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American Association for Psychoanalysis in Clinical Social Work

Spring 2015

newsletter

From the President

Penny Rosen, MSW, BCD-P

As discussed in my last column, an emerging point of interest within our organization is how to build our membership for the next generation. The board is concentrating on this issue, in conjunction with addressing our goal of providing a meaningful place of belonging for our members.

It is of no surprise that a resounding theme at the in-person board meeting on March 12, 2015, was the importance of connections and relationships among colleagues that make for a meaningful affiliation with an organization. This is what drives membership. The March 2015 conference in Durham, NC, promoted such interactions at stimulating conference sessions, special receptions, and events. In the introductions made to the recipients of the Lifetime Achievement Awards and Professional Writing Award, we also learned how long-term friendships were created through professional affiliations. (The introductions can be found at www.aapcsw.org.)

As a way to open up the organization to the next generation, an opportunity arose to invite six MSW students to our in-person board meeting held in Durham before the conference. The student interns, who were fulfilling their internship requirements in Durham, were given a first-hand glimpse into the proceedings of our meeting, and they were active participants in our discussions. This initiative was successful in helping us to learn about the early career needs of graduate students.

A relevant discussion at the in-person board meeting focused on the professional identity of members. Is our primary identity as clinical social workers or as psychoanalytically oriented therapists/psychoanalysts or as a merging of the two identities? In this vein, the student interns were asking whether to pursue postgraduate training at psychoanalytic institutes or in a PhD/DSW track. As an outgrowth of the interns at the board meeting and the involvement of student volunteers at the conference, board members are offering sponsorships to the student volunteers and interns. To facilitate further outreach to students, we will be pursuing conversations with the students to learn more about their outlook on organizational life and to encourage their continued involvement with us.

Another vehicle to attract new professionals is through scholarship, inviting papers on psychoanalytic topics. A special Call for Papers is des-

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www.aapcsw.org

editor'sword

Donna F. Tarver, LCSW



We were shocked and saddened by the sudden death of David Phillips, our past president. David was instrumental in the formation and early development of AAPCSW. His wisdom and guidance were so helpful and reassuring to me when I became Newsletter Editor. In particular, I remember him pointing out to me what I had not recognized as a new member—though the NMCOP Conference I was at was large, sophisticated, and attended by several hundred clinicians, it actually was being put on by a very small group of people who were working very hard to grow the fledgling organization that they believed in so deeply. We received an outpouring of messages by people across the country whose lives had been touched by David's wisdom and generosity. We have posted those on our website and hope that you will join us there in our remembrance of David. Our deepest condolences to David's family and friends.

I can't say enough about the ambience and excellent learning opportunity of our recent conference in Durham. The analytic community in Durham is welcoming and left no stone unturned in their planning and execution of the entire conference. Our thanks to Penny Rosen, Conference Chair; Bill Meyer, Conference Consultant; Cathy Siebold, Program Consultant; Nancy Perrault, Hospitality Chair; and all of the persons who worked so hard to make the conference a success.

Your AAPCSW Board met for our daylong preconference board meeting on the Thursday before the conference. In addition to our Executive Board and Committee Chairs, we were joined by Area Chairs from across the country and by six students—five from Smith and one from UNC—who were in their field placements in Durham. Though we meet monthly by conference call, the yearly in-person meeting is our only opportunity to meet face-to-face and establish the relationships that are so important in our successfully carrying out the business of the organization. At this meeting, we also had the opportunity to thank and say goodbye to our Associate Newsletter Editor, Ashley Warner, who has worked with our membership and areas to bring you their news and introduce our new members in each issue since 2009. We will miss Ashley on the newsletter but know that she will soon find another way to serve our organization. Ashley has been busy training Christie Hunnicutt, who will replace her beginning with the Fall issue. We look forward to working with Christie and will introduce her to you in the next issue.

The *Newsletter* welcomes readers' letters, articles, and opinions on topics of the day and clinical issues; book reviews; notices of or reports on conferences; and news of interest to our membership. We encourage social workers with an interest in writing to use the *Newsletter* as a vehicle for converting their interest into the writing process.

Thanks to all contributors to the *Newsletter*—Mary Anne Cohen, Joyce Edward, Helen Hinckley Krackow, William A. MacGillivray, Kren K. Redding, Penny Rosen, Ellen Ruderman, M. Louis Ruffalo, Allan Scholom, Diana Siskind, and Ashley Warner.

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On the Psychoanalytic Approach to Schizophrenia

M. Louis Ruffalo, MSW, ACSW

This article was inspired by a presentation I gave at the University of North Carolina Department of Psychiatry in November 2014. My talk, titled “Psychoanalytic Theories of Schizophrenia: A Case Study Review,” was presented at the department’s monthly psychotherapy case conference and was attended by psychiatry residents, attending psychiatrists, fellow faculty members, and psychotherapists. Given the current biological orientation of psychiatry residency training programs, especially in the conceptualization and treatment of severe psychiatric disturbance like schizophrenia, one might expect a certain element of resistance among attendees of such a talk. However, the residents and the department as a whole were very receptive and engaged. I am particularly grateful for the support and kind words given by Roger F. Spencer, MD, a psychoanalyst and long-time professor of psychiatry at UNC. I was encouraged by the appreciation of psychoanalytic theories demonstrated by residents and faculty and wish to briefly outline here some of the major concepts discussed in my presentation.

My work at present consists of the private practice of psychoanalytic psychotherapy with many patients diagnosed as having schizophrenia or a related psychotic disorder, in addition to work on a general inpatient psychiatry unit that at any given time consists of numerous patients diagnosed with a psychotic condition. I am aware of the popular conception among psychiatrists and other mental health professionals that psychotherapy, and especially psychoanalytic psychotherapy or psychoanalysis, is impossible in the treatment of persons with schizophrenia. Some hold the view that any form of analytic or dynamic psychotherapy is actually detrimental in the treatment of this type of problem and should be avoided. There is a widely held belief among people in the field that the manifestations of schizophrenia are meaningless and uninterpretable, that it makes no sense to try to understand why a person suffers a particular symptom such as a delusional ideation, an hallucination, or catatonia. Even among individuals who typically place much value in psychotherapy, there is a sense that schizophrenia and the related psychotic conditions are somehow

beyond the purview of psychoanalysis and that psychoanalytic theory can teach us nothing or next to nothing about the nature of these human problems.

The above rejection of psychoanalytic approaches to psychosis reflects a grave misunderstanding of the nature of psychoanalysis and the problem of schizophrenia. First, it is based on the flawed notion that a single condition or group of conditions is beyond interpretation by a theory we know provides the most comprehensive understanding yet discovered of the human mind and behavior. Second, we know that biological therapies are not curative of schizophrenia and many people with the condition continue to suffer greatly even with the best pharmacological treatment. Having trained on acute and long-term units for schizophrenia and working now with many persons diagnosed with psychotic disturbance, I believe firmly that psychoanalytic psychotherapy can be complementary and synergistic in the treatment of even chronic and severe psychoses. Following is a review of some of the major psychoanalytic thinkers in the field of schizophrenia, including Sigmund Freud, Harry Stack Sullivan, and Silvano Arieti, focusing mainly on the theoretical and clinical work of Arieti and his psychodynamic method for treating persons with schizophrenia. I also review briefly the contributions of the late psychiatrist-psychoanalyst Thomas Szasz as they relate to the problem of schizophrenia. My ending comments about Szasz have been added here for this article.

Throughout Freud’s lengthy active psychoanalytic career, his interests in the psychoses remained secondary to his interest in the psychoneuroses, and indeed, having been influenced mainly by the French schools of psychiatry, Freud spent the majority of his career writing about neurosis. The general avoidance that we see among psychotherapists when it comes to treating persons with schizophrenia likely has its root in Freud’s conceptualization of the condition. Freud interpreted schizophrenia initially as a narcissistic neurosis. In a paper published in 1914, he applies the libido theory to schizophrenia and notes that in the schizophrenic patient, the libido is withdrawn from external objects and is directed in-

wards toward the ego, giving rise to narcissism (Freud 1959). It is precisely for this reason that Freud felt that psychoanalysis was an impossibility with the schizophrenic. The person with schizophrenia lacked the ability to develop transferences, the analyses of which are of greatest importance in traditional psychoanalytic treatment. Nonetheless, Freud maintained that future modifications to the psychoanalytic method could render the schizophrenic patient accessible to dynamic treatment (Arieti 1959).

One of Freud's most significant contributions to the field of schizophrenia is his conceptualization of the role of anxiety in the development of psychosis. Adolf Meyer had originally stressed that the schizophrenic patient should not be studied in "cross-section" but rather "longitudinally," that is, that schizophrenia should be viewed as the result of events and processes that gradually prepare the ground for the psychosis. It becomes apparent, however, that the longitudinal study of schizophrenia, as advocated by Meyer, acquires full significance only when the role of anxiety is considered. Freud, by delineating the role that anxiety plays in human life and especially in the various forms of psychopathology, indirectly opened up the field of schizophrenia to the psychodynamic approach. Jung (1960) eventually became the first to apply psychoanalytic concepts fully to schizophrenia, writing about the presentation of schizophrenia in 1903, "Let the dreamer walk about and act as though he were awake and we have at once the clinical picture of dementia praecox" (86).

Some would consider Sullivan the most influential of all psychoanalytic theorists of schizophrenia. Sullivan introduced a new perspective in treatment by shifting the attention of the psychotherapist from the intrapsychic or intrapersonal to the interpersonal. According to Sullivan, schizophrenia is best understood as an indirect outcome of unhealthy interpersonal relations between the child and his parents (called by Sullivan the "significant adults"). These faulty interpersonal relations do not permit the child to establish enduring patterns of response that eliminate anxiety (Sullivan called this "self-system"). The patient resorts throughout his life to faulty interpretations of interpersonal situations (called parataxic distortions) and finally may lose what Sullivan called "consensual validation," that is,

recognition from others of the validity of his statements. When anxiety increases and becomes overwhelming, the early childhood experiences, which had been disassociated with consciousness and were part of the "not-me," regain conscious awareness in a symbolic manner. In Sullivan's work, as in Freud's, anxiety plays a key role in the development of the psychosis. The manifestations of the condition, that is, the symptoms, are viewed as symbolic and interpretable via psychoanalysis.

Silvano Arieti, the late Italian American psychiatrist and psychoanalyst, authored *The Interpretation of Schizophrenia* (1974), the culmination of his life's work and winner of the National Book Award in the Science category in 1975. Arieti's work remains authoritative in the field of schizophrenia, and it is his work upon which much of my clinical practice with schizophrenics is based.

Arieti viewed the early childhood environment of the schizophrenic patient as being one that was almost always saturated with anxiety, and he maintained throughout his career that in every case of schizophrenia that he studied serious family disturbance could be found. Like Theodore Lidz, Arieti (1974) emphasized the weakness of the paternal figure and the dominance of the mother, although he wrote that only about 25 percent of the mothers of schizophrenics fit the image of the "schizophrenogenic mother." In addition to work on the family constellation in schizophrenia, Arieti outlines completely the theory of psychological regression as it applies to the schizophrenic condition. Writing beautifully in *The Interpretation of Schizophrenia*, Arieti (1974) notes that when the patient "cannot change the unbearable situation of himself any longer, he has to change reality. . . . His defenses become increasingly inadequate. . . . The patient finally succumbs, and the break with reality occurs" (215).

Arieti (1959) also outlines concretized thinking in schizophrenia and the transformation of the abstract into the concrete. He describes hallucinations as the result of perceptualization of the concept and defines them as projections to the external world of the inner subjective experience. In hallucinations, as in delusions, the patient has a dynamic wish to believe the content of his experience. A delusion of pregnancy, for instance, is interpreted as a concretization of abstract feelings of loneliness, helplessness, or abandonment. . . .

only about 25 percent gory in 1974. manifestations of the condition are viewed as symbolic and . Arieti also spent significant time studying the catatonic syndrome and viewed catatonia not as a biological disease but rather as a disorder of the will. The catatonic patient is viewed by Arieti as someone who has been prevented in his early childhood from developing confidence in his own actions and reliance on the capacity to will. At a later stage, the person manifests the symptoms of catatonia.

Arieti, unlike Freud, sees the schizophrenic patient as capable of transference, noting that there is a part of patients that remains healthy, despite the disintegration that has occurred in other areas of the self. Most people familiar with the treatment of schizophrenic persons would agree that in many patients there seems to be a part of their being that remains unaffected, despite the severity of the psychosis.

Arieti sees as the single most important factor in the treatment of schizophrenia the establishment of basic trust though the development of a warm and caring attitude and exchange of feelings between patient and therapist. When the schizophrenic patient comes into therapy, he typically feels unaccepted and unacceptable, as well as distrustful of any interpersonal contact, especially with figures of authority, to the point of being paranoid and delusional. Perhaps he has seen a psychiatrist, or more likely several different psychiatrists, who have evaluated him for fifteen minutes, diagnosed him, and told him to take his medication. This is not necessarily an interaction conducive to the development of trust. The patient's contacts with the psychotherapist must make him feel that he is no longer alone in the world. In the words of Sullivan (1956), the therapy must offer patients a "relationship of security beyond what they have ever had." The therapist should maintain an attitude of acceptance, warmth, kindness, and consideration. The expression, the voice, the gesture of the therapist must convey those feelings. Also, of equal importance is that the therapist must be convincing, strong, and fair, and be respectful of the patient's autonomy.

Of great importance in treating persons with schizophrenia is the appropriate selection of patients for therapy. The most important tool in the analytic treatment of psychosis is countertransference. The establishment of basic trust is essential,

and this trust requires that the therapist actually like the patient. Since the therapist cannot like every patient, Arieti (1959) advises us to limit ourselves to the treatment of individuals for whom we have positive feelings. Additionally, there are certain patients in my own experience who are simply inaccessible to analytic treatment. Arieti advises that if the schizophrenic patient has seen several therapists in the past and therapy has been unsuccessful, depending on the nature of the therapy, that patient is unlikely a good candidate for psychotherapy.

Let the dreamer walk about and act as though
he were awake and we have at once
the clinical picture of dementia praecox.
—C. J. Jung

Arieti (1959) advises against the use of the couch when working with schizophrenics, citing that the patient is very much in need of closeness, even in the physical sense. It is suggested that the therapist sit next to the patient or across from him. If the patient wants to get up, he should be free to do so, to walk around the room; the patient must be allowed to exercise his autonomy during the session. This should not be viewed as a rejection of the treatment but rather interpreted as a way to decrease the anxiety created by interpersonal contact. As for the length of sessions, Arieti proposes that the schizophrenic be treated with somewhat shorter sessions, generally forty or forty-five minutes instead of fifty minutes or one hour. Punctuality is important, and no time should be made up if the patient is late. In my experience, many schizophrenic patients have a tendency to show up late to appointments. They test the therapist, in a way, to see whether this lack of discipline will be permitted. The patient wants limitations imposed on him, as an attempt to reorganize his disordered life. Thus, the insistence that the patient come on time is important.

The technique of the session varies by patient and the stage of the condition and the therapy. If the patient is experiencing an acute psychosis, and wanting to talk about his life, then the therapist must listen patiently and empathically and offer warm reassurance and comfort. The therapist should

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Board Certification for the Clinical Social Worker Psychoanalyst

William A. MacGillivray, PhD, ABPP

The Accreditation Council for Psychoanalytic Education, Inc. (ACPEinc.) is the independent accrediting body for psychoanalytic institutes and programs.

The American Board of Examiners in Clinical Social Work offers a Board Certified Diplomate in Psychoanalysis (BCD-P) credential that is an advanced specialty in clinical social work. It advances the notion that independent accreditation and certification are important steps in the development and recognition of psychoanalysis as a profession requiring advanced training. Yet many institutes and many clinical social work psychoanalysts have not sought independent confirmation of their training standards or training. We want to address what seems to us the curious indifference of our colleagues to independent certification.

Certification is integral to the wider issue of accreditation. Here are reasons why:

- Certification with an advanced specialty (i.e., the BCD-P for social workers, ABPP for psychologists) benefits the profession by clearly recognizing that psychoanalysis is an advanced specialty within clinical social work. Our colleagues worked long and hard to obtain this recognition from the American Board of Examiners in Clinical Social Work (ABE), and this recognition is solely maintained by its use; that is, by demonstrating that psychoanalytic social workers continue to seek this specialty. Regular applications to ABE are necessary, or this specialty may be sunsetted.
- Certification in Psychoanalysis in Clinical Social Work is an important way for institutes and programs to demonstrate that their faculty, supervisors, and graduates have demonstrated expertise to an independent organization (ABE). This parallels the process of having independent accreditation of psychoanalytic institutes and programs through the Accreditation Council for Psychoanalytic Education, Inc. (ACPEinc.). Both certification and accreditation in turn are vitally important in demonstrating that psychoanalysis is an advanced specialty of the mental health disciplines.

- Certification also benefits the public by informing potential patients and candidates that clinical social workers with the BCD-P in Psychoanalysis in clinical social work have demonstrated their expertise to an independent body.
- Finally, certification should benefit the clinical social worker who is able to demonstrate to the public, healthcare and educational organizations, and colleagues that they have demonstrated competence in psychoanalysis.

While the BCD-P may not directly benefit one's practice and income, it would greatly benefit the profession to have more BCD-Ps. We have done a poor job informing our colleagues of the importance of the BCD-P. Even so, a number of clinical social work psychoanalysts have applied for this credential. They have not done so for personal gain or for the lifelong privilege of paying dues to another organization. It is no surprise, of course, that personal connection trumps rational argument.

All of you have shown that we are committed to ongoing psychoanalytic learning. Whether we graduated from a psychoanalytic program or demonstrated learning in other ways, the bottom line is that our members are mainly committed to ongoing personal and psychoanalytic learning. The BCD-P is the best way to demonstrate this dedication.

It is important to acknowledge that obtaining the BCD-P does cost money and does mean a commitment to financially support ABE through membership. We need more of our BCD-P colleagues to take up the challenge, to reach out to your colleagues and peers to apply for independent certification. We need a concerted effort to communicate to our candidates the importance of preparing to seek the BCD-P when eligible. All eligible members who qualify need to be recipients of the one public recognition of our specialty.

When the issue is broached to a colleague, the response often moves to this question: What's in it for me? Hanging out a shingle that says you have a BCD-P in Psychoanalysis is unlikely to result in hordes of potential analysts beating down your

door. The four core reasons listed above may seem largely unrelated to our immediate concerns to make a living at what we love. So maybe a little fear is in order.

The changing climate in healthcare means that all professions will have to demonstrate specialized skills to advance in the profession. Independent certification has become vitally important in demonstrating to the public and policymakers that professionals have recognized competencies. And, the growing recognition and acceptance of ACPEinc. standards in institutes and programs also means that obtaining the BCD-P will be essential for teachers and supervisors in these institutes. Demonstrating that graduates of these programs went on to obtain the BCD-P will be an important measure of a program's success.

Many applied because colleagues asked them and they wanted to be part of an organization that not only would recognize their own commitment to psychoanalytic learning, but also would consolidate their psychoanalytic identity. Here are two proposals: (1) We ask that members who have a BCD-P reach out to at least one colleague and encourage him or her to apply for the credential. (2) We ask every member who does not have a BCD-P to consider applying as a way to support our profession and our institutes as well as recognition of your commitment to psychoanalytic learning.

Adapted with permission from "President's Column" in *The Round Robin*, Winter 2015.

About the BCD-P

The Board Certified Diplomate in Clinical Social Work–Psychoanalysis (BCD-P), offered by the American Board of Examiners in Clinical Social Work (ABE), enables clinical social workers to be recognized for proficiency in Psychoanalysis. For example, the Accreditation Council for Psychoanalytic Education, Inc. (ACPEinc.), expects of its accredited psychoanalytic institutes that their "analysts of candidates" be "certified by their relevant board" (as by ABE and the BCD-P, in the case of clinical social workers) or "demonstrate equivalent clinical expertise through a process independent of the institute or program."

The BCD-P is based on practice competencies identified through research and consultation and embodied in ABE's position statement, *The Practice of Psychoanalysis: A Specialty of Clinical Social Work*. Applicants must hold ABE's advanced generalist certification, the Board Certified Diplomate in Clinical Social Work (BCD), or, in the process of applying, fulfill the requirements for the BCD; and they must meet the criteria (below) whether a graduate of a psychoanalytic institute or not.

To apply for board certification as a Clinical Social Worker Psychoanalyst, email Kate at kab@abecsw.org or call 1.800.694.5285, ext. 16.

Graduated from an Institute:

Training: graduate of a psychoanalytic institute training program

Personal analysis by a training analyst or equivalent (who had at least 5 years of post-graduate experience as a psychoanalyst), in-person, for a minimum of 40 weeks/300 hours during a year (at a frequency of 3–5 sessions per week, on separate days)

Supervision:

- 1) Received supervision in practice for at least 150 hours by a training analyst or equivalent
- 2) Under supervision, conducted 2 in-person adult psychoanalysis cases—at least 1 supervised to completion—lasting at least 2 years in one instance, and at least 1 year in the other

Specialty Practice Experience:

- 1) Within the past year, amassed a minimum of 300 hours of clinical social work practice informed by psychoanalytic theory and formal psychoanalysis with at least 2 analysts
- 2) Within 3 years or more, amassed 4,500 hours of post-master's clinical social work practice informed by psychoanalytic theory

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Analyzing the Affordable Care Act and Its Actors

Allan Scholom, PhD

My intention in writing this is to contribute to an emerging view that psychoanalysis offers a methodology and a morality that can and should be directed toward the understanding of how individual dynamics and social forces interact. The history of psychoanalysis has been saturated with a splitting off of the personal from the societal. This began with Freud who in his early years believed it was necessary for the survival of the psychoanalytic movement. But whereas Freud changed his perspective later in his life we have only in recent years begun to try to connect the individual to the social. Among the consequences of this splitting have been a marginalization of psychoanalysis both professionally in our practice and theory as well as in our relevance to the world our patients live in (Tolleson 2009).

In the spirit of healing the split, I will take up the Affordable Care Act and two of its actors—Barack Obama, the star, and the American Psychological Association as a supporting actor. My purpose is to elucidate the connections between the societal, personal, and community from a psychoanalytic perspective. In doing so, we can offer a more comprehensive perspective as to what is happening in the world that might then lead to more effective action, much like a good interpretation.

With the passage of the Affordable Care Act in 2010 the battle between Democrats and Republicans has centered on the role of big government in health care. Fears that “big brother” is exerting ever

more control over our lives dominate the scene as demonizing or defending the act continues to unfold. In reality, the act represents a capitulation by both parties to the continuation of a fundamentally market based solution to the problem of universal coverage, quality healthcare and cost containment. A senior Bush administration official responsible for driving the Medicare drug bill through Congress in 2003 recently assured a group of investment managers, “[Obamacare] is not a government takeover of medicine. It is the privatization of health care” (Davidson 2013).

As such, the current system remains essentially the same one ranked worst in the world among developed countries (Commonwealth Fund 2014). Americans suffer poorer health and these outcomes are getting worse since the 1970s (Woolf and Aron 2013) in almost all categories compared with citizens of every other industrialized country. The US is ranked 70th out of 132 nations worldwide in health and wellness (Social Progress Imperative 2014). This is despite the fact that the US spends more than twice as much in GDP and per capita health care costs as nations with single payer or nonmarket based systems. In reality, Americans get fewer services, including outpatient visits, hospital days and surgeries, for far greater cost with far worse results.

How can this be? In essence, it is the costs of the for profit/market based system that are responsible. These include administrative costs (about 30 per-

The Social Justice column arises from the passions of some of our committee members and the larger AAPCSW membership. The Committee on Social Responsibility and Social Justice is hoping that the column can ultimately be dialogic and conversational, that is, that it will encourage a reflective back and forth within the organization. Toward that end, we invite and encourage submissions of articles relevant to the committee’s mission (page 9), as well as responses to articles that have been printed. Please contact Jennifer Tolleson, Chair, if you are interested in joining us, or with any submissions or ideas (jentolleson@comcast.net).

Next issue: Brenda Solomon, PhD, “Dollars and Sense: Market Pressures on Social Work Education”

cent going to the health insurance industry versus less than 5 percent for Medicare), excessive profit (due largely to drugs costing more than twice what other countries pay), and profit unrelated to health care service delivery (for stockholders, advertising and marketing, debt repayment from mergers and acquisitions and executive compensation). The bottom line is that in health care, the market does not work effectively. Nor does it work humanely, as health care is a privilege of wealth and not a right for all. Thus, the market IS the problem, which is reflected in exorbitant profits for many corporations not directly providing health care services (Scholom 1997, 2013).

Under the ACA, many millions more people will get coverage (ten to twenty million, depending on who is doing the estimating) which, to be sure, is a positive step. However, tens of millions will remain uninsured, and many, if not most, will become increasingly underinsured (the new normal). “Malinsurance,” as in insurance so limited that it compromises our physical and economic health, will vastly rise (Gaffney 2014). Quality of care will increasingly depend upon financial resources and costs will continue to escalate well beyond inflation. Americans will be spending more on healthcare (premiums and out of pocket costs will rise to an estimated 37 percent this year) as our incomes continue to deteriorate and economic inequality grows. At root, this amounts to cost shifting, with average citizens paying more so corporations can increasingly profit. There is no evidence that anything in the ACA will stop, much less reverse, this direction.

While 75 percent of Americans believe the US healthcare system requires fundamental change (Commonwealth Fund 2014), the public debate centers on the role of big government and not the limits of the market. How is this so despite these facts? Put another way, how is it that we continue to act against our own best interests by allowing to remain in place a system that is harmful to us? The situation is not unlike one we see as practitioners when a patient arrives at our office knowing something is wrong with her/his life but having little to no awareness of what the real problems may be. We are charged with helping our patients look more deeply into their struggles to facilitate understanding and acting on their own behalf.

Herein lies the potential for the psychoanalytic

approach to aid in our understanding the connection of the individual to her/his social world. Lynne Layton (2006) has called attention to the unconscious pull to dissociate individuals from their social milieu in the US. In seeking to comprehend this unconscious pull in the health care context, it is important to consider the mythologies concerning big government and the free market and to elucidate the fantasies that permit such myths to go unchallenged.

Regarding big government, the actual size of the government or spending by the government has not changed appreciably over our recent history. This has been the case whether Republicans or Democrats were in power. What varies are the directions one party takes in contrast to the other regarding how resources are to be used and what laws are passed that direct our lives. For instance, when Republicans (generally seen as against big government) push to control women’s choice or marital freedom, or determine what children are taught and tested on in school, or decide who can vote, they use big government for their own ends.

Concerning the free market, this too is dependent on the rules made that determine the direction the market may take. For example, when the rules allowing banks to consolidate banking and commercial activities were changed under a Democrat (generally seen as more protective of individuals and the environment against the excesses of the market), the stage was set for the economic crisis of 2008. Similarly when the various free trade agreements starting in the 1990s were written favoring corporations without sufficient labor or environmental protections, jobs were lost and the environment degraded.

I cite these examples to illustrate that there is no such thing as “big government” or the “free market.” Rather, these are myths that serve to confuse and mystify the public such that it cannot see its

The AAPCSW Committee on Social Responsibility and Social Justice, formed in 2007, is a national committee of social workers, psychoanalysts, and allied professionals who are concerned with integrating a human rights and global justice discourse with clinical practice. Toward this end, we work to promote critical social-political awareness among clinicians, to conceptualize psychoanalytic clinical practice within a broader social-political context, and to expand the usefulness and availability of psychoanalytic clinical services for all people.

own self-interest. Big government and the free market become potent oversimplifications, illusions or mythologies, used by both parties to manipulate the public for political ends. This largely is to preserve their own influence, the status of which is vastly dependent upon serving the interests of those who provide the financial resources necessary to gain power.

From a psychoanalytic perspective, we can endeavor to explicate the underlying fantasies these myths speak to. As to big government, concerns about the dangers of dependency are foremost. We might remind ourselves how we typically face patients who are afraid of close relationships (for understandable historical reasons) such that being influenced by others can become threatening or coercive. Many may seek the illusion of independence or self-reliance as a potential solution. This may find some expression in an idealization of the free market as an embodiment of individualism and safety, free of external threat. Of course, the opposite may be true in that some people may seek to be overly dependent so as to avoid the perils of separation/individuation.

To be sure, I am oversimplifying, as the fantasies around independence and dependence underlying the myths of “big government” and the “free market” can take myriad forms in the same person and certainly in a collective sense as well. My point is not to map, in some one-to-one fashion, how a given person or group may travel from fantasy to mythology and back, but rather to illustrate that there do exist fantasies that make us vulnerable to political mystification. Furthermore, we in the psychoanalytic world are uniquely positioned to help with the demystification on an individual and collective level.


Let us turn to the role of Barack Obama, undoubtedly the star actor in the creation and passage of the ACA to examine how his personality dynamics may have contributed to the bill. I do this not to assign undue responsibility either on him individually or on the numerous other actors in the story but rather to draw attention to the unconscious forces that are at play in significant ways. If we are to understand and act with clarity in the social realm, these dynamics are important to be aware of. Certainly, any president will be an object for all manner of projection and transference. For Obama, support-

ers on the left express disappointment that he has not done more, while those on the right see him as doing too much, an embodiment of big government.


Let us look at Obama in his own terms and examine the difference between what he has said and what he has done using health care as a case in point. Were he a patient of ours, we would tend to look at this as a measure of conflict, ambivalence or splitting. Obama, in his early political career, was a single payer (enhanced Medicare for all) supporter (Holan 2009). He viewed this approach, used by all the other countries ahead of the United States in access, outcome, and cost containment as the best way to achieve universal coverage. Further, even during the debate over the act, he indicated that a single payer solution would be the best way to reach these goals. However, he never put the enhanced Medicare for all option on the table, not even to stake out a negotiating position. This stance is despite the fact polls continually indicating a significant majority of Americans (60 to 70 percent) are supportive of such a system (PNHP 2014).

Instead, he embraced the Romney plan established in Massachusetts, which was developed by the health insurance industry in order to solidify its

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own position. He did this despite the fact that the industry itself is largely responsible for the costliness of our current system (as they constitute an expensive middle man providing no necessary benefit to the provision of health care). The last straw, of course, was the abandonment of the “public option,” which would have been the more cost effective and comprehensive approach.

Even those in the health insurance industry acknowledged this point but argued that the government plan would be unfair to the private sector precisely because it would be a superior solution. This extraordinary anti free market argument prevailed despite the fact that entities that do a better job at lower cost are supposed to win. Since single payer or a public option would have been better solutions, we can surmise that the exploitation of conscious and unconscious fears embodied in the big government myth of controlling peoples lives played a major role.

To return to the hypothetical Obama as patient, we might wonder why he gave in before the battle began and later during it. Lest we see this as an isolated issue, we could point to what he has done on numerous other issues not subject to Republican control. For example we can cite his: failure to prosecute bankers for their role in the 2008 economic crisis, while continuing to bail out the banks; increasing militarization by sending more troops to Afghanistan and significantly stepping up drone attacks; deporting more immigrants and prosecuting more whistle blowers by far than any other president, while increasing spying on the public; rejecting climate control treaties other countries have put forward while negotiating more free trade treaties without adequate labor or environmental protections; and so on. All of this is despite his speaking out on behalf of economic justice, decreased militarism, civil liberties, immigration reform, climate control, and so forth. I cite these examples as evidence to illustrate the extent of his splitting or conflict—being of two minds without one.

Were we to analyze why our patient was unable to stand up for what he says he believes (along with hurting himself in the botched roll out of the health insurance exchanges,) we ought consider the difficulties in his history. To begin, he is the biracial child of a white mother, who twice abandoned him when he was ten and fourteen, and an absent father. From that point on, he was raised by white grand-

parents. Referring to his race as a teen, he “wondered if something was wrong with [him].” At the time of his father’s death, Obama said, “My father remained a myth to me, both more and less than a man” (Bio 2014).

We might hypothesize about his need to bring people together despite it being impossible, as is often the case in the political arena (and of course in the personal realm as well). From another vantage point we might consider this as a conflict between ideals and actions, as his powerful eloquence and intelligence is often not matched by a capacity to follow through. His extraordinary drive and ambition may lead him to identify with and idealize those who have made it (whether economically, politically or racially). In so doing, he splits off painful feelings related to the rejection and unmet needs of childhood. All of the above make it difficult for him to stand up to the powerful forces that dominate the political landscape, as in health care. Sadly, this speaks to Cornel West’s contention that “he lacks backbone” (Luscombe 2014).

Certainly, I do not say this to offer some definitive analysis but rather to illustrate that Obama, like the rest of us, brings to the table personal history that has significant implications. This background plays a role that can and ought be understood in the sociopolitical realm. Herein we can make a substantial contribution.

Lastly, let us come closer to our professional home and take up the role of the American Psychological Association (APA). While the APA was certainly not a major player in the passage of the ACA, it is important to look at its participation as one of many supporting actors. We might see this as the place of our community in contributing to the ACA and moreover how societal realities become constructed and maintained at this level. First of all, we ought bear in mind that the APA is an organization made up of diverse constituencies. Second, the APA is a bureaucracy with all that this entails, including its own preservation. All professional associations have been authorized by the government for the purpose of organizing and policing themselves in carrying out their public responsibilities. As such, they are subject to governmental pressures. In appreciating this, we are better able to understand the APA’s avoidance of taking controversial public positions.

For example, in light of the money and membership that come from the military, the APA has avoided taking a stand against torture. Furthermore, in the last decades, all of the professional mental health organizations have offered little opposition to the fact that total health care spending nearly doubled from 1986 to 2009 while mental health funding remained about the same (Rampell 2013). In essence mental health funding has been cut in half since 1986 relative to all health care spending, a direction spearheaded by the insurance industry and government. In this context, APA has kept very much in line with and reactive to current political and economic forces.

The ACA seeks to restrain cost by pushing people into Accountable Care Organizations, which are virtually the same as HMOs. This is a retrying of the failed capitation model of the 1990's that shifts financial risk onto practitioners such that the incentive is to provide less service under the guise of "accountability" (essentially code for austerity or most people getting less). Since Americans do not get more services (in fact generally less, but do pay more for those they get) compared to other countries, the current fee for service system is not the problem. Thus, patients are paying increasingly more for services and practitioners are being paid less so that the insurance and drug industries, among others, can continue to profit. As previously stated the free market is the problem in health care—too many entities making too much money while contributing little or nothing to delivering services.

The role of the APA comes into play here under the banner of "accountability" with so called evidence-based practice (and "practice guidelines"). I am referring here to how science can be misused for political and economic purposes (Hoffman 2009). In this case what is at issue is how evidence-based practice (EBP) functions as code and rationale for more limited service (people getting less or austerity), usually seen as being embodied by cognitive behavioral therapy. Thus, the APA and large numbers of psychologists actively participate via EBP in what is currently being pushed by the ACA, which undermines longer-term, depth-oriented approaches in particular. It's no surprise then that the health insurance industry, which has been driving the severe curtailment of mental health services over the last thirty years, played a major role in the development of the ACA.

Psychotherapy before the EBP movement was already among the most research supported of all health care treatments. Yet, an important implication of the EBP mentality is that the effectiveness of psychotherapy, including longer-term treatment, is somehow not yet well established. This undermines what has already been done, leaving the playing field to short term double blind studies. One result is the ongoing marginalization/elimination of psychoanalysis from curricula and training programs.

This is not the path that those of us committed to depth psychotherapy and humanistic values would take, whatever divisions we belong to or professional affiliations we might have. We would oppose the movement toward commodified, manualized and minimized approaches to mental health care, or living for that matter. We would stand for subjectivity and personal freedom as opposed to objectification and adaptation.

In fact, we would support Barack Obama, our hypothetical patient, in standing up for the values and positions he speaks of rather than surrender to market forces. Similarly, we would want the APA and all in the mental health world to more actively resist efforts to reduce human suffering to what the market profiteers are willing to pay for. Ought not our professional organizations fight more vigorously against the insurance industry, whose creation of the term "medical necessity" (the vehicle through which the surveillance and control system known as managed care functions) is used to determine what gets paid for, thereby ensuring their profit? Ought not patients and practitioners decide what is "medically necessary"?

All professionals, and in particular those of us in the psychoanalytic world, are left vulnerable to practicing outside the narrow realm of what is called EBP and practice guidelines. The specter and reality of treatment denials, audits and lawsuits follow from the involvement of the APA and many of its members in providing justification via EBP for the health insurance industry to limit service and increase profit (Walls and Scholom 1996). More broadly, this further permits the domination of a market based ACA to continue to enhance the very system that excludes so many and limits what so many more could and should get.

To illustrate another aspect of APA's approach, its own EBP guidelines (APA 2006) include three cri-

teria for judging whether a "treatment" is sufficient to be called evidence based: research support, therapist expertise, and patient characteristics. Nevertheless, the latter two are not generally addressed when a treatment is called evidence based by researchers, policymakers, or health insurance companies. While the APA strongly endorses EBP, there is no designated body responsible for determining whether a treatment can be called evidence based. This would necessitate including these two crucial criteria when a treatment is said to be evidence based. Could manualized treatment ever constitute therapist expertise?

On a final note from a personal vantage point, I hope I have some realistic perspective as to what I or we can do to make the world a better place. For the last thirty-five years or so I have been trying to make sense of things from this personal-social point of view and live with this in mind. In working with patients, students and colleagues or within organizations and in politics, it has been heartening to find so many open to taking in this perspective and taking up the cause. When we in the psychoanalytic world push for change, we are far better positioned as allies with our fellow citizens when we are guided by our own values and commitments, whether we work inside or outside of the APA. By using our expertise to analyze on the individual and social level, we can make ourselves increasingly relevant in the struggle for constructive social change. By standing for the health and well-being of all Americans, psychoanalysis might then be viewed as the force for human freedom it can be. We have been reluctant to take the power of psychoanalysis into the wider world. We can change course by using more broadly the perspective, method and values we share and make an important contribution to the kind of society we want. This is, after all, all we can do.

Allan Scholom, PhD, is a clinical psychologist and psychoanalyst. He is the secretary of the board of the Chicago Center for Psychoanalysis and chair of the Professional Affairs Committee. He is on the faculty of the Institute for Clinical Social Work, and is the founder and chair of the Illinois Coalition of Mental Health Professionals and Consumers. Dr. Scholom has published and presented extensively on issues relating to the interface of psychoanalysis and politics. He has been in private practice in Chicago for more than thirty-five years.

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Still Practicing: The Heartaches and Joys of a Clinical Career

By Sandra Buechler, PhD; Routledge, 2012; 230 pages

Reviewed by Mary Anne Cohen, LCSW

As I read *Still Practicing: The Heartaches and Joys of a Clinical Career*, I am astonished that I cannot put this book down. I am as engrossed as if it were a novel whose protagonist is a lot like me, and I cannot wait to see how she (I) develops and evolves.

Dr. Sandra Buechler is the protagonist of this engaging narrative about her professional life as a clinician and supervisor for over forty years. With humanity and humility, she chronicles her journey from newly minted therapist to seasoned analyst and, in the process, delves into what it means to be a clinician in ways that are deeply personal and relatable. As an example, she writes, “A career as a clinician has at least one similarity to an acting career. You never stop auditioning. You are always being

measured by someone else. Increasingly, those sizing you up are less than half your age.”

Dr. Buechler is a psychologist and a training and supervising analyst at the William Alanson White Institute as well as a supervisor at the Columbia Presbyterian Medical Center and the Institute for Contemporary Psychotherapy. She is the author of *Clinical Values: Emotions that Guide Psychoanalytic Treatment* and *Making a Difference in Patients’ Lives: Emotional Experience in the Therapeutic Setting*. She has also written numerous articles on little explored and intriguing topics such as joy in the analytic session, the analyst’s loneliness, and “passionate neutrality.”

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Lasagna for Lunch: Declaring Peace with Emotional Eating

By Mary Anne Cohen; New Forge Press, 2013; 346 pages

Reviewed by Helen Hinckley Krackow, LCSW, BCD

This is a superb text for both eating disordered clients and the psychotherapists who treat them.

Mary Anne Cohen, LCSW, BCD, has written a work that is both scholarly and accessible. The founder of the New York Center for Eating Disorders (EmotionalEating.org), Cohen has specialized in the treatment of eating disorders for more than forty years, helping women, men, and adolescents recover from binge eating, chronic dieting, bulimia, anorexia, and body image dissatisfaction. Complex treatment issues are clearly illustrated in her book, with many clinical examples drawn from her practice and from her personal life. She richly demonstrates her warm and empathic therapeutic style with patients.

I found the many footnotes and annotations helpful as well.

As I write this review, I think about my work over the past week and how many of my clients have referred to their struggles with emotional eating. One man, feeling more at peace than he has in some time, reported that he stopped consuming his habitual pint of ice cream at midnight. In contrast, another client is a woman who gained fifty pounds over the course of the year, while her mother was dying. She recently rejoined Overeaters Anonymous, but she must continue to work through her grief as well. A third client is a twenty-year-old who is struggling

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The Year After: A Memoir

By Ashley Warner; Routledge, 2013; 258 pages

Reviewed by Joyce Edward, BCD

At a time when rape is being used as a weapon of war in many parts of the world, when we read all too frequently of rapes on college campuses and in the military, and when it is estimated that one out of every six American women has been the victim of an attempted or completed rape in her lifetime, Ashley Warner's poignant memoir about the year following her own tragic assault attests to the individual, unique suffering behind these grim reports.

Ashley has recorded her thoughts, her feelings, her doubts, her fears, her loneliness, her despair each day for the year following that dreadful moment when a young man followed her up the stairs to her apartment, forced his way in, grabbed her by the throat, and raped her at knife point, stealing not only her money but more importantly her life as she had known it.

As we follow Ashley's thoughts, we are reminded that each assault involves a unique victim, and while there are common reactions, each individual's responses are also determined by who they are and the circumstances of their trauma.

Ashley is twenty-four at the time of the rape, earning a meager income as a waitress, unsure of her direction in life, and sharing a small apartment with a friend, an apartment that lacked the barest of security protections. Advantaged by encountering for the most part concerned and competent law enforcement officials and medical personnel, she also has several close friends who care and seek to help her, though their ability to do so is limited and in time they move back to their own lives. She faces her worst moments, mainly alone.

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Important Change of Plan for Book Reviews

As psychoanalytic social workers are writing more and more books we need a more efficient system for the way reviews are handled.

- When you have written a book you wish to have reviewed or have read a recently published book that you feel would be of interest to our members, please send me the book title and a sentence about the subject of the book.
- Copy Barbara Matos, our administrator, on the email to me (barbara.matos@aapcsw.org) and send the book to her. She will keep records of all books received. Once she receives the book she will contact me and I will choose a reviewer and Barbara Matos will send the book to the reviewer.
- If you have a colleague in mind as a reviewer of your book please let me know. I am always interested in adding reviewers to my list.
- Reviews should be four to six double-spaced pages. The book title and publisher should appear at the top of the page followed by the reviewer's name. At the end of the review the reviewer should include a sentence or two about themselves.
- The review should then be sent to me so I can read it. I will then send the review to Donna Tarver for publication in our *Newsletter*. We only review books; we do not review book chapters or articles.



- On some occasions a film relevant to our field may be reviewed and if you see such a film and would like to review it please write directly to me.

I thank all the authors and reviewers who have made such excellent contributions to the *Newsletter* over these many years.

Diana Siskind, MSW • Book & Film Review Editor • dwsiskind@aol.com

Lasagna for Lunch, continued from page 14

for an adult life and an adult woman's body.

So much pain is enacted through the body because we do not have words for it. Cohen's work is very helpful in this regard, particularly her chapters on grief, body image in our society, abuse, addictive behaviors, and pathological attachments. She also includes very fresh material on impasses and client resistance. I urge you to read this book, written by a clinician who is a credit to clinical social work.

Reprinted from *The Clinician* 45, no. 2 (2014). www.NYSSCSW.org.

Helen Hinckley Krackow is a former president of the New York State Society for Clinical Social Work. She chairs the state Mentorship and Newsletter committees and co-leads the practice committee The Older Clinician and the Older Client.

Still Practicing, continued from page 14

Still Practicing recounts with refreshing candor her times of doubt at not always knowing "the right answer" for her patients and supervisees. She confides that even after four decades there are still times she grapples with confusions, conflicts, and contradictions.

By sharing her struggles with inadequacy, I am reminded how over forty years ago, when I first began studying to become a social work psychotherapist, I wrote down verbatim what my supervisor advised. I memorized it, and then earnestly stated it back to my client. I was so worried about doing the right thing that I depended on my supervisor to tell me what that right thing was. With analytic training, supervision, my own psychoanalysis, and the tincture of time, I began to allow my heart and soul to play a more intuitive role in my relationship with my patients which deepened their therapy and enriched their lives. Dr. Buechler champions therapists to forge their own "particular signature style." This style is "not merely a set of skills being acquired but rather a capacity ultimately inseparable from who one is as a human being."

Dr. Buechler's book recalls another wonderful book, Dr. Judith Viorst's *Necessary Losses: The Loves, Illusions, Dependencies, and Impossible Expectations That All of Us Have to Give Up in Order to Grow*. Dr. Viorst explains, "The road to human development is

paved with renunciation. Throughout our life we grow by giving up. We give up some of our deepest attachments to others. We grow by losing and leaving and letting go."

In *Still Practicing*, this same cycle of loving, losing, leaving, and letting go is told through the lens of a psychoanalyst reflecting on the arc of her professional development. Dr. Buechler reminisces about the feelings of loss of past patients and her continued attachment to them. She admits longing to know how they have fared even after they have terminated. She makes it okay to be human and to remember and mourn the loss of our patients.

In the section "The Ordinary Tragedies of an Analytic Life," Dr. Buechler describes, "My former patients are frozen in time, never aging, like pressed, dried flowers marking a memory. I hold the story of their early history; I hold their dreams. . . . I remember so many tiny details and have no one to tell them to. I am alone in an echo chamber, my recollections reverberating only with each other. There is no way to be more alone, more cut off. . . . Losing the patient includes losing the person I could be when I was with her. . . . I lose an aspect of myself when the patient leaves; I have lost the analyst I was when working with that patient. . . . Losing a patient includes losing the person I could be when I was with her."

She stimulates my own affectionate memories of patients from forty years ago including an early client, Adam, who came to therapy with the express purpose to "meet a lonely girl." Through the support of our work together, Adam, a young man with significant emotional and cognitive impairments, did find a lonely girl, and they eventually married. I would love to know how they are doing. I would also love to know how my group of pre-operative Spanish-speaking transsexuals are. They were the first group (bilingual) I ever ran in my first job at a Brooklyn mental health clinic. And I wish I knew how Millie's life turned out, another clinic patient—a beautiful woman whose boyfriend shot her three times and she proceeded to marry him after he was in jail. Only then did she come to therapy for anxiety. Her treatment enabled her to realize that she translated his shooting her as signifying the profound depth of his love. "And now that he's in jail," she added, "I'll always know where he is on Saturday nights, unlike my womanizing father." And then I remember my own analyst who died many

years into my analysis. Where would I have evolved to if he hadn't (so selfishly!) died? And I wonder when was the very last time he thought of me before he died?*

Dr. Buechler highlights two key emotions which she believes are constant companions of psychoanalysts throughout their professional lives: shame and sorrow. "At each stage of our careers," she writes, "from training through early career, mid-phase, and late-career experiences, shame and loss follow us." This includes emotional risks encountered during clinical training (she describes the power games of institute life as a "narcissistic mine field") and the trials and tribulations of building and sustaining a practice. Sadness and shame, she claims, are the occupational hazards of us clinicians who are deeply devoted to helping people grow, while also recognizing that we are fallible despite claiming to be experts on how to live life.

"Where do we find the strength to bear all the disconfirmed dreams, hopes, passions, fantasies, and wishes imposed on us by treatment's necessities?" she asks. How do we learn to "return to a kind of emotional baseline every forty-five minutes" as well as tolerate "assaults on the clinician's self-esteem"? Cultivating "analytic resilience" is the antidote that enables us to bounce back from the blows we are dealt of loss, shame, and burnout. Analytic resilience is the elasticity clinicians need "to sustain hope, curiosity, kindness, courage, sense of purpose, ability to bear loss, integrity, and a sense of emotional balance." To stimulate elasticity, she recommends calling upon our "internal chorus" of past teachers, supervisors, and analysts. Consulting with the internalized voices of these mentors can help us feel supported and less lonely. We can "confer" with their wisdom and insight that we carry within.

Writing, teaching, and speaking are another way to build resilience. "Writing teaches me what I think. Writing performs another feat of magic. It stops time," describes Dr. Buechler. We can replay and re-do and re-imagine how we might have conducted a case differently which widens our perspectives.

I should add that the title of this book, *Still Practicing*, captivated me from the beginning. It connotes an ongoing and long life of work, as in "still alive and kicking," or even Paul Simon's ironic 1975 song, "Still Crazy After All These Years." But I also like the other meaning of the word *still*, as in the therapist

being and sitting still or in the title *The Art of Stillness: Adventures in Going Nowhere* by Pico Ayer. But for me—a "still practicing" therapist like Dr. Buechler—the word is used most poignantly in a poem by T. S. Elliot: "Teach me to care / Teach me not to care / Teach me to be still."

In conclusion, Dr. Buechler's book serves as a wonderful guide as we join her in exploring the analyst's life cycle. She inspires us to encourage our own personal "creative wonder." "Passionate engagement in treatment," she writes, "is a genuine investment in life itself. It is communicated in the 'music' of the treatment—the analyst's tone, manner, directness, allegiance to the truth, and the deeply felt conviction about the meaningfulness of the work."

**Names and identifying data have been changed for confidentiality.*

Mary Anne Cohen, LCSW, is director of the New York Center for Eating Disorders and author of *French Toast for Breakfast: Declaring Peace with Emotional Eating* and *Lasagna for Lunch: Declaring Peace with Emotional Eating*. www.EmotionalEating.org.

aapcsw aims&purposes

- To represent and protect the standing and advancement of psychoanalytic social work practitioners and educators.
- To provide an organizational identity for social work professionals engaged in psychoanalytically informed practice.
- To promote and disseminate the understanding of psychoanalytic theory and knowledge within the social work profession and the public.
- To affect liaisons with other organizations and professions who share common objectives for social work and the advancement of psychoanalytic theory and practice.
- To advocate for the highest standards of practice and for quality mental health care for the public.
- To bridge social work and psychoanalytic discourses by integrating concerns for social justice with clinical practice, and to conceptualize psychoanalytic theory and practice within its broader social-political context.

Unfortunately, she cannot look to her family for support. Her parents are long divorced and there has been limited contact with them since she left home. Unable to tell her mother, whom Ashley feels would worsen the situation for her, Ashley does reach out to her father. While he appears to care for her he is unable to acknowledge what she has been through and shows little sensitivity to her situation. Seeking assurance that she will be alright, he initially ignores her needs. Although he is aware that her limited resources were stolen by the rapist and that she was being pressed to meet a major medical cost, he initially does not offer to help. Only later does he respond in a limited way to her need for money.

Ashley's early response to the assault is to ask of those attending to her medically what she has done wrong. Why did this happen to her? Constant assurance that she has done nothing wrong fails, of course, to reassure. Grateful for the assistance she does receive, she feels she doesn't deserve kindness. She is self critical and filled with guilt.

She is angry, but not at the rapist. There are any number of people to get angry at, particularly those who keep her waiting hours and hours in various agencies or put her through unnecessary processes in her efforts to secure critically needed assistance.

When she is put in touch with another woman who has been raped, Ashley is relieved to think she is not the only one to go through the experience. It helps too when a crisis rape counselor whom she sees early on helps her understand that some of her symptoms like distractibility and forgetfulness are normal under the circumstances. In time, Ashley sees an individual therapist and finally participates in a group of women who have been raped. The group experience is particularly helpful, according her an important sense of feeling understood and enabling her to normalize some of what she is experiencing. In reading this account, one is reminded of how essential it is that services be provided immediately, consistently, sensitively, and competently.

Despite her setbacks, we are impressed by Ashley's efforts to work her way through the flashbacks, the fear of AIDs, the physical pain that lingered on and the ever present concern that some new danger will befall her. We applaud her continued reaching out for and taking advantage of her psychotherapy as well as her efforts to engage in life when the pull

was often to simply give up. Fatigued and despairing, she nonetheless takes a course in self-defense, and when she is a little easier, she takes a singing course and in time even assumes a brief responsibility for directing a theatrical production.

Though pain is the predominant feeling she endures, she does share some positive childhood experiences—a loving relationship with her grandparents and some good times shared with her father as well as with a childhood friend. One presumes that these positive relationships and others like it gave her some sense that life could be better and helped to keep her engaged.

Ashley moves forward, marries, and becomes a psychotherapist, and when, through her fine memoir, she allows her experiences to be shared by others who might benefit from them, it is a testimony to her strengths and to the support of those who helped her along the way and, to some extent, of those societal institutions that functioned adequately. Her attacker is brought to justice. She also wins a financial claim against her negligent landlord, and those who continue to reside in that unsafe building are safer for her efforts. Ashley herself achieved, as she puts it, "something new; stability." She was slowly released from the "grip of [her] own story." Those who have been sexually violated and those who seek to help them, whether they be friends, health and legal professionals, law enforcement personnel, or policymakers, will appreciate Ashley Warner's generosity in sharing her experiences. We can only hope that in doing so she will move us as a society to take the problem of sexual assaults ever more seriously and find ways to spare others from the suffering that she endured.

Joyce Edward, BCD, is a retired social work psychoanalyst. She received the Lifetime Achievement of the AAPCSW (NMCOP) in 2002. Her most recent publication is "The Sibling Relationship: A Force for Growth and Conflict."

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Schizophrenia, continued from page 5

never pretend to accept the delusions and hallucinations as reality but must rather explain to the patient that there are reasons why he experiences things in a different way. If the patient does not want to talk about himself or anything else, he should not be asked questions. Arieti (1959) writes, "Each question is experienced by the schizophrenic as an imposition, or an intrusion into his private life, and will increase his anxiety, his hostility, and his desire to desocialize" (499). This can be a rather difficult situation for the therapist, especially for those who have been trained in the hospital setting and have to collect information from the patient. Nevertheless, it is important to refrain from questioning.

If the therapist is not supposed to ask questions of a reluctant patient, what should he do? Arieti (1959) provides various techniques: (1) Talk about neutral subjects, the weather, sports, etc., conveying to the patient that a sincere effort is being made to reach him. (2) If the patient is mute, or almost mute, or catatonic, the therapist must talk to him, expressing sympathy and a desire to break the incom-

municability. The therapist should tell the patient that he, the therapist, realizes how frightened the patient is, so frightened that he cannot talk. The therapist knows, however, that he feels and understands. Arieti makes an exception in the case of the catatonic patient who seems to resent talking and withdraws even more. In this case, the therapist must "share" a state of silence without being disturbed by it. (3) If the patient is very disturbed, incoherent, or if the speech consists of word salad, the therapist, again, should not pretend to understand but should rather listen patiently. Soon, the word salad too may likely make some sense, or at least some major themes can be understood. (4) If the patient has well-systemized delusions and speaks fanatically about his paranoid beliefs, then an attempt must be made by the treating therapist to detour his attention and reestablish interest in the other areas of his life.

What about making interpretations with the psychotic patient? Arieti (1959) is of the belief that interpretations are not very important, at least not initially, but can be beneficial later on in treatment. He writes, "If the anxiety is decreased to the point



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that acceptance of the psychotic world is no longer immediate or automatic, it is possible to explain to the patient how he concretizes symbols. A patient of mine could recognize that the olfactory delusions about a bad odor emanating from his body were only concrete representations of what he thought about himself” (500). This is true not only for delusional ideations but also for hallucinatory experiences. Arieti writes that many of his patients after successful dynamic treatment of schizophrenia self-report cessation of hallucinations, although he says that this is by no means the usual case. “They are able to recognize that the anxiety state makes them anticipate the occurrence of certain things and situations they fear, for instance, that people are talking about them. But, almost simultaneous with that anticipation is the hallucination itself—they hear people talking about them. In the process of treatment they learn to recognize these stages and to catch themselves at the stage of the listening attitude, before it transforms into a definite hallucination” (500). It should be stressed that these types of interpretations are to be made only after the development of basic trust. The patient must be in a comfortable environment where anxiety has been significantly reduced. In my experience, this is only after several months of treatment.

It should also be noted that when we speak of schizophrenia as a condition, we are speaking only in the sense that schizophrenia is a human condition, and it is not to be inferred that it is an inherently medical condition. When schizophrenia is referred to as a disease, it is done so metaphorically. Indeed, it is a logical and semantic error to place schizophrenia in the same category as melanoma or diabetes. Arieti (1974) writes in his *Interpretation of Schizophrenia* that schizophrenia is not a disease

because it does not meet the classic Virchowian criteria for classification as disease, namely, demonstrable and objectively identifiable alteration of cells, tissues, or organs. This is a view that is elucidated most clearly in the writings of Thomas Szasz. Strictly speaking, there is no such thing as schizophrenia but rather only persons who have been diagnosed as having schizophrenia (Szasz 1976). Schizophrenia exists only in the same way that other theoretical concepts exist. The psychodynamic conceptualization of this human problem, then, is a description of persons and their internal conflicts, beliefs, and behavior.

M. Louis Ruffalo, MSW, ACSW, is a psychoanalytic psychotherapist in practice in New Bern, North Carolina. He serves on staff at CarolinaEast Medical Center in New Bern, has a solo private practice of psychotherapy, and is an adjunct faculty member in psychiatry at the University of North Carolina.

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About the BCD-P, continued from page 7

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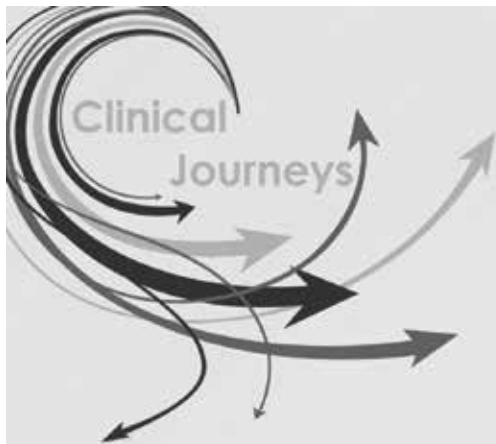
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From the President, continued from page 1

ignated for student and candidate paper submissions, which are eligible for awards. In 2015, the three winners presented their papers at the conference. This year, a new category was created for MSW student paper submissions, with the selection of two MSW student winners in this category. At the conference, all the winners received their awards for recognition of excellence in writing. NIPER, our educational arm, financed the conference fees for the winners and other graduate student presenters on panels. Recently, a NIPER conference student fund was established for donations to cover conference expenses for these presenters, as well as covering other accessibility services. We will continue to extend the conference as a platform for presentations by students and candidates, and the fund will function as a way to seed the future of AAPCSW.

To expand the intellectual connections for AAPCSW, an online monograph is being created as another option for publication of conference papers. President-elect Judith Aronson and I are participating in its development with the Editorial Board—Sheila Felberbaum, Debra Koppersmith, and C. Mark Massullo. Guidelines for this publication are

being formulated. Other online educational initiatives are being worked on and will be reported on as they are formed.

The Winter 2015 issue of the *Newsletter* featured a new design. Of interest in recent Newsletter issues—many of the books reviewed are by AAPCSW members. In a recent communication, Diana Siskind, Book and Film Review Editor, remarked on this significant development in the field, since in the past many social work psychoanalysts rarely have written books. She added that members are able to review books even if they themselves have never published, which is very gratifying to them. AAPCSW has joined a social media network with a page on Facebook, which was recently developed by Louis Straker, Technology Chair, and we encourage you to visit www.facebook.com/aapcsw. These are other opportunities that promote participation by members.

Our national biennial conferences are an integral feature of our organization, where students and new professionals are encouraged to attend. We are grateful to everyone—attendees, presenters, moderators, discussants, committee members, staff, and others—who participated in the conference *The Art*

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of *Listening: Psychoanalytic Transformations*, March 12–15, 2015. The list below will give you a sense of our vibrant community and the many contributors involved in creating a successful conference.

A special journal issue of the 2015 conference papers will be published by *Smith College Studies in Social Work* (Kathryn Basham, Editor, and Jim Drisko, Associate Editor), with its own separate paper submission and peer review process.

We will continue to be attentive to the needs of our membership and the next generation of professionals, keeping in mind our mission, which includes providing an organizational identity for our members as well as promoting and disseminating psychoanalytic theory and knowledge.

Other Noteworthy News

We welcome three new members to our Advisory Board—Kathleen Fargione, Minnesota Area Co-Chair; Rebecca Mahayag, Greater Washington Area Co-Chair; and Christie Hunnicutt, Newsletter Associate Editor.

Tributes

We are saddened by the sudden passing of our past president David Phillips. He was a highly esteemed professional and a scholar and writer on professional ethics, and he made enormous contributions to the field. Tributes written by members on the list-serv can be found on www.aapcsw.org.



Conference Participants

Conference Planners:

Penny Rosen (Conference Chair), William Meyer (Conference Consultant), Cathy Siebold (Program Consultant), Nancy Perault (Hospitality Chair)

Committee:

Samoan Barish, Karen Baker (Call for Papers), Lisa Barnhardt (Exhibits), Barbara Berger, Judy

Byck (Exhibits), Edna Goldstaub (Public Relations), Martha Harbour (Public Relations), Michael Jokich (CEUs), Elizabeth Lansing (Volunteers), Judy Ann Kaplan, Patricia Macnair (Treasurer), Peter Perault, Susan Bokor Nadas, Lois Ostrow (Hospitality), Kim Sarasohn (Call for Papers), Susan Sherman (Student Call for Papers), Diana Siskind (Student Call for Papers), Carolyn Stevenson (Editor), Christy Tronnier (Volunteers), Margaret Wilner (Public Relations), Wendy Winograd.

Presenters:

Theresa Aiello, Sharon Alperovitz, Margaret Arnd-Caddigan, Diane Barth, Kathryn Basham, Barbara Berger, Joan Berzoff, Lynn Borenstein, Jerold Brandell, Suzanne Brown, Christel Buchar, David Byers, Gilbert Cole, Paul Cooper, William Copeland, Joanne Corbin, Elizabeth A. Corpt, Michael De Simone, Anne Marie Dooley, Jack Drescher, Susan Eder, Joyce Edward, Janice Berry Edwards, Amy Eldridge, William Etnyre, Sheila Felberbaum, Jerry Floersch, Ellyn Freedman, Carlean Gilbert, Geri Goldmann, Scott Graybow, George Hagman, Jane Hall, John Heffernan, Robert Hooberman, Rosaleen Rusty Horn, Theodore Jacobs, Joel Kanter, Steven Kuchuck, Harold Kudler, Debra Koppersmith, Lynn Lawrence, Liling Lin, Jeffrey Longhofer, Susan Lord, Hilary Maddux, Kerry Malawista, Harriet Marquis, Elizabeth McKamy, Teresa Mendez, William Meyer, Melvin E. Miller, Richard Miller, Darby Morhardt, Suzi Naiburg, Joseph Palombo, Louis Pansulla, Matt Perault, Peter Perault, Maryam Newman Razavi, Karen K. Redding, Michael Reison, Shoshana Ringel, Judith Rosenberger, Crayton Rowe, Judith Rustin, Cara Segal, Linda Sherby, Susan B. Sherman, Kay Naskyung Shin, Cathy Siebold, Judith Siegel, Sandra Silverman, Alicia Simoni, Golnar A. Simpson, Diana Siskind, Mark Smaller, Marcia Spira, Marilyn Stickle, Frank Summers, Carol Tosone, Ash Turnbull, Patsy Turrini, Deborah Washburn, Audrey Thayer Walker, Ashley Warner, Jay Williams, Rosie Yap.

Discussants:

Karen Baker, Samoan Barish, Elizabeth Corpt, Heather Craige.

Moderators:

Judith Aronson, Karen Baker, Elissa Baldwin, Samoan Barish, Kathryn Basham, Cathy Crown

continued on page 30

membernews...

F. Diane Barth's article "Alexithymia, Affect Regulation, and Binge Drinking in College Students" was recently published in the *Journal of College Student Psychotherapy* (vol. 29, no. 2) and can be accessed at www.tandfonline.com/eprint/xFzW9qHtE9hbmTNhwDsY/full#.VTJDTFxN1FI.

During the last two years, **Linda G. Beeler** has conducted individual consultations and marketing private practice workshops in New York City, offering hands-on strategies for building, promoting, and sustaining clinical practice in the twenty-first century. Workshop discussions have focused on generating new referrals, brainstorming, and inspiring one another to be less fearful of digital age technology. Marketing methods have included social networking, presentations, creating or tweaking a website, utilizing social networks, developing resources, and carving out a specialty. Encouraging creativity is always a major focus. Linda has been in psychoanalytic practice for more than twenty-five years. She is affiliated with AAPCSW, PPSC, NIP, and NYSPP, and is a member of IARPP. She is supervisor and consultant to clinicians interested in expanding their private practice utilizing social media.

Dr. **Rosalyn Benitez-Bloch** was invited to present a paper at a conference in Prague, Czech Republic. The theme of the October conference was "Trauma and Home," sponsored by the Prague Psychoanalytic Society and the Rafael Institute. The book that Dr. Bloch wrote with her late husband, Gottfried Bloch, was translated into Czech, published, and then presented at the conference, which was held at the NYU campus in Prague.

Michael De Simone presented "Recognizing and Working through Counter-Resistance in Psychotherapy" to the Rockland County Chapter of the New York State Society for Clinical Social Work on Sunday, March 8. The presentation addressed the resistances that the clinician brings to deepening psychotherapeutic engagement, with a specific focus on dealing with dependent, erotic, and aggressive transferences. A major theme of the presentation was the importance of awareness of resistances to therapeutic work that the clinician brings to the treatment relationship.



Susan A. Klett

was appointed director of professional development for Advance Clinical Education (ACE), a foundation of the New York State Society for Clinical Social Work (NYSSCSW) on March 1. Her book *Analysis of the Incest Trauma: Retrieval, Recovery, Renewal*, with Arnold Wm. Rachman, was published in May with Karnac Books.

Debra Koppersmith presented her paper "Beyond The Boundaries: Identifying With The Trauma of Domestic Violence" at the 2015 Sandor Ferenczi Conference in Toronto in May.



What's your news? Graduations, presentations, publications, awards, appointments, exhibits, and so on are all items the AAPCSW membership would like to acknowledge in the this column. Feel free to include a photo. **New to AAPCSW?** We invite you to introduce yourself. Contact me at awarnerlcsww@gmail.com.

Ashley Warner, MSW, BCD • Member News Editor; Associate Editor, *Newsletter*

Susan S. Levine published a film essay in the *International Journal of Psychoanalysis* in February: "Means and Ends in Hitchcock's *Vertigo*, or Kant You See?" The essay will also appear as a chapter in the book on dignity she is editing, to be published by Karnac. Susan is in private practice of psychotherapy, psychoanalysis, and clinical supervision in Ardmore, PA. She also offers writing consultations for clinicians.

On May 1, **William "Bill" Meyer** presented "The 'Mother' Returns to Psychoanalysis: Sandor Ferenczi, Welcome Home" for the Training Institute for Mental Health in New York. On April 25, in Hickory, NC, he presented "Holding a Mother/Holding a Baby: Forging Connections with the Low-Income Pregnant Woman" at the all-day conference *Perinatal Mood and Anxiety Disorders: A Guide for Healthcare Providers*.



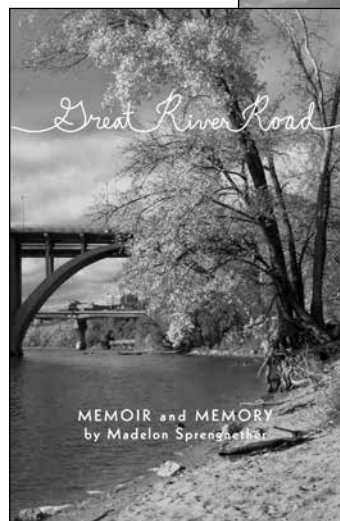
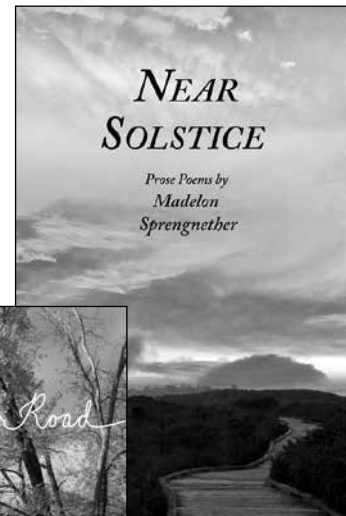
Judith Rosenberger has been working with analysts and professors in China and Israel during this sabbatical year. She wrote a paper with one of her Chinese CAPA students and is doing another paper with a University of Haifa professor. While in Israel, she lectured and was wonderfully welcomed at University of Haifa and Ben Gurion University as well.

Judith's book *Relational Clinical Social Work with Diverse Populations* was published by Springer in 2014 and is now available in hard and soft cover as well as ebook. It is a text for teaching clinical practice *within* cultural diversity rather than addressing diversity as a follow-up to learning practice.



Madelon Sprengnether has two new books out: *Great River Road: Memoir and Memory* (New Rivers Press) and *Near Solstice: Prose Poems* (Holy Cow! Press). Both debuted at the annual Associated Writing Programs meeting in Minneapolis in April.

Great River Road just received a wonderful review by Emily Freeman in the April 12 *Star Tribune* (www.startribune.com/entertainment/books). You can find the book trailer for *Great River Road* at vimeo.com/sprengnether/grr. Check Madelon's Facebook author page for information about bookstore readings and ordering information: www.facebook.com/MadelonSprengnetherauthor?fref=photo.



...&newmembers

Mary Anne Cohen is director of the New York Center for Eating Disorders, where she specializes in treating women, men, and adolescents with binge eating disorder, bulimia, anorexia, and body image disorders. She is author of *French Toast for Breakfast: Declaring Peace with Emotional Eating* (Gurze, 1995; Spanish edition, Madrid, 1997) and *Lasagna for Lunch: Declaring Peace with Emotional Eating* (New Forge Press, 2013). She is the professional book reviewer of www.EDReferral.com, the largest international resource of eating disorder information with a readership of over sixty thousand. Mary Anne is also a monthly columnist for *Image Magazine* since 2002 and, most recently, a writer for www.RecoveryWarriors.com. She lives in Park Slope, Brooklyn, and Taghkanic, New York. Introductions to her books as well as other resources can be found on her website, www.EmotionalEating.org.

From **Cate Desjardins**: “Next week, I am graduating from Wayne State University’s MSW program, where I specialized in the Interpersonal Practice-Psychodynamic concentration. Under the mentorship of Dr. Jerry Brandell, I won the Brehler Manuscript Competition for my essay ‘Practice Makes Progress: Navigating Trauma, Empathy, and Self-disclosure in Clinical Social Work.’ ‘Practice Makes Progress’ is an exploration of the ways my personal and professional experiences have intersected and overlapped to make me a more effective, empathic social worker. Beginning with my experiences working as a detox counselor fresh out of a BSW program, I trace how my experiences with recovering from trauma, starting a family, and re-entering the substance abuse treatment field have helped me become a more competent clinical social worker. Throughout the paper, I incorporate summaries of my findings from the social work, psychoanalytic, and substance use treatment literature on how empathy develops and how social workers can effectively and appropriately use self-disclosure with clients. The research highlights the most salient aspects of my personal and professional growth and reflects areas of concern for many beginning social workers. My manuscript—and all the previous

winners since 1992—can be read at www.socialwork.wayne.edu/brehler-manuscripts.php. In addition to being a psychoanalytic social worker, I am also a birth and postpartum doula. I live in a suburb of Metro Detroit with my husband and our lively two-year-old daughter.”

From **Melissa Koff**: “I am a full time MSW student attending Loyola University Chicago at Carthage College in Kenosha, WI. I am majoring in the mental health arena of social work. My goal is to take and successfully pass the ASWB exam, fulfill the required three thousand hours of supervised clinical social work, and to then take and pass the LCSW exam. Following successful completion of the aforementioned, I would like to work with children and/or veterans. In addition to my academic and professional goals, I am a foster mom. I’ve been so for nine years and it is very rewarding.”



Jocelyn Schur,
a student at

Smith School for Social Work, recently joined AAPSCW after attending her first AAPCSW conference this past March. Jocelyn believes in trauma-

informed care, criminal justice reform, and creating a safer world for women and children. She imagines her clinical journey will be rooted in values of a holistic and integrated approach to personal and social change. In April, she completed her first MSW field placement at Wayside Youth and Family in Boston, MA. In the fall, she will begin her second MSW field placement at Red Hook Family Counseling Beacon Preventive Program, Good Shepherd Services in Brooklyn, NY. She hopes to participate on the AAPSCW Diversity Committee. She extends a heartfelt thank you to Lou Pansulla and Penny Rosen for such a warm and generous welcome to the community.



From **James Wells**, an LCSW

practicing in the Union Square area of New York City: “I work with children of all ages as well as adults in individual, couples and group psychotherapy. While working in these diverse ways is refresh-

ing to me professionally, it also allows people the opportunity to choose what mode of therapy suits their situation the best. In my work with children, I specialize in working with anxiety, depression, identity issues, addiction (including video game addiction), trouble focusing at home or school, difficulties adjusting to medical conditions, and struggles getting along with parents or siblings at home. My work tends to focus on helping children express their emotions in constructive ways and becoming more connected to the important people in their lives.”

James is in his fourth year of training at the Psychoanalytic Psychotherapy Study Center, and has also trained in family and play therapy. His website is jameswellspsychotherapy.com

From **Josh Wolf-Powers**: “I’m glad to join AAPCSW. I graduated from NYU’s Silver School of Social Work just a year ago, and today, I practice psychotherapy under supervision at the Sexuality, Attachment and Trauma Project near Columbus Circle in Manhattan. I also practice at the Contemporary Freudian Society, where I’m doing my psychoanalytic training, both on the Upper East Side and in the Village. Prior to getting my MSW, I worked in finance and government, and in community-based social services, before that. I look forward to being a part of this community.”

arearepresentatives'corner

Southern California

Ellen Ruderman, PhD, PsyD, LCSW, *Los Angeles Area Chair*

Karen K. Redding, LCSW, PhD, *Orange County Area Chair*

The Southern California Area Committee recently presented a seminar titled “It’s All About the Pronouns: Wading Through a Sea of Confusion in a Transgender World.” The paper, written by Paula Shatsky, dealt with the generalized confusion many of us feel, as therapists and human beings, with re-

spect to understanding this complex social phenomenon. It was a very stimulating afternoon, with a rich and lively discussion.

In the coming year, the Southern California Area Committee will explore how the issue of climate change is impacting us as a society. The seminar will explore collective issues of denial and dissociation from the urgency of the problem, with a focus on intergenerational reactions to the crisis.

From the President, continued from page 25

Buirski, Deborah Bunim, Janet Burak, Judy Byck, John Chiaramonte, Bennett Cotton, Heather Craige, Derek Easley, Amy Ferlazzo, Ellyn Freedman, Laura Groshong, Emery Gross, Christie Hunnicutt, Judy Ann Kaplan, Richard Karpe, Molly Kiefer, Diane Leamy, Kate Leslie, Sharon Merrill, William Meyer, Frank Moore, Susan Bokor Nadas, Barry Ostrow, Adriana Passini, Natalie Peacock-Corral, Nancy Perault, Michele Rivette, Graciela Rodriguez, Claire Rosenberg, Florence Rowe, Marjorie Scheer, Anne Segall, Janelle Sharp, Cathy Siebold, Sylvia Teitelbaum, Marsha Wineburgh, Wendy Winograd.

Readers:

Judith Aronson, Terrie Baker, Rosalyn Benitez-Bloch, Joan Berzoff, Ruth Bittner, Karen Bloomberg, Margaret Bluhm, Kelly Bradham, Victoria Brown, Cathy Buirski, Deborah Bunim, Janet Burak, Fanny Chalfin, John Chiaramonte, Jean Clarke-Mitchell, Bennett Cotton, Leslie Cutler, Michael De Simone, Anne Marie Dooley, N. Jill Dunn, Joyce Edward, Amy Ferlazzo, Sally Fine, Judy Friesen, Velia Frost, Susan Goldman, Cole Hooley, Molly Kiefer, Debra Kupper-Smith, Lisa Larson, C. Mark Massullo, Ylana Miller, Susan Bokor Nadas, Suzi Naiburg, Lois Ostrow, Adriana Passini, Saralie Pennington, Nancy Perault, Karen Redding, Michele Rivette, Claire Rosenberg, Kim Sarasohn, Anne Segall, Joan Servatius, Susan Sherman, Cathy Siebold, Diana Siskind, Norman Sohn, Lisa Sokoloff, Marcia Spira, Marga Speicher, David Stanislaw, Donna Tarver, Jennifer Tolleson, Ashley Warner, Lee Whitman-Raymond, Wendy Winograd, Mark Wolny, Peter Wood.

Lifetime Achievement Award Recipients:

Samoan Barish (award presented by Marsha Wineburgh); Donna F. Tarver (award presented by Diana Siskind); Judy Ann Kaplan (award presented by Barbara Berger).

Professional Writing Award Recipient:

Patsy Turrini (award presented by Joyce Edward).

Candidate Paper Award Recipients:

Liling Lin, Kay Nakyung Shin, and Ash Turnbull (awards presented by Susan Sherman and Diana Siskind).

MSW Student Paper Award Recipients:

Ashley Lambert Fasano and Jessica Hallberlin (awards presented by Susan Sherman and Diana Siskind).

Staff:

Lawrence and Tamar Schwartz (Conference Administrative Coordinators); Kelly Martin (graphic artist); Olivier Massot (web designer); Barbara Matos (AAPCSW Administrator).

Co-sponsorship (CEU/CME/CE/NBCC):

North Carolina Psychoanalytic Society—Rex Moody (President), Lisa Long (Administrator).

Entertainment:

“Dulcimer Dan” provided hammered dulcimer music at the Saturday luncheon; Jerry Brandell, John Chiaramonte, and their quartet performed at the Jazz & Juleps event; the “mystery” guest “Duke of Elvis” performed at the Jazz & Juleps event.

Art Exhibits:

Renee Leverty, Pleiades Gallery, Durham, NC; Michael Jenkins.

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Members may make tax-deductible contributions to NIPER (National Institute for Psychoanalytic Education and Research, the education arm of AAPCSW), the NIPER Student Conference Fund, and the National Advocacy for Psychoanalytic Social Work. Please visit www.aapcsw.org to learn more.

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