeting he asked me if I had ever smoked, I said yes and that I had quit. This type of clinical decision, to make a shift in my standard clinical technique, was based on an on-the-spot assessment of the patient's ability to maintain connection to a fantasy of a good object. This patient appeared on the verge of plummeting into severe paranoid-schizoid fears and delusions. Sometimes an interpretation will do; other times, a combination of self-disclosure and interpretation is needed.

Unfortunately, some patients are so inundated with persecutory fantasies about the torturous character of their world and their objects that this type of technical deviation only postpones the inevitable flight out of treatment. However, gratification via the therapist's self-disclosure can foster further analytic exploration and interpretive work. Disclosure can serve as a momentary buffer to the patient's annihilation anxiety, making it possible for some patients to proceed to the more analytic work.

This approach would be applicable only with select patients who are overwhelmed by internal destructive forces and who take interpretations as attacks. These patients are not amenable to analysis at that clinical moment, thereby requiring a temporary parameter. In this sense, the parameter is not "nonanalytic." It is simply a necessary precursor to, or place-holder for, analytic work. It "prepares the soil" for some patients to enter a more traditional analytic treatment.

With one borderline patient, I chose to make a comment that was at once gratifying, self-disclosing, and interpretive. She asked me why I hadn't called her when her father was dying. If I had simply been quiet, she would have reacted violently because her anxiety about being dependent on me was very high. Therefore, I chose to say, "I thought of calling you, but felt it would be too

intrusive or confusing. However, your wanting me to call you sounds like you would have liked me to. I think you want me to call you so I can take care of you and be like a loving father. At the same time, I think you wanted me to call because for *you* to call *me* feels like your being dependent, weak, and vulnerable, and that scares you.” My self-disclosure was in the form of an interpretation.

I consider all of these technical shifts away from standard or ideal analytic procedure still to be true to the basic analytic approach. The goal remains the same: the analysis of the transference, of unconscious fantasies, and of principal conflicts regarding destructive and loving forces.

The flexible approach can be a partial collaboration with the resistant side of the patient. This tradeoff is helpful, but only in cases where it is absolutely necessary. For example, one patient would always become concrete, paranoid, and withdrawn when I would make here-and-now interpretations. I found over time and with experimentation that it was better to make more reconstructive comments than here-and-now transference comments. These genetic reconstructions were helpful and often led to her making associations to more current anxieties, but I was also collaborating with her avoidance of the transference. My approach with her was a technical judgment based on her being very defensive, paranoid, and lacking in certain symbolic functions. If I tried to explore her anxieties, she typically regressed quickly into a fight-or-flight reaction. When she told me that her male friend from college had visited and they ended up “sharing the same bed,” I asked how that was. I thought it was clear that I was asking her how she felt about being in a sexual situation with a man she had only been friends with up to now. She replied, “Well, my ability to stretch out and use the whole area of the bed was compromised.”

If I dug deeper, she rapidly decompensated into a markedly paranoid stance. Therefore, I felt unable to say or do much of anything. In this way, she controlled me as she felt controlled by her objects. She projected the controlled and helpless little girl part of her ego into me and dominated me with the cold, crazy, and cruel mother aspect of her ego. Although she related to me this way many times over the years, I was still amazed at how cold and distant she could be. She was still apt to react with fear and retreat when I made transference comments or when she thought I was doing something unfair and controlling.

The analytic standards of neutrality and abstinence are helpful therapeutic tools. However, the degree to

which these tools are helpful in a treatment depends on the details of the patient’s current fantasies and anxieties. In some portions of a treatment, the ratio of analytic standards to nonanalytic interactions can vary widely. At certain times in an analysis, the treatment might be filled with extratransference material, extratransference interpretations, mutual acting out, and various interpersonal interactions. The analyst has to be aware of this shifting ratio and mindful of why it is occurring and when to intervene to change the balance. However, the clinical atmosphere of day-to-day analytic therapy is always in flux.

Strachey⁵ felt that extratransference interpretations are helpful in bringing the focus back to the transference, that they are important as a vessel for the vital contents inside: the mutative transference interpretation. He writes,

The fact that the mutative interpretation is the ultimate operative factor in the therapeutic action of psychoanalysis does not imply the exclusion of many other procedures (such as suggestion, reassurance, abreaction, etc.) as elements in the treatment of a particular patient. (p. 159)

I would add that the flexible approach to analytic treatment with certain patients is another factor to be found alongside the important mutative transference interpretation. In fact, for some patients it is the flexible approach that makes the use and success of the mutative interpretation possible.

Many patients relate to the analyst by PI and splitting. Klein² writes,

I have repeatedly found that advances in synthesis are brought about by interpretations of the specific causes for splitting. Such interpretations must deal in detail with the transference situation at that moment, including of course the connection with the past, and must contain a reference to the details of the anxiety situations which drive the ego to regress to schizoid mechanisms. (p. 21)

Certain patients are so internally disrupted by the excessive use of splitting and PI that a flexible approach to interpretation is useful.

Case Material

Franz had seen me for 7 years in psychoanalytic psychotherapy. He frequently pulled me into a sadomasochistic rela-

tionship where he first felt attacked by my interpretations and then would pull back and become oppositional. During these times, Franz would feel I was picking on him and being cruel.

The time in his treatment I wish to focus on involved his upcoming graduation from college. He was about to receive his degree in psychology and was very nervous about starting his career. His fantasies about not being liked in job interviews, not being able to compete with other new grads, and general worries about venturing out of the protection of college brought on intense anxiety. He felt trapped and began to see me as part of the group of people and places he was annoyed by. His fear turned to anger and contempt as he shifted to a manic defense. He split his objects into those that were accepting and wonderful and those that were rejecting and nasty. Franz projected his bad objects into me and his local job search. Within a few months, he was convinced that it was stupid to remain in the area when such fantastic career opportunities awaited him elsewhere. He imagined wonderful opportunities and friendship in distant locations. He devalued his therapy and any potential job offers he had in his hometown. It came to a point where he was literally thinking of moving to a far-off city he had never been to solely on the grounds that they might have entry-level psychology jobs. Franz seemed oblivious that he was about to sever his long-term relationships with his therapist, friends, girlfriend, and family.

I found myself echoing with the feelings of a bad object that had been discarded, deemed as unnecessary and worthless. These countertransference feelings were the result of Franz's PI process. These were fantasies of being unwanted and unaccepted in his new post-college life. At first, I acted out these feelings by giving him parental-like advice on the advantages and disadvantages of moving so abruptly. This made us seem to be a rebellious teenager-concerned parent pair. I was aware of this but also quite caught up in it. At one point in our stalemate, Franz pointed this dynamic out to me. I agreed with his observation and said, "I guess I am a bit thrown off course, confused. After our working together for seven years with lots of ups and downs, you told me a few weeks ago that you will probably be gone in two months. I guess I really don't know how to proceed. What should we talk about? It feels so abrupt. It's unclear what to do. I am not sure what you want." This was a deliberate self-disclosure of the effects he was having on his object and a statement of what I felt he was probably unable to deal with directly, without projection. He had projected these unbearable feelings into me and I was now struggling with them.

Franz paused and thought about what I said. He replied, "I think I know what you mean. I've been feeling so overwhelmed by the idea of starting a career that I have not wanted to deal with anything. I am trying my best to ignore all my relationships and just think about escaping somewhere. When I start to think about going to interviews and having people not like me and reject me, I can't bear it." I said, "I think you have been so overwhelmed with that anxiety that you have wanted me to hold onto it for you. So then I look like I'm a lecturing parent. You're hoping I can cope a little better and help you out." In saying this, I was inter-

preting his projection of his own judgmental superego and his demanding oral urges that usually left him feeling either unsatisfied and angry or persecuted by the needs of others. The result of our work in this hour was a decrease in his reliance on the manic defense and more insight into his anxiety. My self-disclosure was the use of PI-induced countertransference to make an interpretation.

Through the process of splitting and PI, I had acted out portions of this patient's fantasies. I had begun to pick on Franz. I was an external vessel for his overwhelming self-doubts and fears of rejection. When I revealed my confusion to him, I was showing my own struggle with doubt, loss, and rejection. This helped him to have hope in his own ability to struggle with these troubles. On another level, I had interpreted the character of his object's struggle, an unbearable aspect of himself he had felt pressured to expel into me.

If patients' fantasies are primarily about their *objects* (as in the object being caring, persecutory, or even harmed), selective self-disclosure can be helpful. If patients are mostly focused on a fantasy about themselves, it is less helpful.

Self-disclosure is not a "reality check" for the patient, nor is it a supportive measure. It is an intervention that is not often necessary, but it can occasionally prove useful with some patients in some circumstances. In these moments, it serves as a way to investigate the composition of transference fantasies and to see if the therapist's experience is the same as the patient's. It is more a clarification of the patient's fantasy.

CAUTIONARY NOTES

Disclosures made *outside* the arena of interpretations are often countertransference acting out. But making a self-disclosure in the service of an interpretation can easily be acting out as well—disguised under the rationale that it was technically necessary. Therefore, one needs to carefully assess who will truly benefit from such a disclosure.

Self-disclosure should not be a license for "anything goes." Some therapists have taken to self-disclosing a wide variety of personal thoughts and feelings without too much scientific reasoning behind that choice. Tauber²¹ writes about trying to undo the stigma of the countertransference. He comments,

This taboo has the harmful effect of inhibiting the analyst from recognizing the creative spontaneous insights that may occur to him in a dream, or in making use of a marginal thought or a slip of the tongue . . . With this as a hypothesis, I have discussed

openly with several patients for mutual clarification, dream material of mine that involved them. (p. 331)

I would consider this a wild use of countertransference and a way of avoiding the digestion of a patient's PI processes, which easily do evoke feelings, thoughts, and dreams.

Another form of self-disclosure that I feel is counterproductive is the expression of affect as a way of "showing" patients what impact they have on others or how affect "should" be expressed. This seems at best some type of educative, supportive counseling rather than analytic technique, and at worst it is manipulation and suggestion. Maroda²² writes,

My own clinical experience has convinced me that actually expressing the affect experienced in response to the patient is often the most therapeutic intervention possible . . . the challenge for the therapist is to show and express feelings without losing control, something the patient is convinced is impossible. This truly provides a model for identification purposes that the patient can use in life. For a patient to observe his therapist experiencing and constructively expressing his or her affect means that someday the patient may be able to do the same. (p. 237)

I believe it is dangerous to think that we can provide the mold for what is right and how to be. This is more of an attempt at re-parenting and making the patient into our image than an analytic exploration. Therapists who practice this way seem to be working mostly within the context of "reality" and interpersonal interactions. They appear to have lost sight of the huge impact of fantasy on a person's life and how that influence quickly dissolves any simplistic one-to-one answers in a complex therapy situation. Although some patients with gross cognitive

impairments may need this type of direction, most patients do not. Unless the treatment is already limited by managed care, acute psychosis, or addiction, such directive and suggestive methods seem counterproductive.

SUMMARY

Persecutory anxieties and a lack of symbolic ego function so grip some patients in the paranoid-schizoid position that they equate the therapist with the bad object, without any as-if quality. These paranoid individuals rely on destructive splitting and excessive projective identification mechanisms to cope with their frightening internal experiences. Unfortunately, these mechanisms generate a vicious cycle in which good objects are unavailable or destroyed and countless bad objects invade the ego.

These patients test the ordinary limits of analytic treatment. Using a Kleinian perspective with a certain analytic flexibility may help keep these patients in treatment long enough to begin addressing their fragile psychic states. Flexibility may include the selective use of self-disclosure. This would be limited to information directly related to the transference and to projective identification dynamics operating in the moment. The hope is that this flexibility will be a containing experience that will gradually allow the treatment to move toward a standard analytic situation. Therapists should proceed cautiously when applying this flexible approach or when using self-disclosure, because countertransference acting out or collusion with the patient's projective identification mechanisms is a real threat. Self-disclosure, even when helpful, need not be a reason to stray from the time-tested emphasis on the analysis of transference, resistance, and intrapsychic fantasy.

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Theory and Technique in Psychodynamic Treatment of Panic Disorder

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The authors elaborate psychodynamic factors that are relevant to the treatment of panic disorder. They outline psychoanalytic concepts that were employed to develop a psychodynamic approach to panic disorder, including the idea of unconscious mental life and the existence of defense mechanisms, compromise formations, the pleasure principle, and the transference. The authors then describe a panic-focused psychodynamic treatment based on a psychodynamic formulation of panic. Clinical techniques used in this approach, such as working with transference and working through, are described. Finally, a case vignette is employed to illustrate the relevance of these factors to panic disorder and the use of this treatment.

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Psychodynamic psychotherapy has become relegated to a secondary status as a treatment for panic disorder in the general psychiatric literature, in large part because of the lack of systematic studies regarding its effectiveness. The necessity for such psychoanalytic research has recently been emphasized by Compton.¹ Nevertheless, many clinicians have observed that psychodynamic approaches can be of significant value in the treatment of panic patients.

One impediment to research in this area has been the lack of a defined treatment for panic disorder. Psychoanalytic approaches have tended to be more broadly applied to generalized diagnoses of character neuroses, without specifications or modifications of treatment techniques for particular disorders. We will outline core elements of psychoanalytic theory that have been used in developing a testable manualized psychodynamic psychotherapy for panic disorder. This therapy, panic-focused psychodynamic psychotherapy (PFPP),² is currently being used by our group in an open clinical trial for the treatment of patients with panic disorder. We include a case vignette that illustrates the use of the theory and techniques.

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THEORETICAL UNDERPINNINGS OF PFPP

In outlining PFPP, it is important to delineate several general psychoanalytic precepts that were central to the formulation of a manualized treatment for panic disorder.

The Unconscious

Psychoanalytic theory hypothesizes that all of mental life exists on two levels: within the realm of consciousness, and also within a less accessible realm that Freud labeled the unconscious.³ Psychic or emotional symptoms arise from aspects of mental life that are at least in part unconscious.

From our early work with patients with panic disorder, it became evident that this group of patients has intense angry feelings of which they are often totally or partly unaware. Typically, panic patients tend to minimize these feelings during initial evaluation, but as exploration with the patient continues, unacknowledged rage is found to be an increasingly important part of mental life at the time of panic onset. We link these partially or totally unconscious feelings to panic onset.

In addition, we have found that patients' feelings that their panic symptoms "come out of the blue," an idea that is underscored in DSM-IV (p. 397),⁴ are related to their lack of conscious awareness of the meaningful stressors and ensuing intrapsychic reactions that led to panic. Many studies suggest that acute stressors, described in the literature as "life events," occur just prior to panic onset.⁵⁻⁷

A related central organizer of mental life is unconscious fantasy.⁸ Persistent unconscious fantasies often underlie people's psychological symptoms, dreams, personalities, and life choices. Unconscious fantasies are important underpinnings to panic symptoms, and it is valuable to help patients become aware of these fantasies with a goal of effecting symptomatic change.

Clinical Example 1. An example of this process is provided by a patient with panic disorder who lived with the persistent unconscious fantasy/wish that she would become closer to her beloved but rejecting physically impaired brother by being ill, impaired, and pathetic herself. At the time of her presentation, she was aware of having strong "irrational" feelings of loving and wanting to protect her brother, even though he routinely was mean to her. It emerged in the course of psychotherapy that she had completely "forgotten" about the existence of a chronic childhood illness he had that had greatly affected her life. She began to remember these things gradually, at a time of tem-

porary worsening of her panic symptoms when she was accepted to a prestigious graduate program—something that she was surprised to discover made her "unaccountably miserable." The patient became aware that her success with graduate school acceptance triggered a fear of the loss of her fantasy of being ill and pathetic like her brother, and her worsening panic attacks served to reestablish her view of herself as being weak and damaged. Her panic resolved and she was able to alter some of her earlier tenaciously held feelings only after she was able to consciously recognize these issues in her therapy.

Compromise Formation

According to Freud, many aspects of mental life, including symptoms (such as anxiety), dreams, fantasies, and various aspects of character, are the result of "compromise formations."³ In brief, a compromise formation symbolically encapsulates a compromise between a forbidden wish and the defense against the wish. Panic attacks represent such compromise formations, often an attempt to compromise between angry feelings and fantasies and fears of abandonment. The following case vignette is an example of panic representing a compromise formation: a symbolic representation of both a forbidden wish and the defense against the wish.

Clinical Example 2. Ms. W., an 18-year-old woman, was driving from one city to another in order to attend her eighteenth birthday party when she experienced her first panic attack. The attack was so severe that she had to drive off the road, call her mother in the city toward which she was driving, and ask her mother to pick her up on the highway. The process of her mother's finding another person to drive with her who could also drive the car back took several hours, and in the meantime, Ms. W.'s party had to be canceled. At the moment that she experienced the attack, Ms. W. had found herself thinking that her eighteenth birthday was very important to her: it symbolized her "total independence" from her family and a new ability "to get rid of them." In the process of unraveling the onset of her illness later in psychotherapy, it became clear that in her fantasy, turning 18 and being "independent" represented the emotional equivalent of killing off her parents and siblings, all of whom enraged her. The fantasy was so full of conflict for her that she had her first panic attack. The panic symptoms represented both the wish to be alone and independent (suddenly she found herself, in fantasy, feeling entirely alone) and the defense against this wish: a sudden-onset, severe illness that made her "independence" from her family (and the very existence of her birthday celebration) impossible and effectively immobilized her escape/fantasy murder plan. Rather than a dangerous murderer, she was now helpless and ineffectual. Additionally, the panic represented a real way in which she effectively punished herself for her homicidal (and unacceptable) thoughts: now she could never be free of her family.

The Pleasure Principle

Freud initially described another central principle in the organization of mental life, the pleasure principle:⁹ that people unconsciously avoid “unpleasure.” Clinically, the degree to which “unpleasure” is avoided varies from patient to patient. Despite the misery of panic attacks per se, from a psychodynamic perspective panic attacks represent the least unpleasurable solution to the intrapsychic conflictual situation at hand. In other words, the intrapsychic conflicts, including angry fantasies and fears of loss that underlie the symptoms, are more distressing to panic patients than the experience of the panic attacks.

Clinical Example 3. Mr. D., a 45-year-old man, presented with severe symptoms of panic, particularly focused on chest pain with fear of having a heart attack and arm weakness with a fear of having a stroke. In the initial evaluation, it emerged that his father had died from heart disease and his mother had suffered a debilitating stroke. Despite this immediate evidence of a psychological source of his fears, Mr. D. struggled with the notion that his panic symptoms were psychologically meaningful and were triggered by intense, overwhelmingly painful feelings. As he began to discuss some of the difficult experiences he recalled with his parents growing up, he became tearful and distraught. Particularly, Mr. D. remembered experiences of humiliation at the hands of his parents, particularly his father, who referred to him as “Dumbo,” even in front of his friends. In calling him this his father was implying that the patient was stupid and was to blame for many of the family’s ills. Mr. D. felt enraged at his parents, but was told that if he ever expressed his anger, he would be sent away to live with a woman named “Mrs. Cruela,” where bad children went. He felt caught between humiliation, rage, and fears of abandonment.

Recollection of these painful experiences proved at least as distressing as the experience of panic itself, as he repeatedly struggled to understand why his parents treated him in this way. He became even more convinced of the relationship between these issues and his symptoms when it was found that his panic symptoms were regularly triggered by the experience of his wife being abandoning, paying attention to her many friends rather than to him. Panic attacks were less threatening to him than the experience of rage at his wife, which he was convinced would cause her to leave him.

Defense Mechanisms

Ideas and feelings that produce unpleasure are screened from consciousness by “repression,”¹⁰ or processes that we now call defenses. We have found, both in clinical observations and in a systematic study, that

the defense mechanisms of reaction formation, undoing, and denial are frequently employed by panic patients.¹¹ Reaction formation and undoing appear to be particularly active in panic patients, as these mechanisms involve both the denial of anger and an emphasis on affiliative feelings.

Clinical Example 4. Ms. C., a 32-year-old woman, developed panic attacks with claustrophobia shortly after her marriage. The courtship had gone fairly smoothly, apart from some tense discussions about whether Ms. C. should convert to the religion of her fiancé (she ultimately did not). Her symptoms intensified further about 3 months later when her husband decided to take a new job that would keep him much busier. Ms. C. readily agreed to the job change, even though she felt isolated in her environment and had already felt ignored because of her husband’s level of involvement with his job. She initially denied any anger at him, stating that it was important to go along with his plan and help him as much as possible in his career because he supported her financially.

Ms. C. grew up in an environment in which she felt intensely pressured by her family to perform academically. She reported being berated repeatedly for not being a top performer. Ms. C.’s real focus was on painting, in which she demonstrated talent beginning at a very early age. In the face of her parents’ pressure and attacks, she alternated between intense rage accompanied by stubborn refusal to compete academically, and a submissive, anxious state in which she felt guilty and agreed with what she saw as her parents’ view that she was a bad or lazy person for not working harder. Ms. C. felt that it was necessary for her to be in this latter state in order to be accepted by her parents.

After discussion, it emerged that Ms. C. worried right from the start of her marriage that her husband would attempt to control her and push his agenda in preference to her wishes, just as she felt her parents had done—even though she had specifically married someone who did not take this approach with her. Ms. C. then began to be aware of intense angry feelings toward her husband for having encouraged her to change religions and subsequently for pushing his career needs ahead of their relationship, even though she had not indicated to him how much these issues bothered her. Her concerns that her anger would disrupt their relationship led to a denial of these feelings and the use of reaction formation, in which she emphasized her wishes to help him when she was actually furious with him. However, this pattern only intensified her unconscious anger, and the danger of its emergence was a trigger for her panic.

Transference

A cornerstone of psychodynamic theory and practice is the psychological phenomenon of transference.¹² Transference is a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously ascribed to un-

related, current relationships. This fundamental unconscious process also importantly occurs in relationships between therapists and patients. In clinical practice, recognition of underlying fantasies that surround the therapeutic relationship can prove helpful to patients, regardless of the type of treatment or the therapeutic orientation of the therapist. From a psychodynamic perspective, the transference situation has far-reaching effects and necessarily influences therapeutic outcome regardless of the therapeutic modality employed.

Clinical Example 5. A psychopharmacologist who specializes in the treatment of patients with panic disorder reported the following case: an older woman patient with panic disorder who had been in treatment with him for years had been on very high doses of benzodiazepines. She and her physician had been engaged in a very slow and gradual taper of the drug as her panic attacks had remitted. She was in the middle of this taper, still on a substantially high dose of benzodiazepines, and had been tolerating the taper well. The pharmacologist lowered her dose again in a “microscopic decrement” prior to leaving for a vacation. The patient had “the worst panic attack in my life,” for which she still has “not forgiven” him years later.

Benzodiazepine taper is well known to be difficult in this patient population because of the common experiences of withdrawal syndromes and rebound anxiety. It is for this reason that benzodiazepine tapers are best accomplished over a period of months. Nonetheless, in the Cross-National Panic discontinuation phase, most of the patients treated with alprazolam experienced their most severe withdrawal syndromes and rebound anxiety either at the very end of the drug discontinuation phase or during the first week in which they were medication-free.¹³ The patient in Example 5 above was in neither situation. However, it is possible that this patient was experiencing a different but equally common panic-related phenomenon: anxiety when being separated from the important objects in her life—in this case, her psychopharmacologist. It is also possible that even in the context of a pharmacological treatment, some degree of focus on the transference situation might have prevented the panic attack.

Signal and Traumatic Anxiety

Two types of anxiety were delineated by Freud.¹⁴ “Signal anxiety” is posited to be an intrapsychic mechanism that generates small doses of anxiety to alert the ego—which is the psychic apparatus that organizes per-

ception, defenses, cognition, anxiety, and mood regulation as well as other mental functions—to the presence of psychologically meaningful dangers and to act as a stimulus to mobilize defenses. Signal anxiety and the attendant triggering of defenses serve to prevent traumatic anxiety. Freud hypothesized that during traumatic anxiety, the ego is overwhelmed by an “excitation, whether of external or of internal origin, which cannot be dealt with” (p. 81). Traumatic anxiety is experienced during what we now label panic episodes.

A Psychodynamic Formulation for Panic

Much has been written concerning the underlying meaning of panic symptoms.¹⁵ Clinical observations indicate that fantasies surrounding separation and independence are common areas of conflict for panic patients. Several epidemiologic studies provide indirect support for this finding.^{16–18} As noted above, clinical observation also suggests that patients with panic disorder have intense difficulty tolerating and modulating angry feelings and thoughts.^{19,20} Additionally, although panic attacks often occur in the setting of conflicted hostility, for some patients the attacks take on an exciting significance of their own, beyond the common manifest panic thoughts of being ill, dying, or becoming “crazy.” Some patients report a frightening or arousing inherent excitement associated with the attacks, often closely tied to sadomasochistic sexual fantasies.²¹ Panic attacks can serve a self-punitive function with which patients unconsciously atone for guilty transgressions, as was illustrated by the second clinical example above.

Panic patients are overwhelmed by anxiety much of the time. Either their signal anxiety function is malfunctioning, or the signal warning does not help because their defenses are not operating effectively. From a psychodynamic perspective, panic symptoms are indicative of specific, intense unconscious conflicts that serve an important psychological purpose, the understanding of which forms the cornerstone of psychodynamically based treatments for panic.

We have found that fears of separation and anger are central to panic onset and persistence. From early life, individuals prone to panic struggle with feelings of inadequacy and a sense of being dependent on caretakers to provide safety. This fearful dependency can develop from an inborn excessive fear of the unfamiliar^{17,22} or from actual traumatic developmental experiences, such

as loss or abandonment threats. In either case, the child experiences the parent as providing inadequate protection and becomes angry at the perceived rejecting or abandoning behavior. This anger triggers anxiety because of a fear that it will lead to further disruption in the relationship to caretakers, increasing fearful dependency. A repetition of this vicious cycle is triggered in adulthood when fantasies or experiences of disruption in attachments occur, frequently triggered by meaningful life events. The defenses of reaction formation and undoing represent efforts to deny anger and make attachments closer through compensatory positive feelings. However, because of angry feelings that are at least partially unconscious, these defenses ultimately fail to modulate the experienced threat to attachment—leading to the onset of panic.

AN OUTLINE OF PFPP

The following is an overview of our manualized form of psychodynamic psychotherapy for panic disorder. The number of sessions allotted to different phases of treatment varies from patient to patient. PFPP differs from more traditional, open-ended, psychodynamic psychotherapies in that the therapist focuses on panic symptoms and associated dynamics and relates new material in sessions to panic disorder.

Phase I: Treatment of Acute Panic

During phase I, the therapist focuses on elucidating the conscious and unconscious meaning of panic symptoms. The initial evaluation and early treatment include exploration of circumstances, life events, and feelings surrounding panic onset, exploration of personal meanings of panic symptoms, and exploration of feelings and content of panic episodes. We have observed that individual patients attribute unique significance to their symptoms, and that they also experience a variety of unconscious and conscious emotions in addition to anxiety during panic.

The therapist uses this information to begin to elucidate unconscious conflicts in panic disorder. These conflicts commonly revolve around separation and independence, anger recognition and management, and sexual excitement and its perceived dangers. The expected responses to phase I of treatment are panic symptom relief and a reduction in agoraphobic symptoms.

Phase II: Treatment of Panic Vulnerability

During phase II, core dynamic conflicts related to panic, often connected with unconscious aspects of fears of separation, anger, and sexual excitement noted above, must be understood and altered. Dynamisms are identified with the patient, often through their emergence in the transference. Phase II tasks include addressing the nature of the transference and working through.

The expected responses to phase II of treatment include improvement in relationships; a less conflicted and anxious experience of separation, anger, and sexual excitement; and a reduction in panic recurrence.

Phase III: Termination

During phase III, termination, the therapist can directly address panic patients' severe difficulties with separation and independence as they emerge in the treatment. The termination process permits patients to reexperience conflicts directly with their therapists in order for underlying fantasies to be articulated, understood, and rendered less magical and frightening. There is often a reexperiencing of central separation and anger themes in the transference, sometimes with a temporary recrudescence of symptoms as termination approaches.

The expected responses to phase III of treatment include a new ability to manage separations, anger, and independence.

A BRIEF OVERVIEW OF CLINICAL APPROACHES AND TECHNIQUES

Initial Evaluation and Early Sessions

The initial psychodynamic evaluation of the panic patient includes a careful and thorough psychiatric evaluation, including a history of the panic attacks, and thus must focus on details about where and when panic attacks occur, whether the patient experiences symptoms when alone or when with others, and what feelings and fantasies accompany panic attacks. As noted above, it is crucial to remember that the patient's view of symptoms as coming out of the blue represents a defense against the intense emotions that precipitating events have engendered. An important area of inquiry concerns which of

the many panic symptoms are most distressing to the patient, since these details often can point the way to underlying fantasies concerning the psychological meaning of the attacks. Small variations in thoughts often carry important psychological significance.

Early sessions are focused on panic symptoms. If the patient does not spontaneously mention panic, the therapist eventually actively inquires about these symptoms. Early in the treatment, it is important for the therapist to help the patient begin to think about the psychological underpinnings to these symptoms and become more aware of his or her own feeling states.

Indications for Psychodynamic Psychotherapy

Much has been said in the psychiatric community about patients' varying abilities to make use of psychodynamic psychotherapy, and there is a belief among some psychiatrists that patients should be considered candidates for psychodynamic psychotherapy only if they are verbal, psychologically minded, and curious about their motivations. Although all of these qualities can be helpful in facilitating the process of psychodynamic psychotherapy, panic patients often have difficulties in one or more of these areas because of the very nature of their somatic symptoms: that is, they experience intense affects and fantasies as symptoms in their bodies rather than as verbal thoughts.

In our clinical work and in the open trial of PFPP that we are conducting, we have not found that these personal qualities necessarily influence the outcome of psychodynamic psychotherapy for panic disorder. In our experience, patients without many of these abilities have derived significant symptomatic relief from psychodynamic psychotherapy for panic disorder. For instance, 6 of the 10 patients who had completed treatment at the time of this writing in the PFPP study were not judged to be psychologically minded, and 5 of these 6 responded to the treatment.

Reassuring, Engaging, and Calming the Patient

Patients with panic disorder often require a significant amount of reassurance that their problems can be treated. It is essential that therapists provide this reassurance to calm patients enough to begin to explore the underlying meaning of their symptoms. In PFPP, reassurance

is employed in a manner that does not close off exploration. For example, the therapist may say: "We know that your internist has reassured you that there is nothing wrong with your heart, so we need to understand more about why you still have the fear that you're dying of a heart attack."

Patients' interest and curiosity can often be engaged by the demonstration of the ways in which panic symptoms are related to current and past modes of thinking and feeling. This process can be facilitated by connecting ongoing emotional concerns with panic symptoms *per se*.

In clinical practice, psychodynamic psychotherapy is often combined with antipanic medication to calm patients enough to enable them to think.²³ In the open trial of PFPP, however, medication is not being used. Several techniques are employed to calm patients, including reassurance; employing a firm, unruffled, but sympathetic attitude;²⁴ and making beginning inroads into the understanding of the psychological significance of symptoms, which demonstrates to patients that they can gain control through psychological understanding.

Working Through

The process of working through involves repetition of specific interpretations in different contexts as they apply to different manifestations of the same intrapsychic phenomenon. Although limited in a time-limited psychotherapy, the process of working through is particularly important for this population because of panic patients' difficulty putting their feelings into words and because many aspects of the psychological significance of conflictual material often do not emerge on first appearance.

Working With the Transference

Transference is a powerful phenomenon that permits the patient, within the setting of psychotherapy, to tangibly reexperience and begin to understand affective states and fantasies about important relationships. Our hypothesis is that interpretation of transference phenomena can be an important agent of therapeutic change in PFPP. We avoid unnecessary external distortions of the unfolding of the transference—such as unnecessary manipulations of the patient's environment, directive behavioral guidance on the part of the therapist, or unnecessary involvement of the patient's family in treatment—because they will make the task of delineating

central transferential fantasies more obscure. Some common difficulties that arise in addressing the transference in these patients are that patients often have real reactions to therapists as real people; that therapists can miss patient cues; that an overly aggressive focus on the transference can foster feelings of being misunderstood and intruded on; and that panic patients commonly avoid all feelings about their therapists, much as they avoid other strong feelings.

Approaches to Termination

Termination can be a symptomatic period in these time-limited treatments, as patients grapple with chronic anxiety and rage about separation, independence, and abandonment. Some panic patients feel the urge to flee treatment at this time, in an effort to undo the experience of being abandoned and the emotions associated with loss. Because of this inherent situation, the final one-third of our study treatments (which are 24 sessions long) directly addresses patients' conflicted feelings about termination.

A TECHNICAL CLINICAL EXAMPLE

Mr. A., a 36-year-old married lawyer with three children, presented with panic disorder and hypochondriasis, having failed a year-long competent trial of cognitive-behavioral therapy. Early sessions in treatment focused on his terror and sadness over losing his mother to a chronic illness when he was 14 and his feeling that when she died he lost his identity and all sense of security. He was frightened about whether he could withstand examining himself in psychotherapy: "If I tear apart who I am and everything I do, what will I have left?" The therapist related this fear to the feeling that he had "lost himself" when his mother died.

After initially feeling angry with the therapist about the "rules" of the therapy (that he explore his feelings, that he bring in a panic diary as part of the protocol), he soon felt relieved by his beginning new self-understanding. Exploring his anger at his therapist led him to remember a feeling that his mother did not love him unless he was meek and compliant, and to discover a fantasy that his anger had killed her and would kill others, leaving him alone. These feelings were linked to castration fears, which undermined his ability to be competent and adult.

As he explored these areas, his panic attacks began to subside and he started to describe a feeling of "loving more" than he previously felt able to do. He experienced panic remission after the first five sessions. His enhanced sense of well-being made him feel terrified that now everything would surely fall apart, in punishment for his feeling better. He continued to experience 15 seconds per day of nonpanic high anxiety every morning, and continued to worry about

his health in an exaggerated way that he found embarrassing.

The following excerpt of dialogue was taken from his sixteenth session. It provides an example of his anxious concerns, his style of not wanting to know, and his avoidance of frightening feelings—characteristic of panic patients—along with the inroads made toward understanding his defenses, and thereby his symptoms. The session begins with Mr. A. making a slip and denying first the occurrence of the slip, and then its significance. The patient seemed to have grasped the concept of unconscious meaning and its relation to panic before this session, so the therapist noted but did not immediately address the significance of his naive attitude. She gently but firmly confronted the patient about his efforts not to address the meanings and feelings behind his slip. Later, the therapist recognized that the scenario was an reenactment of the patient's relationship with his mother, in which he played the naive little boy and his mother "took charge." This aspect of his relationship with his mother also underlay one aspect of his panic, which turned him into a sick, helpless little boy whom others had to coddle. This connection was addressed productively.

PATIENT: That's how whacked-out I can get in terms of dying, thinking that you can die from the common cold. That's me—Joe the hypochondriac.

THERAPIST: You're saying that you feel weak and defenseless.

PATIENT: I do feel that, but I don't remember saying that.

Ideally I would like to get through a common cold without going to a doctor. Because there's an old adage: take the medicine and you'll be better in seven days, or bed rest and it will be gone in a week. These articles I read tend to make me believe if I don't go to a doctor and get medicine, I'm not being treated and I'm not going to get better. I was taking pills while I was going with you. It was a five-day course of antibiotics.

THERAPIST: Going with me?

PATIENT: I was taking them while I was still here with you, I had been going to you. The last time I took one we had already started our sessions.

THERAPIST: When you say something like that, when you make a slip like that, it has a meaning. It's a flag pointing to some thought or idea that you are unaware of, some unconscious idea of which the only expression is a little slip. If you turn your attention to the slip, what comes to mind? What do you think about?

PATIENT: Let's start with *what* slip.

THERAPIST: I think you said, "while I was going with you."

PATIENT: I meant while I was going *to* you.

THERAPIST: Oh, I understand what you meant to say, but you meant something else from another part of your mind. We are interested in that. Anything that comes to mind about that?

PATIENT: No, not really.

THERAPIST: Let your imagination go a little.

PATIENT: You are full of yourself. The fact that I forgot you were going away had major grandiose implications. I did not think it did. The predominant thought in my mind was, she really feels so important like she has a major significance in my life. The fact I forgot gives me the same initial reaction

as now. In your world there is no such thing as just a slip.

THERAPIST: Yes, there is such a thing as just a slip, but it means something.

PATIENT: Let me reclarify: as a meaningless, pointless slip.

THERAPIST: No. If you say something our job is to not to dismiss it, but to understand what it is that was going on in your mind that gave rise to the slip.

PATIENT: To you that is a window into my subconscious.

THERAPIST: Yes. And I think the process of your dismissing it and saying it does not mean anything is a part of a process of pushing feelings away and pushing meanings away. As much as you do the opposite to explore and try to uncover here, I think you are still tempted to push things away. That's one of the processes that gives rise to your anxiety, which is so intense and which you experience as being "out of the blue," as you experience your slip.

PATIENT: I was going to ask you about that. I don't mean to digress—but I guess I do, because everything has a meaning. Am I correct in the assumption that all these different things we have explored, I guess, they are related? The various panic and anxiety attacks I experience don't have to be necessarily related to what I am thinking at the moment; they can be a by-product of what's going on in my head. All that stored up inside of me.

THERAPIST: Yes, very much so, except that what you're thinking and feeling at the moment that they occur is also important.

This interchange led to a flood of memories and associations. The relationship that was being enacted here was related to the patient's conflict about being an adult man and a father, a conflict that was discussed explicitly in the remainder of the session. Patient and therapist had already explored one of the settings in which the patient panicked regularly—when he had to pay for dinners. He had said, "I feel like one of the kids, but at those moments, I realize I'm the Daddy. I'm supposed to provide. Who's going to provide for me?" He felt fraudulent, inadequate, and abandoned.

These associations triggered thoughts about the other situation that routinely made him panic: shaving in the morning. "Each morning when I shave, it's a reminder that I'm getting dressed to go to work to perform as a grown-up man. It's the transition from my safe bed to the outside world." The therapist pointed out that shaving was also something only men did, not little boys. The patient replied, "It reminds me—when I was little, in my bathroom—ooh. That was a slip. I meant my father's bathroom. I wonder what that means . . ." This led to an exploration of his conflict about being a strong, effective man and a terror that if he were one, it would mean he would be eliminating and replacing his father, as he had in the slip. The patient associated to a number of sexual feelings and fantasies that he thought were inappropriate and were proof that he was an awful person. The therapist related the patient's anxieties over his competitive strivings with his father, his guilt over his sexual desires, and his panic symptoms, which emerged in particular when he "became the Daddy." They discussed his consequent defense against allowing himself to be a

strong, successful, sexually fulfilled man by consistently playing the role of sick, weak, innocent little boy.

The patient then volunteered, "And don't worry—I haven't forgotten your question about my slip 'going with you.' It sort of sounds like dating." This session paved the way for further exploration of the patient's erotic transference, which permitted a deeper appreciation and working through of these conflicts and how they related to his panic. The patient responded to the treatment and remained in remission at 6-month follow-up.

As can be observed in this vignette of the use of PFPP, the therapist actively related issues the patient discussed to underlying conflicts that were associated with panic disorder. The vignette demonstrates one of the core conflicts that we have found in panic patients, a concern that their own aggression will cause disruptions in attachments, creating intense anxiety. Mr. A. appeared to associate success with unacceptable aggressive impulses. He feared the loss of close, intimate relationships, such as the one he had with his mother, through demonstrations of his competence.

DISCUSSION

We have outlined some relevant aspects of psychodynamic underpinnings in panic disorder and have provided a description of some of the methods for addressing these factors in the therapeutic situation. Panic-focused psychodynamic psychotherapy cannot be employed in a "cookbook" manner because even core conflicts involving aggression and fearful dependency, as described above, present in a unique manner in each patient, and other intrapsychic conflicts can also contribute to panic disorder symptomatology. A psychodynamic approach can be employed in conjunction with medication or cognitive-behavioral therapy. Clinicians who routinely treat panic patients may wish to consider incorporating some psychodynamic understanding of the panic syndrome, as described in this article, in their treatments.

Despite some anecdotal evidence of the clinical utility of psychodynamic psychotherapy for the treatment of panic disorder, more systematic studies of this approach, beyond our current open clinical trial, are essential. Given that many panic patients relapse after receiving short-term psychopharmacological and/or cognitive-behavioral interventions, it may take some time to determine what combination of treatments, over what time period and for which particular patients, are

most effective in the treatment of panic vulnerability. Until such data are available, it is important for clinicians

to have a variety of tools available for the treatment of panic patients.

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Is There a Cost Offset to Psychotherapy?

Tracy D. Eells, Ph.D.

An important question debated by health care experts concerns the so-called medical offset effect of psychotherapy. The question is whether costs incurred in providing mental health services, and psychotherapy specifically, are offset by reduced costs elsewhere in the health care system, primarily in the general medicine and surgical sectors. An influential meta-analysis by Mumford and colleagues¹ found that 85% of 58 studies examined reported a decrease in medical utilization following psychotherapy. Across 22 controlled studies reviewed, hospital stays for individuals who underwent psychotherapy were 1.5 days less than the control group mean of 8.7 days. Although influential during its time, this study is largely obsolete today because of cost controls brought on by managed care. One effect of decreased hospital stays, reduced reimbursement rates, and increased utilization review, among other recent changes in health care economics, may be the elimination of a medical offset.

To examine evidence for a medical offset effect in the current health care environment, I conducted a literature search for relevant journal articles published since 1996. Using PsychINFO, the online database of the American Psychological Association, I requested articles containing the words “medical offset” in any field of an article’s database record. In selecting the articles reviewed below, I used a broad conception of “offset.” Instead of restricting myself to articles examining an offset of nonpsychiatric medical costs, I included two that examine possible offsets of alternative or additional mental health services and two that investigate possible cost reductions to society as a consequence of psychotherapy. Although the narrower definition of “medical cost offset” is of primary interest to health insurance organizations, the broader definition that incorporates societal costs better addresses the interests of policy makers.

ABSTRACTS

O’Farrell TJ, Choquette KA, Cutter HSG, Brown E, Bayog R, McCourt W, Lowe J, Chan A, Deneault P: Cost-benefit and cost-effectiveness analyses of behavioral marital therapy with and without relapse prevention sessions for alcoholics and their spouses. Behavior Therapy 1996; 27:7–24

Summary: Cost-offset analyses were conducted on 59 couples in which the husband was newly abstinent from alcohol after a 5- to 6-month course of behavioral marital therapy (BMT). These 59 couples were randomly assigned to receive or not receive an additional 15 relapse-prevention (RP) treatments. For each group, the study authors compared alcohol-related health and jail costs over a 12-month baseline period before BMT and over a follow-up period after BMT, during which half the sample received RP. These costs were compared with those of providing BMT and BMT plus RP in order to determine cost-benefit ratios.

Findings were that BMT and BMT plus RP, considered together, led to a mean savings of more than \$4,000 in alcohol-related health and legal system costs from baseline to follow-up. The benefit-to-cost ratio for the entire sample was 3.84, indicating a substantial cost offset. BMT plus RP did not produce a greater cost offset than BMT alone, although post hoc analyses suggested that the additional RP sessions may have prevented re-hospitalization better among cases with higher baseline medical and legal costs than did BMT alone.

Comment: This is a promising study despite the small sample and other limitations, including considerable

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variability in cost data among subjects, the relatively brief measurement periods, the possibility that baseline cost data are overestimated due to an exacerbation of alcohol-related problems just prior to receiving BMT, and the absence of a control group not receiving BMT, which limits causal inferences and the ability to determine the specific cost offset from BMT. Aware of the high variability in costs, the authors conducted analyses using medians, which are not influenced by extreme scores, and found substantially identical results. Similar results were found when they omitted cases incurring no alcohol-related health or jail costs during the baseline and follow-up periods. The offset might well have been much higher had the authors measured a broader range of costs related to unremitted alcoholism. These could have included loss of productivity due to work abstinence of the alcoholic and his spouse; legal costs related to domestic problems and divorce; and medical costs related to alcohol use but not directly aimed at treating alcoholism.

Kuipers E, Fowler D, Garety P, Chisholm D, Freeman D, Dunn G, Bebbington P, Hadley C: London-East Anglia randomised controlled trial of cognitive-behavioral therapy for psychosis, III: follow-up and economic evaluation at 18 months. *British Journal of Psychiatry* 1997; 173:61-68

Summary: Forty-seven patients with medication-resistant psychoses were followed up 18 months after beginning a 9-month randomized, controlled trial of cognitive-behavioral therapy (CBT) plus "standard treatment" or standard treatment alone. The follow-up included an assessment of the potential cost-offset effect of CBT. The patients originally met criteria for schizophrenia, delusional disorder, or schizoaffective disorder. Compared with those receiving standard treatment, the CBT group showed a significant and continuing improvement, as measured by the Brief Psychiatric Rating Scale. Delusional distress and hallucinations were also significantly reduced in the CBT group.

The additional costs of CBT appear to have been offset by reductions in service utilization and associated costs during follow-up. The most noticeable differences between the two groups relate to psychiatric inpatient stays (CBT group: mean = 14.5 days, SD = 31.0; standard treatment group: mean = 26.1 days, SD = 53.6) and day care (CBT group: mean = 23.5 attendances, SD = 49.2; standard treatment group: mean = 36.7 atten-

dances, SD = 48.9). Because of the high within-group variability, the group differences were not statistically significant. A comparison of monthly costs showed the CBT group to be less expensive, although the difference was not statistically significant.

Comment: Despite a variety of methodological problems (e.g., low sample size, lack of double-blind design, and difficulty controlling for medication effects), this study suggests, at a minimum, that CBT did not add to the standard costs of caring for medication-resistant patients with psychotic disorders. The authors were able to measure only the cost offset due to inpatient hospitalization and day treatment programs. They did not measure additional potential cost offset such as reduced medication costs, lost employment in patient caretakers, and lost productivity of patients. As with earlier studies, there was considerable intragroup variability with regard to cost savings.

Von Korff M, Katon W, Bush T, Lin EHB, Simon GE, Saunders K, Ludman E, Walker E, Unutzer J: Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. *Psychosomatic Medicine* 1998; 60:143-149

Summary: Cost-offset analyses were conducted to assess whether the costs of enhanced management of depression in a primary care setting might be offset by savings in medical care or specialty mental health service costs. Two completely randomized, controlled studies are described. In the first, 217 depressed patients received either "usual care" by a primary care physician, which involved antidepressant medication, or "collaborative therapy," provided by psychiatrists and involving enhanced pharmacotherapy management and brief psychoeducational interventions to enhance adherence. In the second trial, 153 patients received either usual care or usual care enhanced by four to six sessions of cognitive-behavioral therapy. Patients were stratified into major depression and minor depression groups.

The authors found a modest cost offset due to reduced use of specialty mental health services (outside of those provided in the study) among Collaborative Care patients, but costs of ambulatory medical care services did not differ significantly between the intervention and control groups. Among patients with major depression, there was a modest increase in cost-effectiveness, but no cost-effectiveness differences were found among the pa-

tients with minor depression. The cost per patient successfully treated was lower for Collaborative Care than for Usual Care patients. The authors conclude that it may be more cost-effective to improve the quality of services for patients already treated for depression with usual care than to increase the number of patients treated under usual care. Furthermore, when patients with major depression are targeted in the primary care setting, effective treatment can be achieved with only a modest increment in the costs of treating depression.

Comment: This study has a major advantage over the previously reviewed studies in that it uses randomized, controlled designs and larger sample sizes. The study has practical significance in that it assesses whether a cost-offset effect occurs from efforts to enhance the treatment of patients already recognized as depressed and already treated pharmacologically by a primary care physician. The results are relevant to the question of whether a health plan using specialty mental health providers in the primary care setting is likely to produce reductions in other health care costs. The results indicate that such savings may be seen in the use of specialty mental health settings, but not in the use of ambulatory medical services.

Kessler RC, Zhao S, Katz SJ, Kouzis AC, Frank RG, Edlund M, Leaf P: Past-year use of outpatient services for psychiatric problems in the national comorbidity survey. *American Journal of Psychiatry* 1999; 156:115–123

Summary: The authors present nationally representative descriptive data ($N = 5,877$) on 12-month use of outpatient services for psychiatric problems. The focus is on the relationship between 14 DSM-III-R disorders and use of services in four major sectors. The sectors are 1) general medical (seeing a nonpsychiatrist physician, nurse, or other allied health professional in either a hospital emergency department or a physician's private office); 2) specialty mental and addictive disorders services (seeing a psychiatrist or psychologist regardless of place; seeing a social worker or counselor in either an emergency room, psychiatric outpatient clinic, drug or alcohol outpatient clinic, physician's office, or drop-in center for people with emotional or substance abuse problems); 3) human services contact (seeing a counselor, social worker, or nurse in a social service agency; seeing a minister, priest, or rabbi in any setting; seeing

another nonmedical professional such as a school counselor, or using a hotline); and 4) self-help (determined by asking interview respondents if they had ever gone "to a self-help group for problems with your emotions or nerves or your use of alcohol or drugs").

No evidence of a multisector offset was found as measured by number of visits. The mean number of visits for respondents seen in multiple sectors was similar in magnitude to the sum of the means for the respondents seen in only a single sector. For example, the mean number of visits to a general medical setting only for a psychiatric problem was 4.0 and the mean number of visits to a specialty setting only was 12.4, whereas the mean number of visits for individuals seen in both a general medical setting and a specialty setting was 16.8, roughly the sum of 4.0 and 12.4. Total visits were an additive function of the number and types of sectors used.

Comment: An offset would have been demonstrated had patients who were seen in multiple sectors used fewer total services than the sum of services provided to patients seen in only one sector. The authors point out that their data do not provide insights into how multiple-sector care was coordinated, if at all. They also note that patients seen in more than one sector may have had greater need and/or greater motivation than those who used only one sector. If so, a demand for mental health services may exist that was not measured in the current study and that may confound efforts to measure a cost offset regarding multiple-sector use. These findings address only the offset of additional mental health service costs that may derive from receiving such services in one or more health care sectors. They do not address whether providing mental health services leads to a cost offset of nonpsychiatric health care. Nor do the data differentiate psychotherapy from other mental health services.

Fraser JS: All that glitters is not always gold: medical offset effects and managed behavioral health care. *Professional Psychology: Research and Practice* 1996; 27:335–344

Summary: Three studies assessing medical offset effects were conducted by using data from a large behavioral health care organization. Although the results replicate positive findings of other studies, the author urges caution in their interpretation because of the high variability of costs within comparison groups.

The first study compared inpatient hospital costs and hospital use in days for patients receiving either 1) psychotherapy alone (3–15 sessions), 2) medication alone, 3) medication and psychotherapy, or 4) no medication and no therapy after having initially sought treatment. Also included was a control group that did not seek any mental health services. Respective percentage increases in costs (not adjusted for inflation) for these groups from a 12-month period preceding treatment to a 12-month period succeeding treatment were 12, 85, 71, 84, and 145. These results suggest that therapy alone was associated with the least cost increase; however, the high degree of within-group cost variability led to a nonsignificant result when the groups were compared with analysis of variance. Hospital use was relatively infrequent, with many subjects showing no pretreatment-to-posttreatment change in costs.

Contrary to prediction, the second analysis failed to show a greater medical offset effect for participants with more severe diagnoses as compared with those with less severe diagnoses and those who had not sought treatment.

The third analysis found that patients incurring high hospital costs in the 12 months preceding treatment experienced a greater medical offset following mental health treatment than did the medium-cost group, the low-cost group, or control subjects who incurred low costs. The high-cost group showed a 51% increase in costs, whereas a control group showed a 175% increase from the pretreatment to the posttreatment time period. Similar effects were not observed for the medium- and low-cost groups. After mean difference scores were converted to rank-order scores to offset within-group variability, a significant between-group effect was found across the treatment condition (treatment vs. control) and cost level (high, medium, low). The author concludes that the major area of significant hospital cost reductions was in the high-cost group; patients receiving mental health treatment show significant hospital cost reductions as compared to untreated high-cost control subjects.

Comment: The primary value of this study is that it highlights methodological problems in many studies investigating the medical offset effect. The nonexperimental nature of the design casts most of the ostensibly impressive offset findings into considerable doubt. For example, results of the third analysis can plausibly be explained by chance effects due to regression to the mean. That is, the high-cost subjects might have incurred

lower hospital costs in the posttreatment period whether they had received treatment or not, simply because they returned to a more usual level of utilization. Nevertheless, the findings are suggestive and should be tested in more rigorously controlled studies.

Gabbard GO, Lazar SG, Hornberger J, Spiegel D: The economic impact of psychotherapy: a review. *American Journal of Psychiatry* 1997; 154:147–155

Summary: Culling through peer-reviewed articles published between 1984 and 1994, the authors identified 35 that addressed psychotherapy and included an outcome measure that had some implication for cost. Of these 35, they identified 18 that included either random assignment of subjects to treatment groups (10 studies) or a comparison group (8 studies). Eighty percent of the studies involving random assignment and 100% of those without random assignment suggested that psychotherapy reduces total costs. Dependent variables examined included appointments with a specialist, rehospitalization rates, cost of nursing care visits, relapse rate, employment income, welfare income, disability payments, and work absenteeism. Disorders examined were affective disorders, schizophrenia, borderline personality disorder, anxiety disorder, and substance abuse. The authors conclude that psychotherapy appears to have a beneficial economic impact on society and that much of that impact accrues from reductions in inpatient treatment and decreases in work impairment.

Comment: This review of carefully selected, rigorous studies expands evidence of cost offsets outside the medical arena. Unfortunately, data addressing variability within treatment groups are not provided. As with all the studies previously reviewed, it is highly likely that considerable intragroup variability exists, which militates against prematurely concluding that psychotherapy has a general cost-offset effect. It remains to be discovered which patients are likely to produce such a benefit and in what circumstances.

CONCLUSIONS

This review provides considerable suggestive evidence of cost offsets due to psychotherapy. These offsets may occur with nonpsychiatric medical services and nonpsychotherapy mental health services, as well as with

extramedical costs. The evidence must be viewed with some skepticism, however, because of methodological and analytical difficulties in investigating cost offsets. These difficulties arise in part from the high degree of variability of costs within groups obtaining mental health services or not receiving these services. Despite the methodological difficulties, it is notable that many of the most rigorously controlled studies demonstrate cost savings from psychotherapy.

As Mumford and Schlesinger² have cautioned, however, any medical offset should be considered an incidental effect of psychotherapy. Mental health services should not be justified on economic grounds alone, but must be viewed in light of their primary goal of relieving human suffering. These authors further reason that cost offsets of psychotherapy should not be universally ex-

pected. One might expect populations that overuse or misuse general medical services to show a medical cost offset—for example, somatization patients. However, populations that underutilize medical services may well increase their use of these services following psychotherapy.

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1. Mumford E, Schlesinger HJ, Glass GV, et al: A new look at evidence about reduced cost of medical utilization following mental health treatment. *Am J Psychiatry* 1984; 141:1145–1158
2. Mumford E, Schlesinger HJ: Assessing consumer benefit: cost offset as an incidental effect of psychotherapy. *Gen Hosp Psychiatry* 1987; 9:360–363

Book Reviews

The Psychodynamics of Leadership

Edited by Edward B. Klien, Faith Gabelnick, and Peter Herr
Madison, CT, Psychosocial Press, 1998, 360 pages, ISBN 188784113X, \$55.00

Reviewed by Walter S. Smitson, Ph.D.

In the field of mental health, there are many chief executive officers and managers who were educated as clinicians and later moved into leadership positions without benefit of training in leadership theory. The editors of this book have chosen the type of material that will appeal to those readers—CEOs, middle managers, educators, and consultants who are grounded in psychoanalytic theory. Many of the authors appear to be writing for that audience as they weave together the psychologies of person and system with organizational realities. Seven of the chapters are theoretical and appear to be written for an academic audience.

This book offers a number of useful ideas for psychodynamically oriented leaders. The idea that successful leaders do not shape their identities, but rather allow themselves to be shaped by aspects of the culture, has relevance for everyone in a leadership role. The leader-follower definition by David Berg calls for followers to redefine themselves and empower the role of followership by developing a collaborative relationship with the leader. W. Gordon Lawrence gives middle managers some useful insights into the anxiety and survival issues faced by CEOs. James Krantz's material, on how teams can become key to the success of the whole system, could prove use-

ful for all members of an organization. This chapter is reader-friendly and offers some practical help in organizing members of the entire work group in ways that promote system goals and enhance top-down and bottom-up communication.

The chapters on women in the workplace have some helpful insights concerning vulnerability and connection. Barbara Winderman and Margeret Sheely provide insight into the workplace struggles of women and the high personal and emotional costs of increased authority. Unfortunately, the reader has to sift through a large amount of material that is interesting from an academic viewpoint but may be of limited practical value to leaders and managers in the workplace. In fact, the editors note that this book invites reflection, and that it may help readers expand visions of the relationship of person, task, and role, but it will not provide answers.

A disappointment is the absence of helpful discussions about difficult issues such as employees who are not motivated, employees who are consistently mistrustful of the system, how to react to merger mania, and how to successfully market one's organization. The field of mental health, particularly, has many employees who are basically mistrustful of the system—and who in fact devote their careers to helping persons cope with oppressive systems, whether encountered in marriage, family, or communities. Downsizing in corporate America over the past decade, along with increased pressures for productivity, has greatly increased worker mistrust, which in turn has brought new challenges for today's leaders. These are the greatest challenges facing today's CEOs in mental health settings, and they are likely to become

challenges for all types of organizations as workforces become more disaffected and detached from their organizations.

This book does indeed encourage reflection. I hope it will also prepare people in leadership roles to move beyond reflection and identify the action steps needed to manage organizations successfully when they are confronted with challenging issues, so that their organizations can survive and grow. For those leaders who are able to use reflection as a way to develop answers for the tough day-to-day problems, this will be a useful book.

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How to Practice Brief Psychodynamic Psychotherapy: The Core Conflictual Relationship Theme Method

By Howard E. Book
Washington, DC, American Psychological Association Press, 1998, 181 pages, ISBN 1-55798-465-4, \$39.95

Reviewed by Howard B. Roback, Ph.D.

This volume is true to its title in providing a "clinically based and clinically illustrated manual that walks the reader through the development of the Core Conflictual Relationship Theme [CCRT] focus that is necessary to practice this form of brief psychodynamic psychotherapy." The

author, Howard Book, is a psychiatrist, a psychoanalytically oriented psychotherapist, and an educator. Motivated by several factors—including findings from psychotherapy research literature, residency training needs, and a recognition of health care's growing emphasis on briefer therapies—Book sought additional training in short-term psychodynamic psychotherapy from Lester Luborsky, professor of psychology at the University of Pennsylvania. Dr. Luborsky is one of the major architects and researchers of CCRT. Book is currently associate professor and coordinator of the highly regarded Brief Psychotherapy Training Program at the Clarke Institute of Psychiatry, University of Toronto School of Medicine.

Part I of this interesting and instructive book introduces the brief psychodynamic psychotherapies, and more specifically the CCRT approach. Inclusion and exclusion criteria for these treatment methods are addressed. Issues such as identifying the CCRT focus and its three components are covered extensively. That is, the patient's wish (W) in the context of a relationship, the actual or anticipated response from others (RO), and the patient's response from self (RS) are explained in depth and with clear clinical vignettes. The author also discusses the three phases of treatment: the first phase (sessions 1–4), in which the therapist helps the patient to identify the repeated occurrence of the CCRT in the patient's relationships; the working-through phase (sessions 5–12), in which the patient works through the childhood roots of the RO; and the termination phase (sessions 14–16), in which the therapist and patient process the upsurge in the patient's RO and RS.

Part II illustrates how to practice

the CCRT method by reference to verbatim transcripts (as well as alternative scenarios) of the case of "Ms. Benton." Chapters in Part II conclude with a question-and-answer section.

There is much to admire in this thoughtful and far-reaching volume. It is as if the author were engaging the reader in a running conversation—a dialogue that is always instructive. One gets the impression that one is being taught by a master psychotherapist and clinical supervisor. Dr. Book's richly documented clinical vignettes and insightful comments reflect both his knowledge of and his fascination with the CCRT method. The book is well organized, and the presentation of this complex material is easy to follow and does not overwhelm the reader. The chapter summaries are excellent. Although I would have welcomed a chapter dealing with the scientific aspects of CCRT (e.g., whether independent evaluators agree on a patient's primary CCRT; objective data demonstrating the efficacy of the intervention), that was clearly not Book's intent in writing the manual. Apart from the absence of such material, there is little to fault.

I would recommend this volume strongly to psychotherapy supervisors, psychotherapy-oriented clinicians, and mental health trainees regardless of professional affiliation. For the clinician trying to keep informed of brief therapy models of treatment, this important reference source is a must.

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Working With Emotions in Psychotherapy

By Leslie S. Greenberg and Sandra C. Paivio
New York, Guilford Press,
1997, 303 pages, ISBN
1-57230-243-7, \$35.00

Reviewed by Stewart L. Aledort, M.D.

The authors of this book beautifully describe the hierarchical order of emotions, how to identify specific emotions, and ultimately how to work and restructure the client's relationship to powerful and damaging maladaptive emotions. Greenberg and Paivio reviewed a large number of taped interviews of emotionally focused therapies that were successful. The clients had a wide range of complaints, including depression, anxiety, and problems of living. The authors discovered through this research three important steps in successful treatment: 1) bonding, 2) evoking and exploring emotional experiences, and 3) restructuring the emotional schema. These steps are synonymous with the working alliance; the development of the transference and its past components; and the working-through and resolution phase of classical psychoanalytic treatment.

The first part of the book sets forth the theoretical framework for emotions and the idea of core maladaptive emotion schemas. The authors discuss the role of emotion not as an irrational feeling state, but instead as an organizer of past interactive experiences, memories, hopes, fears, and dreams that are specific for each person and arise from relationships past and present. These sche-

mas are organizers not only of emotion, but of identity and of the subjectively felt meaning of one's self. I think this is the most important piece of their work. The notion that "bad fits" organize emotions and hence organize one's identity is a major component of my clinical experience. These authors do not specifically talk of bad fits in early life, particularly preverbal life, but the concept is inherent in their work and their book. The passion of the bad fit or the emotions that are aroused by a bad fit help to organize and concretize the emotions in the identity.

The authors' experience is that if the maladaptive emotional schemas can be restructured, clients will develop a different relationship to these emotions that have plagued them. They will also develop a different sense of themselves, in terms of how they deal with emotions generated through their relationships. In this section, emotions are broken down according to their adaptive and maladaptive functions and are differentiated as primary, secondary, or instrumental emotions. This classification is useful to all therapists; we work with emotions every day but may not have realized the importance of differentiating them as to their origins, effects, and functions.

The second section deals with the

types of interventions that occur in Emotional Focused Therapy (EFT.) Emphasis is placed on the specific moment-to-moment intervention of the therapist as he or she stays attuned to the slightest changes and shifts in the emotional makeup of the client. Through this attunement the therapist and client build a working alliance, and the resultant bonding accentuates a validation of the client's feelings. Emotional evocation, which is central to their EFT, relies heavily on the "empty chair dialogue." This dialogue is Gestalt in origin and is not meant to be just a cathartic emotional experience: restructuring and validation of the new self follows.

In the third section, the authors describe in great detail the working of EFT with different emotions, and they present a clear picture of how the therapist attempts to deal with clients in this modality. They end with a brief chapter on research and supervision.

This book carries some important assumptions that need to be examined. Is it possible for the therapist to achieve such carefully fine attunement with the client as they suggest? I doubt it, and what is not talked about is the rupture in attunement and how that affects the process and transference issues in EFT. There should be a whole chapter focused on this issue alone. The whole issue of

transference and countertransference is not addressed, and it is not clear how long the clients have to be in treatment for the EFT to be effective. I think it is dangerous to assume that a therapist can stay attuned to moment-to-moment changes in a person's emotional schema, since that assumption sets up an unrealistic expectation for both parties. It makes ruptures more difficult to heal because of the mutual narcissistic injuries. And is it difficult to train new therapists to do what clearly the authors do with a long-standing natural ease?

For people who are interested in cognitive and experiential work with emotions, this book is invaluable. For those with an analytic bent, the chapters on the emotional schema will only help them to formulate what they have already been doing every day in their offices; even so, such readers will find these chapters interesting and important.

Dr. Aledort is Clinical Associate Professor of Psychiatry at George Washington University Hospital, a clinical faculty member of the Washington Psychoanalytic Institute, and a member of the National Group Psychotherapy Institute at the Washington School of Psychiatry. He is also in private practice in Washington, DC.