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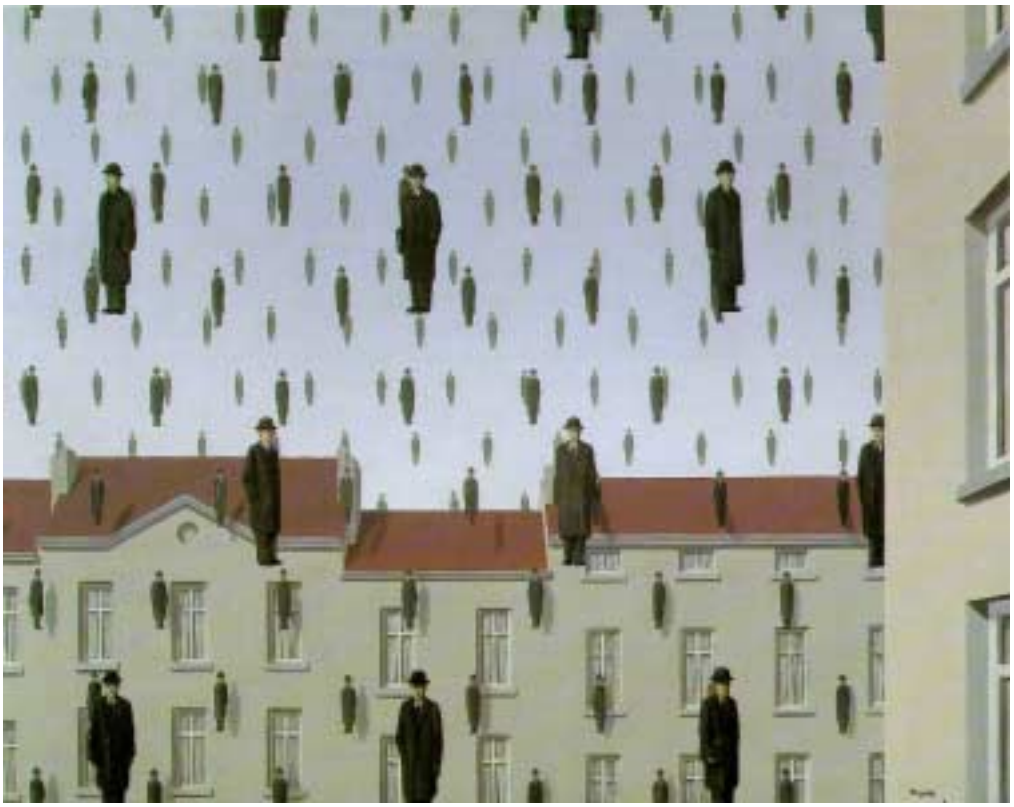

Winter-Spring 2000

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MESSAGE FROM THE PRESIDENT

Happy New Year!

Whither Psychoanalytic Theory, Practice, and Research in the Twenty-first Century, now one hundred years since Freud published his seminal *The Interpretation of Dreams*? Pummeled, bleeding and left for dead at the hands and fists of so-called Managed Care and "Medical Necessity"; or reinvigorated from new theoretical and inter-disciplinary pluralism and the prospect of greater applicability to a larger number of people? Where do we go from here? These are some of the questions we want to look at during the New Year and new century.

The Open Chapter has been busy organising and presenting special events. In June, David Downing, Garth Amundson, Cathy Wilson, and I presented a *Symposium,* "Psychoanalysis as a Hidden Activity" at the Rolling Meadows campus of ISPP. This was in advance of presentations in Boston at the 104th Annual American Psychological Association Convention in August; and at The International Federation of Psychoanalytic Education (IFPE) Annual Conference in San Francisco this past November. These papers, from clinicians/educators working in varied mental health settings, share a common theme of struggling to conceptualise and apply analytic concepts in settings that often do not regard psychoanalytic theory or practice. We have included drafts of these papers for inclusion in this edition of the *Newsletter*. Please send us your comments and suggestions for future topics -- or submit your own papers! Recently, Peter Shabad, PhD of Michael Reese Hospital spoke at ISPP/Meadows Campus, giving us an advance look at some of his fascinating ideas on trauma that will be published in book form sometime this year by Jason Aronson. Mark your calendars for 22 January at 10:30 AM when Chet Mirman, PhD will present a *Symposium* entitled, *Is God Necessary? … A Dialectical Approach to Spiritual Development* at the Rolling Meadows campus. On 13 February at 9:30 AM, Charles E. Turk, MD

On The Psychoanalyst's 'Capacity To Be Alone': Working Psychoanalytically In Anti-Psychoanalytical Spaces

David L Downing, PsyD

Paper Presentation, The American Psychological Association Convention,
Boston, Massachusetts, 23 August 1999

> If, however, there should actually turn out to be one of you who did not feel satisfied by a fleeting acquaintance with psycho-analysis but was inclined to enter into a permanent relationship to it, I should not merely dissuade him from doing so but actively warn him against it. As things stand at present, such a choice of profession would ruin any chance he might have of success at a University, and, if he started in life as a practising physician, he would find himself in a society which did not understand his efforts, which regarded him with distrust and hostility, and unleashed upon him all the evil spirits lurking within it (Sigmund Freud, Introductory Lectures on Psycho-Analysis, 1917/1966, p 18).

Freud' s trenchant observation would appear to have maintained its currency, despite the intervening eighty-four years since their delivery during the 1915-1916 Academic Year at the University of Vienna. These reactions towards psychoanalysis and psychoanalysts unfortunately place especially onerous burdens on the individual practitioner. He or she must not only bear the regressive strains attendant with managing the daunting vicissitudes of the psychoanalytic situation per se, but must operate within a milieu that may be not only passively non-supportive, but is subtly or even openly disparaging and hostile.

The situation for the psychologist-psychoanalyst may even be somewhat more precarious than the medically-trained, psychiatrist-psychoanalyst. This owes to the exclusionary "ownership" of psychoanalysis within the medical community in the United States which excluded psychologists from receiving training outside of a few institutes in the New York City area until recently. This not only stultified the refinement of psychoanalytical theories and clinical practices by sealing them off from the possibility of being investigated through various modes of research within academic communities – it precluded any possibility of open, informed debate and collegial dialogue with proponents of diverse theoretical positions in the scholarly marketplace of ideas.

Whereas departments of psychiatry integrated psychoanalysis (at least in the past) throughout their organisational structures, departments of psychology rarely had faculty or administrations that were knowledgeable of, or even curious about, let alone sympathetic to, psychoanalysis. Indeed, department chairs and faculty in psychiatry were often psychoanalysts themselves; and the best and brightest of residents were encouraged to enter psychoanalytic training institutes. The anti-psychoanalytical bias rampant in the halls of academic psychology often meant, and can still mean, that students do not receive an exposure to a fair and accurate representation of even so-called classical or Freudian psychoanalysis per se, let alone knowledge of the diverse pantheon of contemporary theoretical positions. Certainly, psychoanalysis has enjoyed a veritable renaissance in expanding and refining theory and applications, as well as a

renewed emphasis on subjecting certain constructs (such as the unconscious) to empirical "validation". Yet, faculties and their students still tend to be unaware of these trends which are extant in the contemporary psychoanalytical movement. Thus, they may receive no information on, nor training in, psychoanalytically-informed and driven refinements that have so energised the treatment of severe psychopathology; the practice of crisis and short-term, albeit clinically-determined, treatments, and so forth. Perhaps even more telling is the ill-reasoned assault on psychological testing as a whole (the specious rationale at times arising from the fact that such important and clinically necessary skills and procedures are often not reimbursable by insurance carriers). However, it again seems that the psychoanalytically-derived and informed instrumentation such as projective assessment, receives an inordinate amount of scrutiny or scorn, relative to the more "scientific" (or more "medical" and hence, prestigious?) neuro-psychological assessment procedures.

Whatever antipathy as exists within organised psychology which may be historically understandable, as derivative of the afore-mentioned antecedents, new assaults have been brought to bear on the broader front of the independent professional practice of clinical psychology as informed by theory, research, and accepted norms of practice. The chief progenitor of such trends can be discerned by the intrusion of so-called managed care, and the concomitant erosion of confidentiality and privilege that have resulted from numerous lawsuits (eg, the Tarasoff versus Board of Regents of the University of California decision, which led to still other deleterious legal precedents being established).

Thus, even some of the ethics of psychoanalysis, in reference to, amongst other matters, absolute confidentiality, would seem to place us at odds with growing requirements toward "mandated reporting", positioning us as potentially vulnerable and alone vis-a-vis the established ethical codes of psychiatry, psychology, social work, etc. In no small measure, these organised professional associations appear to actually be rushing to capitulate and abjure their independent, professional authority to such entities and the political-economical forces they embody. As Bollas and Sundelson (1996) note, in 1977, when California's State Legislature was drafting a Child Abuse Reporting law that swept away any protection of the patient's confidential communications, the only concern registered by the California Psychological Association was to write to the committee so as to ensure that psychologists were included in the final bill as another professional group who must report allegations of child abuse (p 49).

Therefore, we psychoanalysts become further estranged from, and at odds with, our professional associations as well as state licensing boards. This further stresses the psychoanalyst faculty member/administrator, who must delicately address such threats, while maintaining in our communications and teachings to students an absolutely ethical position and ethos of "Do no harm". Navigating the "aspirational" and "mandatory" aspects of the ethical codes while attempting to inculcate a non-judgmental mindset of curiosity, openness to understanding, and non-impinging enquiry, without the immediate leap to report or inform à la thought-police agents of the State, is only one prime example of this. Rather, it is only through such an eventual resonance or "knowing", which is often labored and incremental, that we may come to offer, eventually, interpretations or other interventions which are contextually embedded and developmentally appropriate, for each unique patient. It is folly to presume that there can be any circumvention of the constituent parts of such "knowing" – including the development of the transference, the work with the inevitable and informative "resistances", let alone elaboration of the symptom complex and associated domain of the unconscious core. Such tasks are all necessarily associated with extended periods of, and struggles with, "un-knowing". Freud's (1937) paper on Analysis Terminable and Interminable is particularly eloquent in these respects.

In short, the affronts to psychoanalysis (theory, practice, and research) are numerous, over-determined, and are manifested culturally, societally, across disciplines, and across theoretical orientations. With regard to the latter, the attacks seem to have become increasingly shrill, partisan, and aggressive. For example, we have the burgeoning pharmaceutical industry with its buying out of managed care and health maintenance organisations; the "Dust-Bowl Empiricist"

pronouncement that psychoanalytical treatment is invalid or even harmful, as well as unsupported by data; that only certain cognitive-behavioural treatments can lay claim to being "empirically supported" techniques (the nomenclature being changed from "empirically-validated" after a well-deserved hue and cry arose over Division 12 (Clinical Psychology)'s egregious and politically-charged phrasing with regards to certain cognitive and behavioural treatments). Indeed, even within psychoanalysis itself, certain sub-cultures question the merits of remaining within any formal health care provision program, given the untenable compromises that have inevitably accompanied the imperatives of third-party payors. Along these fronts as well, our own thoughtful fore-bearance, as brought to life in the here-and-now of the classroom, can be a powerful experience for the learner. Such a position requires as well that we are in contact with our own narcissistic needs for power or influence over others; as well as Oedipally-driven rebellious trends, lest we, or our student "proxies" act-out inappropriately with patients, or within organisational structures, including the supervisory relationship, the School, externships, internships, or beyond.

The admittedly cursory outline of certain challenges to psychoanalysis, and tenuous support for psychoanalytically-oriented practitioners delineated above hopefully communicates that psychoanalysis, and its practitioners of all types, face significant impediments in instituting, guiding, and bringing to appropriate, professionally-determined closure, optimal strategies of care and treatment. This is especially relevant for significant numbers of our patients who present to us seeking relief for what, simultaneously, appear to be increasingly serious degrees of psychopathology.

The 'Position' of the Analyst in Organisational Space and Culture

It is in this regard that the challenges of working within academic settings, and communicating with our non-psychoanalytically-oriented colleagues (as faculty and/or administrator) assumes a darker cast. However, the writings of DW Winnicott can be illuminating and salutary. Winnicott (1958) asserted that an individual's capacity to be "alone" is predicated on the existence of a prior relationship that has been experienced as protective, reliable, and good-enough. The internalisation of such a relationship paradoxically permits the discovery of one's self, and is associated with psychical integration and emotional maturity. Such a capacity attenuates the experience of persecutory (or annihilatory) anxiety. "Loneliness" suggests the lack of internalised, stable, and abiding self- and object-representations that can attenuate and neutralize regressive trends that may become mobilized in the face of such dynamics. Now, it is one thing to speak of such matters as pertinent to the "patient", but in light of the gist of this paper, let us consider this as a most necessary accompaniment for the psychoanalyst-academic, and, in particular, the psychoanalyst-administrator as well.

Drawing upon an extrapolation of Winnicott's (1960) notion of the holding environment, Stapley (1996) extends the concept to an examination of organisational life and "culture". Organisations, while fictive, non-human, and "as-if" constructions, tend to assume a variety of characters/qualities that become quite real for their "inhabitants". Such "realities" are, however, subject to the myriad of more-or-less distorted transference-like phenomena; facilitative, containing, impinging, or even pathological mechanisms located within individual members' psyches, as well as the collective culture of the organisation itself. These vicissitudes approximate the clinical psychoanalytic situation.

At this point, we would do well to take to heart Freud's (1937) cautionary assertion that no patient may proceed beyond the neurotic complexes of his or her psychoanalyst. If the academic professional training organisation is indeed singularly crucial to the socialisation and training of subsequent generations of practitioners – if, as part of its accrediting, "gate-keeping" functions is the perpetuation and transmission of the "culture" of the profession – I submit that it is all the more crucial for psychoanalysts to not only enter educational and clinical training programs, but to proactively assert themselves and their theoretical/technical positions at every level of their contacts with faculties, administrators, as well as students -- across baccalaureate, masters, and doctoral programming. If others on the organisational stage do not have available to them

objects for identification, particularly, the ability to internalize relationships and experiences (and associated remembered images) of being mentored and "held" in light of the daunting vicissitudes of the contemporary climate, another very real danger exists for the professional and personal readiness for subsequent generations of psychoanalytical practitioners (and perhaps, even, that there should be subsequent generations!). This includes the capacity and willingness of the psychoanalyst to "go it alone", if need be, in order to advocate for students, for a psychoanalytical presence in the academy, etc. To remain utterly "hidden", afraid of being "seen" (and hence "targeted"?) is to communicate a most unfortunate message, one that reifies a message of danger, scarcity, and rapacious self-servativisim. In short, no organisation may progress beyond the collective limitations of its Faculty and Administration.

Having exploded the myth of the "well" psychoanalyst vis-a-vis the "ill" patient, the psychoanalyst functioning as an administrator/faculty member must certainly shed some of our field's well-known aloofness and abstruseness, which superficially can be experienced as elitism and inaccessibility. Grandiosity can sometimes mask our own sense of inadequacy, as seen through various rescue phantasies or heroic inner scenarios, as we strive to be, as articulated by Brightman (1982), omniscient, omnipotent, and beneficent. The not-uncommon schizoidal attributes of the psychoanalyst practitioner can become still another impediment to the administrator's need to be seen and available as a very real object on the stage of organisational life. The need for active, collegial, collaborative engagement with numerous, often conflicting constituencies also requires that the psychoanalyst administrator/faculty member be capable of exercising a firm degree of action in the material world.

While our training emphasizes understanding over doing, the administrator must never-the-less be prepared and able to develop appropriate action plans based upon his/her assessments. And, with the organisational "frame" established, s/he must be capable of confronting and managing deviations from, and challenges to, this frame. Unlike the Marvel comic book character The Watcher -- a Supreme, Other-Worldly, implacable, and mysterious alien being – tall, statuesque, garbed in a toga, and equipped with a huge, bald cranium (symbolical of an associated superior consciousness) – who is forbidden to intervene (impinge) upon the course of human events -- the administrator cannot always afford to be "in, but not of" the organisation that they must manage.

In this regard, we need to be prepared to deal with the inevitable conflicts that will proceed from the establishment of administrative parameters. Students and faculty will necessarily have diverse, and over-determined responses to such structural imperatives. In this regard, interpretation of resistance can be informed by our appreciation for its manifestations in the clinical scenario. That is, we should attempt to understand its individual and organisational stirrings, as well as disentangle our own contribution to the situation (or impasse). It would be tempting to leap to an assessment that either it is a resistance based on our own personal inadequacy, character, etc; or derivative of a disdain for psychoanalysis; envy, and so forth. These dynamics can most certainly tax the self-esteem and sense of adequacy/efficacy of even the most dedicated and "self-sufficient" psychoanalyst-administrator – all the more reason to have some internal and external wellsprings of narcissistic and ego supplies to draw upon.

On Neutrality and Relatedness

I tend to prefer a notion of psychoanalytical "neutrality" that is a more liberal rendering of Freud's (1912) metaphor of the "blank screen". Freud's (1912) other, oft-quoted provision of an "evenly hovering attention" seems to be in accord with positioning myself in such a manner as to be available, within the "potential space" offered by the paradoxically open and closed field of the organisational milieu. It is "open" in the sense of Winnicott's concepts of transitional space and phenomena, as well as the potential space wherein something unique, phantasied, and ultimately possessed by the creator (learner, student, and faculty member) may transpire, happen, or, simply, reside. The play between internal and external, me and not-me can proceed adaptively only insofar as the space is also "closed" or perhaps, more

appropriately, "contained" (time, space, roles, responsibilities, etc being spelt out). Thus, we may be "used" in the Winnicottian sense as "as-if", constructed, de-constructed, and transferentially distorted objects. We can expect to be "scanned" for our preferences, personal histories, biases, values, etc, etc, just as in the clinical situation.

The academic environment is perhaps seductive in terms of its disingenuous retreat from such carry-overs generally associated with clinical work. We are more active in a real, or at least, "hands-on" kind of way; we talk much more (and face-to-face); we may give people frank directives and hold evaluative responsibilities with regards to others duly implementing them. We hold and conduct meetings, yet at times, a more "social" and certainly egalitarian/collegial atmosphere indeed prevails. But we need to be exceedingly mindful that our own observance of deadlines, time-frames, professional yet warm comportment/decorum are exemplars of our own honesty, integrity, ethicality, consistency, constancy, and concern. Our own capacity to directly manage conflict, and even bring to manifest levels latent, destructive processes or phantasies that impede optimal organisational functioning, while necessary, often goes against the grain of psychoanalysts used to and more comfortable with private clinical practice with individual patients.

Who Am Us Anyway?

Those of us in administrative and/or faculty positions may be viewed as some odd species, neither fish nor fowl, espied with suspicion by our clinical psychoanalyst colleagues, and non-psychoanalysts alike. "Why do you want to do that?" I have often been asked in one way or another. While I don't feel like I am a "museum piece", or a "traitor to the cause" (depending on the particular "camp" addressing me), these are the sympathies often expressed. Also troubling, are reports I often receive from students indicating that they are exposed to fairly active, biased, denigrating assaults on psychoanalytic theory and practice (perhaps even psychoanalysts, as clinicians). Thus we must at times assume a very thoughtful, reflective, and non-accusatory stance in addressing such delicate matters (including the matter of assessing the veracity of the reports). This can facilitate the movement toward appropriate, respectful discourse and civility. Indeed, it may help to illuminate what the "real" problem is, as compared with the presenting or ostensible one. For example, is it related to a faculty member's or student's sense of being slighted, not receiving validation for a job well done, being passed over for a promotion, etc.

On the Importance of Being a Psychoanalyst in an Academic Setting

Interestingly, psychoanalytic training may provide excellent preparation for assuming administrative and program leadership roles. For example, organisations are replete with manifestations of the symbolic-metaphoric-derivative spheres. The psychoanalyst is trained to attend to the uniquely and collectively constructed meanings of an organisation that become reified. Micro- and macro-transferences and their vicissitudes; management of parental and sibling transferences, splitting, and secrecy versus openness are amongst some of the typical issues that one encounters (Downing & Horowitz, 1996). The psychoanalyst must redefine the meaning of "patient" to include systems and remain aware that multiple legitimate needs and agendas must co-exist within larger systems. There may not always be a concordance amongst the goals and aims of the individual system or entire organisation. The psychoanalyst must then attend to the tension between organisational cohesion and goals; and individual needs, desires, and goals (Downing & Horowitz).

While challenging, such work is also highly stimulating and rewarding. Such inter-disciplinary discourse and student contact has the broad potential to enrich all parties. By creating and maintaining a place for psychoanalysis within the academy, we ensure the on-going evolution of psychoanalysis, and its relevance for the treatment of a diverse range of psychopathology. Additionally, if psychoanalysis is to survive, it cannot continue to be seen as solely a unique treatment methodology (as exemplified by psychoanalysis, proper). Our training prepares us to function effectively as educators, consultants, and administrators as well.

David L. Downing, PsyD, is a graduate of the Wright State University School of Professional Psychology in Dayton, Ohio, 1985. He received his certificate in psychoanalysis from the Center for Psychoanalytic Study. He is the Past-President and current Treasurer of the Chicago Open Chapter for the Study of Psychoanalysis and is the Treasurer of the International Federation for Psychoanalytic Education. He is presently Director of Clinical Training and Professor at the Illinois School of Professional Psychology-Meadows Campus. He maintains a part-time private practice in psychoanalysis, psychoanalytic psychotherapy and supervision in Chicago and Rolling Meadows, Illinois.

Psychoanalytic Psychotherapy in the Research Setting: A Subversive Activity

Russell S. Omens, PsyD

Paper Presentation, The American Psychological Association Convention,
Boston, Massachusetts, August 1999

As we have moved from a dynamically informed model to one of symptom management, psychoanalytically oriented inpatient therapy has fallen out of favor and is becoming nearly impossible to practice because managed care has put so many restraints on treatment. It is ironic, for at the same time; there has been a reinvigoration of psychoanalytic thought driven by new developmental understanding and expansion of theory. This has resulted in a theoretical pluralism that has widened the scope of therapy and offers greater applicability to a larger number of people. Despite the financial considerations that have helped determine the prevailing treatment models, some institutions have been able to reintegrate current developmental and theoretical perspectives in practice, but they are in the minority. The challenge of doing meaningful psychoanalytic psychotherapy on a *research* unit is the focus of this paper. I hope to look at some of the issues one must consider when pursuing such an activity in isolation and in the face of the potential for biological reductionism where the person may be overlooked for the disease.

I believe we can conceptualize and apply psychoanalytic theory and principles successfully on psychiatric units by thinking about resistance to explore countertransference issues on the part of staff and how it can influence milieu treatment – whether it involves individual psychotherapy with inpatients or by understanding and making use of staff dynamics. Because healing depends, in part, on therapeutic responsiveness, examination of countertransference is integral so patients' recreations of their internal object relations can be explored. But to accomplish this, the therapist must be able to seek out and establish a safe and supportive network that will act as a foundation from which to explore and address these issues. There is a way to offer psychoanalytic education to staff in a setting that does not hold the discipline in the regard it once had. This is often done through example, and by creating and nurturing a space from which countertransference issues and a dynamic conceptualization of behavior can be explored.

In a setting where the first line of care is pharmacotherapy for symptom reduction and clinical stabilization, treatment is often characterized as succeeding when medication accomplishes these goals. When it fails, blame is usually attributed to a deficiency in behavioral management. For psychotic patients, an integrated approach consisting of drug treatment, psychosocial rehabilitation, and psychotherapy is known to be effective along with family involvement and a systemic understanding of family dynamics. Acutely ill patients really do need structure and medication, but sometimes it can feel as if the baby is thrown out with the bath water. Part of this is economically driven and part is due to the fact that we often do not take the time to look at possible motivations behind our treatment. Invariably, this can lead to staff reacting rather than reflecting. For example, it can be disconfirming for a patient, if by treating psychotic productions and focusing only on reality based skills, we fail to consider the meaning of these productions for the person.

Ideally, an inpatient milieu provides safety, structure, and ambience needed to do any therapeutic work. This is enhanced when the healing power of the therapeutic relationship is recognized by the staff as a crucial component and is integrated with effective pharmacotherapy and psycho-education. The proper mix of these therapeutic ingredients can help to empower patients and enable them to begin to retake charge of their lives. Without staff recognizing the significance of the relational aspects of treatment, there is the potential to retraumatize patients through relationships that may *not* be empowering and which have the potential to recreate negative transference dynamics.

For the therapist who uses an approach to treatment in an environment that does not value that type of work, doing therapy can seem like a hidden activity. It can seem subversive because it can be conceived as occurring in a milieu that has constructed a reality driven by economic concerns. A differing orientation can be subversive if it challenges the hegemony of the symptom management model and integrates developmental perspectives that have the capability to restore a sense of personhood to the patient. In this way, subversion can have a transformative potential. This is *not* to say good clinical work is not done or that research concerns come above clinical ones.

Here I'd like to give a bit of background by describing the setting in which I work and the roles I have as Clinical Care Coordinator. I work for a university department of psychiatry where I oversee and coordinate clinical issues and multidisciplinary training, as well as being responsible for psychiatric ratings and assessment for clinical research trials on a fourteen-bed adult inpatient unit. Most of the research protocols involve new medications or new uses for existing drugs and are funded either by grant money or through sponsorship of pharmaceutical companies. These can include placebo-controlled trials. Protocols often involve a medication-free period that can aid in diagnostic issues and in determining a baseline from which to track the progress or lack of progress of biological interventions. All patients are voluntary and are recruited from a variety of sources including clinical inpatient units, private outpatient referrals, intermediate care facilities, group homes, and state operated facilities. The average length of stay is a little over two months, but patients can stay significantly longer as they stabilize and develop appropriate placement and discharge plans. It is ironic that this type of treatment is possible today, for patients have time for longer, and hopefully more comprehensive treatment only because funding is paid for participating in research. This, of course, begs the question, who is the client – the research or the patient? And, it is precisely these kinds of issues that must be addressed in order to do this type of work. Working in a multidisciplinary setting requires an understanding of the differing roles and philosophy of treatment each discipline brings to the whole. Because it is a training facility, there's a wide range of experience and understanding among staff reflective of the level of education and supervision available. Consequently, there can be a discrepancy as to what the philosophy, model, and the technique of treatment really is.

Research Issues

There are a number of ethical issues involved in working on a research unit, for example, the ability for patients to give informed consent to participate in research, or the role of washout periods and trials where patients can be randomly assigned to non-active treatment. It is only by listening to the patient that we may ascertain the meaning, as well as the actual experience of participating in research. On a research unit, the study protocols always impinge on treatment. Patients taken off medication have the potential to regress, or become asymptomatic, and in fact, according to statistics generated on our unit, 15% of patients do so, which of course, can have a major impact on the patient and for treatment!

Participating as a research subject can be a stigmatizing experience to patients as well. Funding issues may have led to their volunteering to come to the hospital and they may feel defeated and helpless. Conversely, the hospital has a good reputation, and many patients come in with high hopes that may not be realistic. Understandably, patients can be extremely sensitive to issues that stimulate feelings about having a mental illness,

which, in turn, can stimulate issues of loss, exploitation, trauma, and vulnerability. Patients often say that the pressure to volunteer to participate (coming from family or professionals in and outside the institution) can make them feel like guinea pigs and victims, and they feel intruded on and exploited for having an illness and few options. It is important to recognize protective stances, the patient's need for them, and to make sure they are allowed to keep their defenses while they are in a vulnerable position.

Due to the need for regular clinical assessment, patients are often prodded and probed with needles and questions. They are expected to be open and disclosing about their psychiatric symptoms. They often correctly feel under the microscope, and depending on their symptoms, this can be a significant mediating event. Once they begin a specific protocol, there are often limits set on the type of adjunctive medications they can receive (e.g., for agitation, sleep). These issues, as well as the patient's perception of their success or failure in the protocol, are always in the background with potential to move forefront to the therapy. This may be especially salient if a patient has been taken off a study due to a worsening of their condition as they may feel that they, rather than the treatment, has failed. Staff must be willing to give patients as much information about the studies including the probable length of stay, possible side effects of medication, and their ability to decide to stop the study, begin clinical treatment, and have their wishes implemented by staff. For the patient to trust the research and caregivers, caregivers must also trust the research and their ability to assess whether or not that patients can understand they have voluntary control to start or stop the study. Also, the patient must feel he or she can trust staff, and especially the therapist, to make decisions that are in his or her best interest – that is to stop the study should he or she lose control. More importantly, the patient has to feel confident staff will not be punitive for behavior that occurs during a psychotic regression.

What is it like for the Patient?

At the same time that patients have to deal with being treated as an "illness" and the possibility of becoming further removed from the community of others, they are often in a dependent and vulnerable state at a time when their capacities are diminished. While dealing with the overt manifestations of their condition, the meaning of the illness and its effect on the individual can be relegated to the background.

Hospitalization can be a traumatizing event in that it concretely means there has been a loss of control and one must be prepared to help the patient cope with these feelings as they may surface in other areas where issues of control are stimulated. In addition to the deficits characterized by their illness, the patient has the added burden of having to depend on or have limits set by strangers when they feel exposed.

Severely regressed patients tend to soak up anxiety and affect of staff and can become agitated in response. (E.g. , when there is tumult around the nursing station). Acting-out behaviors are usually not seen as having a self-regulating function to bind anxiety or discharge tension. When attachment figures cannot act as a secure base, patterns and expectations of the environment and feelings of abandonment are evoked with the potential to reiterate attachment deprivations.

Issues of medication compliance are paramount issues on a biological unit. Often these issues follow from concerns about side effects, the imposition and reliance on medications, and, at times, the meaning of losing symptoms (e.g., friendly voices, and mania). The meaning of medications to each individual must be understood and addressed in an empathic manner.

I frequently ask patients what it is like to be in the hospital, and if they feel comfortable enough to complain freely, the complaints are often disguised in the form of criticisms toward more mundane things like housekeeping, meals, and unit rules. These objections usually are related to larger matters reflecting their concern about the quality of care and understanding they receive. They also talk about the lack of privacy, limitations set on their freedom, having to attend boring groups, boredom from lack of structured activities on weekends, and generally feeling "cooped up". But more often than not they speak to staff inconsistencies and their frustration that unit rules seem arbitrary as different people

interpret them in different ways. This is a common theme that comes up time and again in our community meetings and can also be viewed as problems with boundaries insofar as patients believe staff can set and change them to fit their own needs. This also reflects the need for safety on the part of both patients and staff. This theme occurs despite staffs' explanation that each patient's treatment and goals are individualized. Patients feel they cannot get a straight answer so they can't feel secure in knowing what the consequences to their actions (or inaction) will be. This uncertainty can feed into other feelings about their safety and care. Additionally, they often feel infantalized and resent being treated like children, and many patients can actually regress with prolonged hospitalization. Negative transference dynamics and other ways of responding then get mobilized.

What is it like for the Staff?

First line treaters (nurses and mental health technicians) usually feel unsupported, frustrated, and undervalued. They spend the bulk of their time with the patients and follow orders and procedures set forth by management and administration, often without understanding the rationale for them. They feel they know the patients best and yet no one will listen to them. They can often feel fearful of patients they see as dangerous, unpredictable, and who act out their psychoses. When a staff member feels unappreciated, he or she can easily retreat to a defensive stance that can seem intractable to those who don't understand their fears. Each staff member brings their own feelings about their work, feelings of helplessness, and emotional constitution into the mix. One way to help them be more empathic and less judgmental to patients and to consider alternate ways of evaluating and understanding behavior is for administrative staff to be more empathic and less judgmental to them.

What is it like for the Therapist?

The way one deals with therapeutic failures, for example, splitting by staff or the inability to alleviate the suffering of the patient, can take many forms. Therapists can become jaded and inured to dealing with feelings of helplessness, sadness, futility, and shame as a way to protect themselves. They may feel so uneasy that they change their mode to one of doing rather than listening. Consequently the therapist may take a distancing stance. In this case, they need to work through countertransference in supervision or consultation. Like other staff, the therapist must also realize that his or her behavior may be influenced by a defensive posture to ward off feelings that may threaten their self-image as caregivers. In the worst scenario, an anxious therapist may project his or her feelings adding yet another encumbrance on the patient. Therapists need to notice ways in which they are avoiding issues, for example avoiding confrontation, taking stands, being defensive, characteristic withdrawal, or via arrogance.

Patients' feelings are often projected on to staff who may not understand what is being required of them – primarily to hold and metabolize intolerable feelings for them. Therapists may feel increased pressure because they may believe they are supposed to tolerate them by dint of their status as a clinician. The therapists can also have angry feelings towards staff's resistance to looking deeper and reflecting about issues and becoming increasingly frustrated and estranged if there is no place to work through. If the theoretical orientation to treatment is neither understood nor respected, it can contribute to the therapist feeling apologetic for the way he or she conceptualizes clinical material and may go underground with it.

A 21-year-old male was voluntarily admitted from a state facility where he had been hospitalized for the first time after becoming confused, delusional, and unable to continue school. Staff suspected him of being involved with gangs, as he wore gang colors, made gang signs, and tried to put out an image of street toughness. It was, however, determined that he was more a "gang wannabe" and actually came from an affluent suburb. He used accoutrements and language of gangs to assert an aura of gang activity to appear rough and ready to take on any patient he felt threatened by. This also made him feel more powerful in a situation where he felt powerless and out of his element. While he had no acting-out

behaviors during the first few days of his admission, he subsequently attacked a couple of male patients and was put into full leather restraints. Staff and patients became fearful of him and staff exerted considerable pressure to have him transferred back to the state operated facility. When I spoke with him, he revealed that he had attacked the other patients because they were looking at him with "gay eyes", and he felt he had to assert his manhood, to demonstrably let them know that he was not gay. He was prepared to back this up with his fists. Staff was not swayed by the interpretation, and the patient was eventually sent back. He was more forgiving and understanding of this decision than I was. I needed to balance the need for the safety of the unit and somehow not seem punitive for sending him away and, in effect, abandoning him to his illness. I came in during the weekend to not only check in with him, but also to support staff who felt threatened by his unpredictable behavior. He regretted his actions, but felt it necessary to act. He said he couldn't help himself and staff were quick to label him as having poor impulse control, forgetting he had no prior history of acting out. Apologetic, he attributed his actions to his illness and confusion. This was the best he was capable of. As he began to work with staff, he moved from hitting others to throwing furniture, which, he pointed out, was his way of discharging his feelings without harming others. I remarked that this choice indicated that he had the capacity to control himself and this interpretation served the purpose of helping him to recognize that he could re-take control of his behavior, and consequently, his feelings.

It was important to understand that his way of reacting was a way to disavow and rid himself of conflicting feelings. By taking into account the culture he comes from, where toughness is thought of as a way to survive, we might see his need was to establish his own boundaries before others violated them. This way of looking at his behavior could result in more empathy and understanding. Instead of seeing the possible reasons for his behavior, staff were more concerned over the trouble he could cause, their safety, and own feelings of fear and helplessness. This patient needed to have his illness and confusion accepted for him to feel safe and understood, and staff needed to communicate that there are alternate ways to deal with the feelings and fears he has about potentially being solicited by gay men. My presence on the unit was not only seen as therapeutic to the patient, but also *reassuring* to the staff, as they did not have to handle any possible danger to themselves alone. Staff needed to understand the patient's behavior from the above perspective and also feel supported and not alone so they can stay available and helpful. Both issues can begin to be resolved when feelings are validated and alternative ways of managing them explored in an open manner. This situation I've just described is not atypical and yet it raises another complex set of issues that is beyond the scope of this paper – What role might psychoanalytic understanding play in addressing the particular intersection of personal vulnerability, "delusional" ideation and social ideology, that, for a small percentage of individuals culminate in hate crimes? Could this type of early intervention play a role in preventing the later solidification of a delusional ideology that leads to the taking of human life?

"Boundaries" is an overwrought term that has different meanings in different settings. There is always a territorial reaction by staff to crossing interdisciplinary boundaries. Boundary issues are often talked about with patients explicitly, especially with regard to the management of intrusive manic and psychotic patients who may be more open. During an acute episode, they must rely on staff to establish and maintain boundaries for them. And so staff assumes auxiliary ego and control functions to contain difficult-to-manage impulses and a superego function to consider judgment and potential consequences of acting on those impulses. For staff, it is a violation to advocate so much for a patient that they pejoratively label the therapist as "over-involved" for pursuing objectives that deviate from team staffing goals. Yet, staff is less concerned with their own breaches and multiple treaters often impinge on treatment without realizing that it often gives mixed messages to patients, or violates fragile boundaries with repeated interventions that may stem from a wish to be helpful, but can be poorly conceived and

retraumatizing. I've mentioned that feeling protective and defensive about applying psychoanalytic theory may result in the therapist's taking it underground, making it impossible for staff to consider alternate ways of thinking about behavior, and difficult for therapists to feel supported and thus limits the work they hope they can achieve. I mentioned possible accusations by staff that therapists are following a hidden agenda and deviating from recommendations by the treatment team. But what happens when well-meaning staff members attempt to work with the patient and unknowingly work in opposition to the treatment strategy of the primary clinician? Again, we are talking about crossing disciplinary boundaries, and invading personal space.

A young woman in her early twenties with a history of incest was admitted to the unit after becoming psychotic and depressed. She had difficulty relating to her family and others and was experiencing hallucinations that were also persecutory and derogatory in nature. The patient's family did not communicate well with each other and it was some time before the family realized that the patient was psychotic and had been repeatedly abused over time by another family member.

Initially, therapeutic work involved the young woman's adjustment to the unit and staff, and stabilization of her symptoms. One of the evening shift nurses had read the patient's chart and learned of her history of abuse. Thinking she was going to be helpful, empathic, and restorative, the nurse approached the patient saying that she had heard she was abused and offered to talk to her about it. The patient became tearful and withdrew from most unit activities that evening and throughout the next day. The nurse's intervention not only violated the patient's boundaries and left her more open and vulnerable, but by her reaction to the nurse, clearly acted to retraumatize the patient who felt she did not have secure boundaries on the unit just as she did not have at home. The implicit message given was that the unit (and the world) is not a safe place and people are intrusive and demanding. Let's take this a bit farther and consider a parallel process between the clinician-administrator and the nurse as it could play out in another possible boundary violation. Ideally (and according to policy), the nurse is supposed to interact with the patient, be supportive, and make an assessment. If she uncovers any issues she feels may be significant, she should direct the patient to bring this up with her primary therapist. But just as the patient may feel violated, so may the nurse if she is confronted for violating the patient's boundaries. The attitude of the clinician-administrator must be supportive and therapeutic as well to maintain the general therapeutic ambiance of the milieu. Without such a stance, splitting may occur.

I am reminded of the concept of vicarious traumatization (Pearlman and Saakritne, "Trauma and the Therapist"). Professionals working with victims of trauma can get traumatized themselves by so much listening to horrific stories and tend to shut down and become defensive just as the patient may. Perhaps this can also be conceptualized as a form of projective identification, where the individual is trying to communicate the depths of his or her experience and suffering. The challenge then is to find ways to stay open in the present, hold and metabolize affect and try to make the feeling conscious or risk the potential to act the feelings out in various non-therapeutic ways. Trauma focused therapy recognizes that patients may become stimulated, and can help by reframing issues such as medications, psychoeducation, and other interventions in ways that can be empowering. For the therapist, it is useful to take in this information and relate to patients in ways that will not have the potential to retraumatize them. Due to our own countertransference and institutional issues, one can posit that it can be a way of avoiding their own issues around suffering and helplessness. It can be helpful if the professional is willing to look at and work at the developmental level of patients and concomitant characteristic ways of relating and experiencing and then offer them a way to feel they are helping themselves rather than be managed. This can allow vulnerable patients to feel more control over their lives. This applies equally to psychotic or depressed patients who also struggle with issues of loss of control. Interaction has to be respectful to developmental needs and secure boundaries to give patients a sense of control over their lives. This

model integrates multi-modal treatment to empower patients whom in the face of terrible suffering and sense of helplessness need profound respect that can restore their sense of dignity and efficacy.

It is difficult to put boundaries and parameters in settings where there may not be regard or understanding of the need for them. Moreover, boundaries are important for both staff and patients – and staff need to know the rationale for them. Boundaries are needed for successful forms of relating. In therapy, they're necessary to develop an area of potential space so both patient and clinician can jointly create the climate to do creative work. There are anxieties about boundaries for both members of the dyad: the patient's fears about connection (merger, and autonomy) and the therapist's fears of losing a sense of reality and entering too far into the patient's internal world.

Doing Therapy: What Decisions Must be Made

Therapy is an arena where patient and therapist continually construct a shared reality and create a space where change and connection is possible and new ways of relating experienced. The therapist must use developmental understandings to choose, at times, between relating and interpretation. An important role a therapist can undertake given the limited time they have to work is to educate patients to the therapy process to let them know what it can be like, what to expect when they leave the hospital and continue outpatient treatment, and significantly, that the relationship between therapist and patient can be real and affecting.

I've raised a number of issues and questions that relate to doing psychoanalytic psychotherapy on a research unit where treatment is primarily biologically oriented and how thinking from an analytic perspective can make a therapist feel defensive and at odds with staff. If the therapist feels disenfranchised and isolated he or she cannot stay connected to work that needs to be affectively engaging so as to enliven therapy, the relationship, and make room for spontaneity and creative play. So, for the therapist, its vitally important that he or she stay connected to the psychoanalytic community and theory. He or she must look outside the institution for support. Join a study or peer supervision group. Seek consultation. Take a class, subscribe to a journal and stay current with the literature. Attend or give presentations!

I've suggested that for the clinician, working from an analytic framework can be construed as subversive. But to be subversive can not only be conceived as going against the grain of accepted practice or undermining to the status quo of the prevailing model. It can also mean being open, reflective, and disclosing when it is not the general style of the rest of the staff. It can mean being in synch with yourself and your priorities. This means having a sense of your own interiority and establishing a value base from which to operate. To keep these sensibilities requires cultivating and maintaining a foundation so one doesn't feel isolated or distanced from one's values and beliefs. While the therapist can be shy and self-effacing about his or her work in an unsupportive environment, so might they also become arrogant, pedantic, and inflexible in defensive retaliation. Without a firm theoretical grounding, the chances to collude with patients and act out repetition compulsions and countertransference increase.

The *key* point of feeling one's work is subversive or hidden is that it also has transformative potential. By being open and thoughtful with staff, you can offer them the possibility to think in different ways that allows both staff and patients to validate their feelings and reclaim a sense of their personhood. This can foster the creation of a place where all can feel safe to explore and understand their effect on others. Otherwise, a restrictive environment can foster a siege mentality where defensiveness and acting out reign. By making space to discuss issues and feelings related to transference and countertransference material in safety, there is potential for discovering different ways of understanding developmental needs of patients and legitimizing the needs of staff to feel supported and valued for the work they do. Staff can then see that their countertransference reactions do not have to be toxic, harmful, or humiliating to either themselves or their patients. The clinician must find a way for creating a potential space for them to acknowledge their

frustrations and make room for increased empathic understanding. To accomplish this, he or she must model for staff as well as patients – not act out reflexively, but act in reflectively. By showing staff that he or she is willing to process, the therapist can set the tone to more easily engage staff in collaborative efforts. Psychoanalytic inpatient treatment may be a vanishing breed, but its value as a way of looking at human interaction and motivation remains unchanged and actually is enhanced by new relational theories. What has happened is that clinicians who conceptualize from this broad perspective have gone underground with it.

The irony is one has to feel subversive as opposed to transformative and such a stance can become an underground activity when it has the potential to humanize issues and create a more therapeutic environment. The goals of instilling hope, restoring and preserving dignity, and healing through relationship for the patient are the same goals that staff ultimately need for themselves. If we can allow ourselves to step outside of a paradigm that forces us to compete for respect in the currency of empirical and economic viability, then we will be freer to recognize the value the discipline offers – a way of being/seeing and a way of relating to self and others – and better able to embrace its transformative potential.

Russell S. Omens, PsyD, is Assistant Professor of Psychology, Clinical Care Coordinator, and Head of Psychological Assessment for the Adult Research Unit, for the Psychiatric Research Center of the University of Illinois at Chicago. Dr. Omens is a member of the Psychology Training Committee and teaches seminars in clinical interviewing, assessment, and diagnosis to psychology interns, residents, and social workers. More recently, he has taught interviewing techniques, the doctor-patient relationship, and run an annual workshop on the Mental Status exam for medical students. Dr. Omens sees outpatients through the Neuropsychiatric Clinic of the Department of Psychiatry at the University of Illinois at Chicago.

The Chicago Open Chapter for the Study of Psychoanalysis
APA Division 39 (Psychoanalysis), Section IV (Local Chapters) in Collaboration with
The Illinois School of Professional Psychology/Meadows Campus
Present a Symposium on

Is God Necessary? … A Dialectical Approach To Spiritual Development

Presenter:
M. Chet Mirman, PhD

WHEN: ***Saturday, January 22, 2000***
10:30 am to Noon

WHERE: *Illinois School of Professional Psychology-Meadows Campus , Continental Towers, 1701 Golf Road, (Tower II) Room 23, Rolling Meadows, IL 60008* ***(NB: Different building and suite from mailing address)***

FEE:

Free	*Members of the Chicago Open Chapter ISPP/Meadows Campus; ClinicalTraining Site Supervisors; and ISPP/Meadows Faculty and Students*
$30.00	*Non-members pre-registered with check*
$35.00	*On-site registration*
$10.00	*CEU Registration: Division 39 is approved by the American Psychological Association to offer continuing education for psychologists. Division 39 maintains responsibility for the program. Three CEU's are offered for this Symposium.*

This presentation will propose a model of ego development that conceptualises a more spiritual consciousness as the natural result of psychological/narcissistic maturation. One's beliefs – for example, belief in a god, an afterlife, a soul, karma, reincarnation, etc. – are not seen as the sine qua non of a spiritual consciousness. Of greater relevance is the posture that the individual has towards the world. That is, a person's level of spirituality is most clearly reflected in the degree to which that individual has an attitude of faith, a sense of mystery and awe, and the capacity to both be alone and fully engaged in the world. The transcendence of ego is thus seen as a regression in the service of the ego, and not a flight from it.

Dr. Mirman: ***is currently in private practice. He is also founding partner and co-director of the Center for Divorce Recovery, a group practice that specializes in relationship and divorce-related issues. Dr. Mirman received his PhD in Clinical Psychology from Michigan State University in 1984, and has taught Psychology courses at Michigan State University, Loyola University, and Oakton Community College. He has also served as the Director of Clinical Training at Forest Hospital from 1994-1999.***

Registration Form

IS GOD NECESSARY? … A DIALECTICAL APPROACH TO SPIRITUAL DEVELOPMENT

Please complete the registration form below and return it with your check payable to "Chicago Open Chapter" [where applicable] to: David L. Downing, PsyD, ISPP-Meadows Campus, 1701 Golf Road, One Continental Towers, Suite 101, Rolling Meadows, IL 60008; or fax form [if no fee is applicable] to 847-290-8432.

FOR QUESTIONS, PLEASE CONTACT DAVID L. DOWNING, PSY.D. AT (847) 290-7400.

NAME:_____ DEGREE/MH PROFESSION: _____

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The Chicago Open Chapter for the Study of Psychoanalysis
APA Division 39 (Psychoanalysis), Section IV (Local Chapters) in Collaboration with
The Illinois School of Professional Psychology/Meadows Campus
Present a Symposium on

A Clinical Seminar: A Commentary on the Treatment of a Psychotic Patient: Wading through Blood to the Signifier. Could this be Psychoanalysis?

Presenter:
Charles E. Turk, MD

WHEN: ***Saturday, February 12, 2000***
9:30 am to 11:00 am

WHERE: *Illinois School of Professional Psychology-Meadows Campus , Continental Towers, 1701 Golf Road, (Tower II) Room 23, Rolling Meadows, IL 60008* ***(NB: Different building and suite from mailing address)***

FEE:

Free	*Members of the Chicago Open Chapter ISPP/Meadows Campus; ClinicalTraining Site Supervisors; and ISPP/Meadows Faculty and Students*
$30.00	*Non-members pre-registered with check*
$35.00	*On-site registration*
$10.00	*CEU Registration: Division 39 is approved by the American Psychological Association to offer continuing education for psychologists. Division 39 maintains responsibility for the program. Three CEU's are offered for this Symposium.*

This clinical seminar will include an introduction to Lacan's discourse on Freud's subversive discovery, Psychoanalysis. The presentation will illustrate the effort to create a space for a patient to articulate the unspeakable, supplemented by a theoretical view of Lacan's attempt to incorporate linguistic science into psychoanalysis.

Dr. Turk: ***is a practicing psychiatrist and psychoanalyst, with particular interest in the psychotherapy of psychotic patients. He received psychoanalytic training at the Center for Psychoanalytic Study in Chicago, where he is now a faculty member, and is a founding member of the Chicago Circle of GIFRIC. The National Alliance for the Mentally Ill presented him with an "Exemplary Psychiatrist" award in 1993, for fifteen years work as medical director of a day treatment program, which cared for severely ill patients, most admitted after confinement in a psychiatric hospital. He received his medical training at Western Reserve University and his psychiatric training at the Neuropsychiatric Institute, University of Illinois in Chicago. Dr. Turk is the past President of the Chicago Open Chapter for the Study of Psychoanalysis.***

Registration Form
A Clinical Seminar: A Commentary on the Treatment of a Psychotic Patient: Wading through Blood to the Signifier. Could this be Psychoanalysis?

Please complete the registration form below and return it with your check payable to "Chicago Open Chapter" [where applicable] to: David L. Downing, PsyD, ISPP-Meadows Campus, 1701 Golf Road, One Continental Towers, Suite 101, Rolling Meadows, IL 60008; or fax form [if no fee is applicable] to 847-290-8432.

FOR QUESTIONS, PLEASE CONTACT DAVID L. DOWNING, PSY.D. AT (847) 290-7400.

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The Chicago Circle of the Freudian School of Quebec (Ecole Freudienne du Quebec)
in association with The Chicago Open Chapter for the Study of Psychoanalysis
APA Division 39 (Psychoanalysis), Section IV (Local Chapters)
invites you to a Symposium by the Chicago Circle of the Freudian School's founders:

The 388: A Psychoanalytic Treatment Center for Psychotic Young Adults & A Clinical Day Devoted to the Freudian School's Clinical Approach

Presenters:

Willy Apollon, PhD ***Danielle Bergeron, MD*** ***Lucie Cantin, MA***

FRIDAY EVENING

PRESENTATION: **The 388: A Psychoanalytic Treatment Center for Psychotic Young Adults**
WHEN: ***Friday, March 3, 2000*** *6:30 pm to8:30 pm*
WHERE: *30 North Michigan Avenue, Conference Room 1015, Chicago, IL 60602*
FEES:

$30.00	*Friday Presentation Only*	*$25.00*	*Student – Friday Presentation Only*
$65.00	*Both Friday and Saturday Presentations*	*$50.00*	*Students – Both Friday and Saturday Presentations*

The presentation will include a discussion of the rationale for this form of treatment as the treatment of choice for psychotic individuals, and the development and organization of 388. A clinical vignette will illustrate the kind of work done at the Center.

SATURDAY

CLINICAL DAY: **A Clinical Day Devoted to the Freudian School's Clinical Approach**
WHEN: ***Saturday, March 4, 2000*** *9 am to5 pm*
WHERE: *30 North Michigan Avenue, Conference Room 1015, Chicago, IL 60602*
FEES:

$50.00	*Saturday Presentation Only*	*$40.00*	*Student – Saturday Presentation Only*
$65.00	*Both Friday and Saturday Presentations*	*$50.00*	*Students – Both Friday and Saturday Presentations*

Attendance will be limited on Saturday to individuals having some background in the works of Lacan, or who have a strong interest in familiarizing themselves with his clinical theory. Part I: Two clinical presentations will be made by clinicians who have participated in the training seminars conducted by the founders of GIFRIC (Quebec City), the Interdisciplinary Freudian Group for Research and Clinical and Cultural Intervention, who later formed the Freudian School and its Circles. Part II: Willy Apollon, Danielle Bergeron, and Lucie Cantin will discuss the cases from the perspective of their teaching at training seminars at GIFRIC. Part III: Members of the Chicago Circle will present various perspectives on the case of Little Hans which will then be discussed by Drs. Apollon, Bergeron, and Ms. Cantin. The three will continue with theoretical presentations based upon the clinical teaching in the seminars.

Registration Form

The 388: A Psychoanalytic Treatment Center for Psychotic Young Adults & A Clinical Day Devoted to the Freudian School's Clinical Approach

Please complete the registration form below and return it with your check payable to "Chicago Circle" to: Charles Turk, MD, 30 North Michigan Avenue #1909, Chicago, IL 60602.

FOR QUESTIONS, PLEASE CONTACT CHARLES TURK, MD AT (312) 269-9180.

NAME:_____ DEGREE/MH PROFESSION: _____

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❑ FRIDAY EVENING ($30.00) ❑ SATURDAY CLINIC ($50.00) ❑ BOTH DAYS ($65.00)
❑ FRIDAY EVENING, STUDENT ($25.00) ❑ SATURDAY CLINIC, STUDENT ($40.00) ❑ BOTH DAYS, STUDENT ($50.00)

Chicago Open Chapter for the Study of Psychoanalysis

Section 4 (Local Chapters) Division 39 - Psychoanalysis, American Psychological Association
344 West Chestnut Street
Chicago, Illinois 60610

Membership Application

The *Chicago Open Chapter for the Study of Psychoanalysis* is affiliated with Division 39 (Psychoanalysis) of the American Psychological Association. Founded in 1985, its mission is to provide a forum for the discussion of various trends in psychoanalysis, and to promote the application of psychoanalytic theory to a wide variety of areas (including, but not limited to, anthropology, history, literature, and religion). The *Open Chapter* strives to provide a democratic and egalitarian atmosphere for the exchange of ideas. Hence, although the organization sponsors presentations by nationally and locally recognized analysts, it does not view psychoanalysis as the sole domain of mental health professionals. As its name implies, the *Open Chapter* is truly "open", in that it encourages the application of psychoanalytic inquiry to the work being done by other disciplines.

If you are interested in becoming a member, please complete the registration form below and return it with your $40.00 check made payable to "Chicago Open Chapter" to: David L. Downing, PsyD, ISPP-Meadows Campus, 1701 Golf Road, Suite 101, One Continental Towers, Rolling Meadows, IL 60008. If you have questions, please contact David L. Downing, PsyD at (847) 290-7400.

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Facility/Agency Name (if applicable)

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