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The purpose of the Editorial Board is to publish a quarterly bulletin that will reflect a high level of scientific discourse in the field of psychoanalysis. While particular emphasis will be directed toward the psychoanalytic situation in Los Angeles, contributions from other national and international sources will be welcomed and encouraged. The editors will consider papers dealing with theoretical and applied psychoanalysis, reviews of psychoanalytically relevant books, reports of scientific meetings, essay reviews, brief communications and letters. Materials can be accepted for publication only on condition that they are contributed solely to the Bulletin.

All opinions expressed in the Bulletin are those of the authors and do not necessarily reflect those of the Los Angeles Psychoanalytic Society and Institute or its officers. All manuscripts, letters and business communications relating to the Bulletin should be sent to the Editor, Los Angeles Psychoanalytic Bulletin, 2014 Sawtelle Boulevard, Los Angeles, California 90025. Manuscripts should be typewritten, double-spaced on 8½ x 11 paper.

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INTERVIEW WITH: GEORGE KALMAN, M.D.

by Robert Rodman, M.D.

INTRODUCTION

When George Kalman gets up to speak, people squirm. His way of talking about the business of psychoanalytic practice seems to make him something of a pariah, to whom agreement can be expressed, *sotto voce,* only by the few, if they. Is it what he says, or is it his way of saying it, or perhaps both? Ever the businessman, the trader, the dealer, the promoter, the buyer and seller, he also presents himself as an ardent defender of the status of the psychoanalyst, whose unsurpassed expertise in matters of the mind he believes to be disastrously underestimated and underpublicized in today's rapidly evolving market of so-called mental health professionals.

As a former inmate of Nazi concentration camps, orphaned by war, and as a businessman, he speaks in tones which sometimes grate on the ears of psychoanalysts. Though he thereby and constantly evokes disagreement, he cannot be accused of abject despair. He is full of proposals for change. It was with the aim of making these proposals explicit that this interview was undertaken.

INTERVIEWER

I want to hear your ideas about the practice of psychoanalysis. When you got up at a recent meeting and said we are dinosaurs, you were saying what many others outside our ranks are also saying. But it's disturbing to hear it from one of our own. We are the very people who know the value of psychoanalysis and believe its survival is guaranteed, on the basis of that value, even if a kind of dark age should overtake us. People are very uncomfortable when you start to talk this way. They don't want to sit still while you do it.

KALMAN

Well, the concern is not that psychoanalysis is not useful or practical, but in the new economic climate I don't know how it's going to survive. In order to survive we would have to have a much better discipline, a much better organization. At one of the dinner meetings, I talked about an organization of psychoanalysts who might eventually provide leadership for the whole mental health system. It is going to be taken over by the big corporations. As a matter of fact, they are doing it now. Every hospital I know of, of any size, is being bought out by the multinational corporations. The practice of psychotherapy is not going to be left in the hands of the cubbyhole practitioner. The hospital is going to hire the doctors. What they're going to do is this: they're going to hire one doctor and have fifty therapists. Del Amo was just bought up by a multinational corporation. A friend of mine who is the medical director of a big hospital, was bought out by National Medical Enterprises. There is a new book out on the medical-industrial complex. It deals with this subject. All of which points out how the big money, big industry essentially, will come in and pick up medicine. A whole industry is picked up, either as a health maintenance organization or some other thing. The hospital hires therapists. They may have one psychiatrist and 10 or 20 or 50 therapists and wipe out the private practice of God knows how many doctors. They charge lower fees, and by doing this, they wipe out psychiatry. The big medical corporations are going to do the same thing. Now this will affect psychoanalysis in the sense that an individual belongs to an industry. If that industry goes to a preferred provided organization or a health maintenance organization, a man cannot practice private analysis. Because they will say, look we're going to pay you for ten visits. That's it. The third-party payments are over for prolonged psychoanalytic therapy. And it's here. The few analysts who are in a position to manage to get a private practice of very wealthy people will survive. But the younger people and those who cannot find these very wealthy patients will not survive. What are your going to do?

INTERVIEWER

And your point is that analysts in general are blind to this. They're not reacting.

KALMAN

I tell you, I've been trying now for the last year to address the membership. I was told I am not allowed to address them. I have to present things first to the Board of Directors, or whatever. I wanted to address the membership at the dinner meetings, and I was not allowed. Finally I was allowed to address one issue. But let me ask you. Have you attended a business meeting at the Society lately, where they took minutes? Are you aware that in our Society, which is basically in very serious shape economically and politically, we don't have a business meeting once a month? We have no minutes. We

don't approve of minutes. We don't have a business meeting. I don't know how our business is conducted. I don't know who conducts our business. I don't know if anybody gives a damn that we have business to conduct. I was not permitted to address the membership, to point these things out to them. I don't know why. Can you imagine, in an age where we have such serious problems in terms of our very survival? I would like to move that we have monthly meetings, business meetings, where we can organize and we can at least look at the problems we are facing. But without business meetings we cannot do it. No one ever bothers to realize that we don't have those meetings. It's as basic as that. So our Society doesn't conduct business, doesn't have minutes, where the membership can at least discuss what we are facing. This is to me the most incomprehensible thing.

INTERVIEWER

Why do you think that is?

KALMAN

The only way I can tell you is by telling you a story about something that happened during the war. A bad day in the camps was one in which the Germans were going to come and pick up so many people to be gassed. I could read the signs, and I could predict that they were going to come and take so many people. I told my friends, look, I see the signs, I know they are going to come. You come with me, we'll disappear so we can stay alive. My friends would not do anything. They refused to move. What happened was they were killed. I was watching from a hiding place. I saw them going to the crematorium. I told them. Now, when I told you that these people are dinosaurs, that the situation is not pretty, essentially that is what I am telling you. True, it's not a life and death issue this time. But in terms of survival as practitioners, that's where we are. And again, I can't even get up at a business meeting. I can't move that we have monthly business meetings with minutes, where the Society could conduct business and really look at our position and expectations and goals, and how we are going to fit into the mental health picture. I can't get them to look at it. It's that simple. I do expect if I had my way, if I could organize this thing, I would like to see analysts on the top of the mental health ladder to provide leadership. Because people are going to get very bad treatment. Very bad treatment.

INTERVIEWER

How would you do it?

KALMAN

I have proposed to convert the whole Society into an enormous clinic, and run the whole Society as a clinic.

INTERVIEWER

Everyone would belong?

KALMAN

Absolutely. And use the entire Society as a resource for all sorts of things, whether it's support and supervision, ideas, whatever, to other HMO's, for other PPO's. We would be the ultimate resource for all sorts of things. I mean public and private. But in order to do that, the thing has to be organized. The people have to understand that they belong to a Society which, on one level is a scientific Society, but on another level is also a business organization. It's run for the benefit of each member. And each member can be compensated for whatever contribution he has. The money would go to the Society and the Society would in turn pay the practitioners. The Society does all the things we have done all along. But parallel to it there is another organization, and this is strictly an organization for business. It promotes the Society, or promotes psychoanalysis. It does all the things that a corporate entity would do for improvement of its members. In other words, we would promote ourselves. We are the ones that should be involved with the courts, for example. Just take this new issue with those molested children. It sounds like mass hysteria to me. The person who is interviewing the children is not a trained psychoanalyst. It's a "sex therapist" of children. Why on earth do we allow this, and not a voice is raised? Nobody says one word. If we do such a thing, it shouldn't be done with some inexperienced, untrained, incompetent God knows what. Shouldn't it be a reputable child analyst? Shouldn't the Society be involved in some way to at least question this? Are we dealing with mass hysteria? Are we dealing with some people who are out to make a name for themselves? Who is that person who is doing play therapy with these children? I don't recommend that we go and do it, but at least we should be offering ourselves as friends of the court, not as individuals, but as a Society. We do not say that we know all the answers, but at least we ought to be offering our services as friends of the court to look at what really is. It is our job to study this. But this cannot be done as an individual thing. I could sell this as a representative of the Los Angeles Society. I would say that we have these enormous, vast resources, men with enormous training and experience who would be willing to be friends of the court. We can approach them and present this to them. I'm using this merely as an example.

INTERVIEWER

You are saying that massed together as a group as could have great influence in all corners of society, that we do not exist at the moment as a group, except in quiet, unknown circles. We don't exist publicly.

KALMAN

We make absolutely no impact as a group, as a discipline. In any kind of thing that comes out, we are not consulted because no one knows us. As an individual I cannot promote anybody. But if I say, yes, the Society, and every

member of our Society becomes a member of this group, then we have something powerful, something very, very impressive. I've been studying other options, things other than corporations. The legal entity can be other than a corporation. I have been playing with many, many thing.

INTERVIEWER

What would be the problem with a corporation?

KALMAN

They may throw at you a charge of monopoly, antitrust laws. There are many ways they can get us.

INTERVIEWER

Who would oppose us in this matter?

KALMAN

You have no idea of our enemies. At the last meeting of the Westwood Hospital, the Allied Health Professionals stood up there well prepared, well documented in their attack on the new by-laws. The By-Law Committee wrote new by-laws in which there was a question of turf. The Allied Health Professionals were there and they were disciplined, organized. They brought letters, and they were effective. Either you do it our way or we have a lawsuit, they said.

INTERVIEWER

Who are the Allied Health Professionals?

KALMAN

They are case workers, clinical psychologists, clinical social workers, sex therapists, family guidance counselors. All these people are after our turf. And they are encroaching very seriously. Over ten years ago, I proposed, before the other Society did, that we give Ph.D.'s to ourselves. I said that the time will come when that Ph.D. will be important. Everyone thinks how narcissistic and arrogant it is. But it's not for us. It's for that office-worker who is going to write out a form, sees Ph.D., and says, oh that's five dollars more. Our own way of looking at this is not the way the world looks at it. This is just an example of missing the boat, of not holding ourselves out rightfully as people who are the most trained in America in our field and who should be supervising, who should be acting as speakers for the public and for society. We don't. And we have enormous opportunities.

INTERVIEWER

In this setup you propose, does everyone work full time for the Society?

KALMAN

No, not at all. Everybody works in their own offices. They do their own

things. But the clinic, this entity, this analytic entity gets all the calls. It does all the negotiating. Once that is done, then that entity assigns the patients, assigns the jobs. Let's say if a person is interested in analysis of deaf and blind people, we have an analyst over here who has experience in just that. Or if the Society of Bicyclists needs some special assistance. then we have someone who knows about that. As long as they come to the Psychoanalytic Society, they can be certain they are getting a well trained, competent man, not some Mickey Mouse person.

INTERVIEWER

What about fees for these services?

KALMAN

They will not be low. An attorney gets $200 an hour. The psychoanalyst is trained. He is an exceptionally competent, valuable man.

INTERVIEWER

But then you're going to limit yourself to people who can afford that kind of money for analysis.

KALMAN

Not necessarily. So far I've only touched on the function of this entity as a tool to approach society. This is one level of function. Now, when you talk about individual therapy, individual treatment, this again does not mean it's going to be low fee. It simply means that people know us. They understand what we do. We offer services of the highest order of quality. There is no low fee at all.

INTERVIEWER

But we may supervise other therapists who could offer less expensive treatment.

KALMAN

We may. Let's say a national corporation gets into difficulty because the mental health system doesn't work. Then they may come to us, in which case we will consult, we set up a program. They pay for it dearly. The entity will get the money, and that entity then pays for the overhead, and what's left is paid to the individual men who have done the work.

INTERVIEWER

Why do you suppose analysts might not want to belong to something like this?

KALMAN

Well, only because these ideas did not come from certain sources. I've said it many times. In order to discuss something like this I would hope that we

would have a business meeting with minutes where it's documented what was said, people can read about it. This is absolutely necessary, the only way we're going to survive as a discipline, an organization. I want to tell you a brief story. I went to the APA meetings. There I heard a man say that the treatment of phobias is drugs. Now if you want to improve on that, you use behavior therapy, and the combination is marvelous. Psychotherapy is questionable. That's what the man said. My point is, we're living in an age when a man can stand up and say this, and he wasn't shouted down. No one stood up and said, look, I've been treating phobias for years without drugs. Marvelous results. Nobody. That's where we are.

INTERVIEWER

There's no question that times are changing, and fast. Yesterday, I saw an ad on television for Pfizer antidepressant drugs. A commercial. Pfizer had decided that it was now feasible, now admissible to go over the heads of doctors who must prescribe this medication, to the patients, in order to stimulate demand. It reminded me of the insidious custom of advertising to children over the heads of parents who must accede to the demands so stimulated, or become deprivers. With whatever outcome, there is a breakdown of authority and concern for those in need in the interest only of corporate profit. These are not primarily educational forays, meant to rescue people from needless depression, though they may masquerade as such. They are evidence of greed.

KALMAN

Sure. I have a clipping from County Hospital. They are inviting patients to come. All of these people are taken away from private practice, and especially from analysts. Now unless we do organize together and have an entity that makes a stand and presents itself and provides certain services in the community, as a psychoanalytic organization of the most trained in mental health, we are going to be pushed out by these hordes and hordes of psychologists and God knows what. They have no compunction. So I would like to see that. That's one of my ideas. The second thing I have been advocating for some time is to try as much as we can to proceduralize our work. I have a friend who is a radiologist who spent about 3 or 4 months proceduralizing his work. He took procedures and broke them down. Out of one procedure he made four. Each one was numbered. He charged for it. The whole thing is one thing, but for purposes of the computer, and charging, he simply broke it down.

INTERVIEWER

How would that apply to us?

KALMAN

You would send in a list of procedures that you perform. Let's say some very sophisticated group came to us and said, look, we want to make a deal with

you people. Of all the mental health professionals we feel you're the most competent and we want to do business with you. We cannot sell our time by the hour. No longer.

INTERVIEWER

How would you break it down?

KALMAN

I would proceduralize psychiatry and psychoanalysis, and it can be done. The DSM III is a useful tool in this process just because it is a bastardization of everything we know. It's a return to pre-Freudian pure symptomatology. There is absolutely no concept of etiology, no concept of causation, of anything. Pure phenomenology. But it could be put to use as a basis for procedures. They describe all these minutiae, which are basically meaningless in terms of etiology. Their only use is for the computer and to label. This terrible system of classification was invented for many reasons, foremost being that as the economy changes, the working people are cast aside. They are not needed. Everything is becoming automated. This is a glaring symptom of social change. Why should we treat them? Why should we spend money? In an age where we're moving all over the place to get cheap labor, why should we be concerned with the working class? It was done that way precisely to eliminate reconstructive efforts.

INTERVIEWER

Just to clarify, the point you make is that DSM III was constructed as a purely descriptive instrument in order to superficialize treatment, because it is more economical that way. This reflects a lack of concern with the working class. The psychiatrists that produced it were themselves intruments of those who wield fundamental economic and social power in this country. They were expressing a consensus that the working class is no longer of concern to psychiatry.

KALMAN

Yes, exactly. So now, we can use that for our benefit. We can use those minutiae as a basis to proceduralize. A person comes to you for agoraphobia, or panic, and the procedure is panic-ectomy, something like that. But see, you have a basis now to say, panic, see procedure. You-re not doing psychotherapy anymore. You are dealing with panic, you are treating panic.

INTERVIEWER

You have a price for that.

KALMAN

Absolutely. And next a patient has depression, biphasic, uniphasic, whatever. Use it. I would use DSM III as a basis for a procedure, and everything becomes a procedure.

INTERVIEWER

You charge by procedure.

KALMAN

Of course. Not by time. The minute you charge by time you are dead.

INTERVIEWER

So there's a flat fee for a procedure.

KALMAN

Absolutely. You set a fee.

INTERVIEWER

Supposing you don't succeed.

KALMAN

The whole thing is set up not for "cure" at all. Return to function. Not cure. We don't guarantee cure, we don't guarantee anything. We only talk about returning to function.

INTERVIEWER

But let me reply to this to see what you say about it. First, if there is no basis but DSM III, which you abhor, the application of it for proceduralization is dishonest, and therefore likely to engender dishonesty. Second, the effect of doing it would be to divert us from our work. We would be paid, probably better than we're paid now, for our efforts. But the efforts would be limited by virtue of the amount that we're going to be paid. You are not going to spend an open-ended amount of time on something for which you're being paid a limited amount of money. Therefore your own effort may be curtailed by what you get. It will affect your practice. So you make more money at it, but you'll be doing less analytic work. Then again, you may not be talking about patients that we normally have in analysis. Maybe you're talking about people that you're trying to treat in a quick, pragmatic fashion, that the insurance company is covering.

KALMAN

Most people I talk to, most of the analysts, don't see many analytic cases.

INTERVIEWER

But it would reduce whatever there is, probably.

KALMAN

No it wouldn't. As this mass of humanity comes to your door, you see, out of that you will select a few cases who will be analyzed.

INTERVIEWER

The rest will be proceduralized.

KALMAN

Of course. In order to live in this world, we cannot continue to do silly hourly business. If you go by this hourly business, we are out of business.

INTERVIEWER

How can you expect that the insurance companies are going to accept this?

KALMAN

We'll have to negotiate that. And if they don't pay, there will be consequences. If they send the patients to sex therapists, family therapist, and God knows what, the complications are going to be their responsibility. The more you see in a newspaper that a man was seen by a sex therapist and then he killed ten women, as happened recently, the more likely it is that eventually society will wake up. The idea of the maintenance and protection and very careful nurturing of an identity, a psychoanalytic identity, is extremely important. If you want to survive.

INTERVIEWER

And you would do it in these two ways, with the organization and the proceduralization. I don't see how the second contributes.

KALMAN

It does very much so. Look, the surgeon does the operation, not the technician. And no one would dream of doing a surgery other than a surgeon.

INTERVIEWER

That's true. But we do something other than surgery. For example, we don't know how much time something is going to take. A surgeon can tell you it takes me 20 minutes to do an appendectomy, or it's this much for a gastrectomy. He has concrete data to work with. We don't. We have an open-ended thing. We don't know ahead of time. Take a concrete case. Somebody comes to you with agoraphobia. What happens then?

KALMAN

Well, let's take just that. Your initial interviews, your evaluations, can be proceduralized under a regular phobia evaluation. It might take you 10 hours to evaluate. I would want to break down the procedure. You don't know initially, it may take 5 hours, 10 hours, but nevertheless it's an initial phobia evaluation. Then after you make the initial evaluation, there are other procedures. We never realize that such things as working through are procedures. Why can't we call working through a procedure? Remember, at

this moment we are merely kicking around some notions. We could be more specific if we try. But as psychoanalysts we're never taught that within the initial phase of the analysis, the middle phase, the end phase, there are a number of things going on which could be proceduralized. There is no reason why this can't be. Why not call working through a procedure? It's a very technical procedure.

INTERVIEWER

How do you know how much to charge for that?

KALMAN

We may set a fee up front. . .

INTERVIEWER

Or how many hours it will take?

KALMAN

We may just say well, we don't know. This is the phase we are in.

INTERVIEWER

Another question. We do not have outside observers. It's only our word to go on. In other branches of medicine there are objective ways of evaluating what's going on. Why should a third party payer believe what we are saying?

KALMAN

I'll go back to that first part which we will call an entity for lack of a better word. In order to do business with a third party today, I will have to say to them that we will make sure that the man who will do the work is sane, not insane. He will know the work. In other words, the buyer of health services, the commodity mental health, is sophisticated enough today so that he can demand some form of peer review. There is no way I can get away from it. So there is going to be a peer review. They will demand that. I have no objection, because there are a lot of crazy therapists. The incompetent people should be out anyway. So I have no compunction about that. The system will be guaranteed to have a peer review system. The peer review will be done by men who are in the forefront of private practice, making a living and dealing with things as they are. I would pick a type of man of a very high level of integrity and competence. We need to revitalize our society by arousing the interest of people of the highest quality, many of whom are sitting on the sidelines right now, doing very little. In our group, there's been a pattern of bad blood, splinters and splits, unfriendliness and a great deal of factionalism, a lack of cohesion. There is enormous splintering in our Society. It just doesn't ever get together as a group, as an entity. It doesn't have the necessary *esprit de corps.*

INTERVIEWER

Do you believe you are prevented from speaking because your ideas threaten the status quo?

KALMAN

I do threaten the status quo. I intend to threaten it. The funny thing is I have nothing to gain. I don't want to be a training analyst. I'm not interested.

INTERVIEWER

What's the source of your energy for this then?

KALMAN

I happen to be interested in new, novel, innovative, inventive things, and I do invent and innovate many things. Business, investments, art, music, whatever, you name it, I'm interested.

INTERVIEWER

Where does it come from?

KALMAN

I'm curious. Insatiably curious.

INTERVIEWER

Tell me more about your background. You were born in Hungary, weren't you?

KALMAN

I'm a Jew who was born in Hungary. Then during the war I was in the camps. I was in a number of camps and ghettos. Some of the members know about this. Occasionally, I have used stories from the camps to illustrate how people function under enormous tension and anxiety. By the way, that's one of the things they do, untrained and undisciplined people under stress, they splinter, they run a hundred different ways. That's what they do, and that's what analysts do. That's what the medical establishment does. We are being attacked, our way of life is being attacked, so people are running in different splinters.

INTERVIEWER

You survived to the end of the war.

KALMAN

I was very lucky. Everybody in my family was killed. After the war, I was sent to Milwaukee. The Jewish Community brought me over as an orphan. They sent me to Milwaukee, Wisconsin. I stayed there until I finished medical school, University of Wisconsin.

INTERVIEWER

You chuckle about that.

KALMAN

Well it was an interesting time of life for me. I came over here and I sat down and went to school. There were doctors in my family in Europe. When I came over here, I said I'm going to be a doctor. People looked at me and said you're crazy. I came in June or July of '46. When I came here I spoke English a little bit. I said I wanted to go to medical school and be a doctor. People said there's no way. I came in '46 and in '57 I graduated medical school.

INTERVIEWER

And how did you get into psychiatry and psychoanalysis? Where did you get the interest?

KALMAN

I was interested in obstetrics in medical school. I had a fellowship in research. And I thought I wanted to be a surgeon or an obstetrician. But I discovered that I didn't like to be wakened up at night. I also discovered that I cannot stand too long on my feet. In those days everybody stood. I just couldn't do it. I loved surgery, but I just couldn't stand. Then I was interested in internal medicine and that got to be very boring. Then I decided I wanted to be a psychiatrist. To the great displeasure of every one of my teachers. They said, how can a smart boy like you be a psychiatrist?

INTERVIEWER

Why DID you choose it?

KALMAN

The department at Wisconsin was insignificant. In Texas, again organic, not inspiring. I was an intern at the University of Texas, in Galveston. I realized that I was interested in the puzzles of mental illness, they fascinated me. Probably what I saw in the war was an influence in getting involved in healing and in helping people. Once I was in psychiatry, I went to Cincinnati. There was no greater teacher in the 50's than Maurice Levine. I met Levine and we were instantly taken with each other, and he said, you are accepted for a residency. And there was no better place. Once you are in Cincinnati with Levine, you can't stop. It's understood that you go on and become an analyst. From there I went to the service, and from there I came here. I was in Florida at an Air Force Hospital with 180 beds. We did a lot of research. It was a fantastic experience.

INTERVIEWER

You have been here in Los Angeles for twenty years or so. How would you

characterize in general terms the changes that have taken place?

KALMAN

When I came here in 1963 there was an enormous excitement. I came with an incredible amount of excitement and curiosity and desire to learn. The men that I met were the old-timers, very impressive men. Some of these old-timers are gone now. Just talking to them to me was a great experience.

INTERVIEWER

Who are you talking about?

KALMAN

Greenson, Vatz, Ekstein, Brunswick, Hanna Fenichel. These people, they were really exceptional. I don't know, I may be wrong but I don't see that kind of enormous excitement and curiosity today. I don't see in people I meet that kind of endless curiosity. I just don't. I remember in those days meetings were exciting. The candidates used to wait outside. When the meeting was over we all rushed in to hear the speaker. To hear a speaker was something great. Today it's just not there. It's not in the air. Part of it is that we have no leadership. There is no leadership. We don't have a business meeting. There it is for you. We have problems but we don't get together even to attempt to look at the problems. How can you work on a problem when you don't get together. There is no interest, no excitement, no vitality. We're losing it. There are small groups. I belong to a group in the Institute. That group has for years met as a leaderless seminar at Abe Gottesman's home. Same bunch of guys got together for years. Now that same bunch of guys has been sitting listening to Leo Rangell for the last two years. He's giving seminars. The same people who sat at Abe Gottesman's house come to listen to Leo Rangell. But other people never come. We don't even know them. It is so fragmented that there is no coming together, no fellowship, no drive to a goal, no goal set. The Society is just drifting, it has no goals.

INTERVIEWER

And your ideas, especially your first idea, is. . . .

KALMAN

Yet I tell you, the second one. . . it can be done. . . to go into the history would take too long, but I tell you, it's workable, it can be done, and it is going to be of immense importance to get all of us off a taxi meter. As long as we are on a taxi meter, we are vulnerable. The minute you put down on an insurance form 50 minutes psychotherapy, or 40 minutes psychotherapy, or whatever minutes you put down, it's lost. You are lost. You are not the professional that you should be.

INTERVIEWER

I wonder about your special interest and energy in this area, where it comes from.

KALMAN

I apply it in business very successfully.

INTERVIEWER

You do a lot of business. You have a practice, and you also have other businesses.

KALMAN

We run various businesses, in real estate, things like that. I've been involved in many things, developments, developing things, running things. I've been doing it for years. The energy is simply from enjoying what I do. Enormous sense of pleasure. I enjoy it, and I find a challenge and a curiosity in everything. Then I've been talking to the Institute over the years and telling them . . . and it's not because I expect anything in return. I didn't expect to be a training analyst. I never expected to be anything. I simply say, please, look, I have some ideas. Look at them.

COMMENT ON INTERVIEW WITH GEORGE KALMAN, M.D.

I could understand the rationale behind Kalman's idea of reorganizing the Society, but had a difficult time with his second idea, that of proceduralization. On the surface, it would appear to have mainly to do with getting higher fees, as in the case of the radiologist he cites, but his insistence on the principle, as a necessary accompaniment of the creation of a clinic, makes me think, naively or not, that he is speaking also of the dignity of our work. As long as we are paid by the hour, instead of by the task, he seems to argue, we are in a lesser state than our medical colleagues.

This contention could be challenged. Are we really in that state? A case could be made that the doctors who have been made egregiously wealthy by charging fees for service, with the help of cooperating insurance companies, should charge instead for their time, just as we do. We could feel proud of not exploiting patients with fees based on anything but the time we spend. Isn't it beneath us now to try to jump on a bandwagon and claim "our share?" Then too, attorneys charge for time, and cannot be considered less professional for it. Kalman insists that by charging on the basis of time spent we present ourselves to medical colleagues as inferiors, tempting them to classify us with therapists who hold no medical degrees. To claim our rightful place as physicians, we would need to demand payment in accordance with the same rules of all other physicians. We are fighting for our status in the medical profession.

We do have a long tradition behind us of fee per session, and it would be difficult to change and make others see us differently as well. Supposing, however, we did manage to "proceduralize" our work, and we were paid by procedure and task, so much for a "panic-ectomy," for example. What would be the result? Any therapy that required a measured pace, such as psychoanalysis and its variants, would probably be set aside in favor of therapies which are more clearly goal-oriented. The diffuse search of psychoanalysis, which ultimately gathers unsuspected data into novel insights and consequent change, would be left out. Pragmatic approaches, designed to achieve "return to function" as quickly as possible, with maximum compensation to the therapist, would be ardently sought. The result of this might be two-fold. On the one hand, analysts might utilize their understanding with greater ingenuity, developing short-term methods based upon their capacity to grasp situations quickly, with some of the inefficiency of some kinds of psychotherapy pared away. On the other, combinations of treatment, including drugs, behavior therapy, biofeedback, hypnosis — any technique which promises something fast — might dominate. The latter is happening already, of course, in the hands of therapists of many different stripes.

Twenty-five thousand licensed psychologists and an equal number of marriage and family counselors have entered the market in California in the last 5 years, as compared to 314 new psychiatrists. This gives some idea of the revolutionary changes upon us. Twice the number of medical school graduates are generated annually now, as compared to the period before 1970. The physician market is becoming glutted. The competitive atmosphere tosses our stately identities like a salad. George Kalman's radical ideas force us to think about what is ahead. We who hold psychoanalysis dear, we who know what it can be to aim for truth, against the distorting effect of instinctual pressure, will want to have favorable conditions for continuing our work, for our patients' sakes, our own, and for the future of reason. Kalman thinks that by organizing in a way that permits us to offer our ability to be objective, which is to say unmoved by selfcenteredness, we can hoist ourselves onto the high ground.

A recent book by Russell Jacoby, *The Repression of Psychoanalysis,* grew out of the study of a group of secret letters written by Otto Fenichel. The book traces the loss of attention to matters of social concern among pioneers of psychoanalysis, a loss enforced by the conditions of World War II, and what Jacoby terms the "medicalization" of psychoanalysis. Jacoby maintains that much of the vitality of early psychoanalysis came from acute social awareness, from a wish to change society through psychoanalytic insight, and that the loss of this ambition was accompanied by, or caused, the loss of much that is most vital in the field.

One could extrapolate that the inwardness of professional days limited by office walls and the phenomena within has given rise to a less energetic

profession, in grave danger of a solipsism which only the fresh air of society may help to correct. The narcissistic disorders to which we attend these days so breathlessly, have a relationship to our own difficulties as analysts too. We are trying not to be swallowed by our own reflection as much as we are trying to help our patients see beyond themselves into the bright nourishment of the Not-Me (a phrase which leaps in vivid meaning from Walt Whitman to D. W. Winnicott), the reality of other people. Our problem is the result of specialization, the narrowing focus of attention, with its accompanying loss of perspective. Analysts in general are no longer the whole men that many of the pioneers were, in the same way that physicians no longer grasp the full expanse of medicine. As long as there are enough patients able and willing to embark on psychoanalytic treatment, the stimulus to look out the window into the street, let alone to walk out of the office into the roil of colliding interests, is compromised. We become wise men and women for the few. We grow addicted to admiration in the closed and controlled consultation room. Our contribution is limited to the rings of influence which emanate from the patients we have succeeded in helping. George Kalman's proposal that we unite into a clinic which can make the resources of the membership available for the widest variety of social tasks speaks to this point, and he addresses the subject under the pressure of a rapidly changing economic climate which is threatening the peace of traditional psychoanalytic practice. Such a move would put us in touch with issues that many of us only read about now.

Kalman's intent is in a sense the polar opposite of opening our doors to non-medically trained candidates for clinical training. Instead of expansion, Kalman calls for contraction, for concentration of powers newly recognized, yet to be exercised. He calls for a reaffirmation of our analytic identity and a demand that it be recognized and respected. He opts for the resocialization of analytic attitudes, and turns away from the demedicalization process which is in the air. In the latter sense, he is at one with many members of The American Psychoanalytic Association, who are presently rethinking the initial urge to throw open the doors to non-medical candidates. There is probably an immanent sense of the emptying-out of influence, of dispersal and dilution of identity. He tells us to resist the force of the wave. His method is to unite as a clinic and to differentiate ourselves by charging for actual work rather than time expended. These could be powerful counterweights to concluding that since people are becoming "psycho-analysts" in newly-created institutes that have appropriated the word that distinguishes us, we should take the best of them and discard the importance of medical school or psychiatric residency.

These proposals are not all of a piece. Offering our services to society is different from proceduralizing our fees. The precise nature of our analytic ideals must be restated in order to frame an adequate reply. If we resist either suggestion, we ought to be able to say why, and with such persuasive force that we have redefined what we stand for. And if we agree with either, we ought to be willing to change.

BOOK REVIEW

Structures of Subjectivity: Explorations in Psychoanalytic Phenomenology

by George Atwood, Ph.D. and Robert Stolorow, Ph.D.

Reviewed by Jeffrey Trop, M.D.

This book is an ambitious attempt to reconsider the basic thrust of traditional psychoanalytic theory. The authors formulate and consolidate some newer theoretical perspectives in psychoanalysis and expand these ideas to include a more general theory of personality function.

The first chapter describes the philosophical context of their approach. They emphasize that their framework will be formulated to correspond to clinical observations. They describe the hermenautic tradition of psychoanalysis and place psychoanalysis in a tradition derived from the study of the human sciences. This approach emphasizes the search for meaning which occurs in the context of human subjectivity rather than by objective measurement. They feel that psychoanalysis has been burdened from the beginning by a dedication to natural science concepts which are embodied in traditional perspectives of Freudian metapsychology.

The purpose of their book is "an effort to rethink psychoanalysis from a structuralist point of view." Personality structure is defined as the "structure of a person's experiencing" and "structures of experience" are systems of ordering and understanding which are unique to each person and represent a set of unfolding personal schemata based on past experiences which have determined a sense of self and others. Personality structures thus represent predispositions to understand and order experience according to patterns which have emerged repeatedly in relationships with key figures in childhood. They feel that the organizing structures of a person's subjective world operate unconsciously and psychoanalysis can thus be formulated as a science which facilitates patients' awareness of the unconscious structuring of events based on their own repeated past interactions.

Next the two authors expand the therapeutic concepts derived from their theoretical perspective. They define psychoanalysis as a science of the intersubjective which focuses on the interaction between the differently organized subjective worlds of the analyst and patient. The observational stance of the analyst is always within this field. This dictates the use of introspection and empathy to decipher the intersubjective qualities of the analytic situation with special reference to the unique structures of the patient which order their experiences. Thus, the intersubjective viewpoint is not a science of the intrapsychic focused in as an observer of a patient's mental apparatus, but is a viewpoint encapsulating a field consisting of two subjectivities.

They expand on this concept by discussing negative therapeutic reactions. Analysts have regarded negative therapeutic reactions as secondary to intrapsychic mechanisms of patients which impede analytic insight. The authors do not accept the explanatory value of these mechanisms which include unconscious guilt, a need for punishment, and unconscious envy. The authors hold that negative therapeutic reactions are usually a derivative of intersubjective disjunctions. This occurs when the analyst is unable to capture the essence of the patient's subjective experience. They feel negative therapeutic reactions are thus responses to being repeatedly misunderstood, and serve the purpose of protecting the patient's fragile self from intrusion. These chronic disjunctions often occur where analysts adhere to theoretical concepts which do not allow them to center themselves around the patient's experience of the analytic situation.

In this framework, the authors use Kohut's concept of the selfobject and selfobject transference. (Kohut, 1973 and Kohut, 1977) The patient's negative therapeutic reactions then usually occur when the patient's more primitive selfobject needs are mistakenly seen as a resistance. Patients will automatically transfer to the anlyst the hope of being accepted for what is authentic, unique, and vital in their own personalities. Many of these underlying hopes for being responded to have been hidden in order to adapt to the need of selfobjects in their environments. The wishes for optimal responses are revived in the analytic situation. Negative reactions by patients to interpretations are thus usually not indications of resistance, but often are failures of the analyst to understand and appreciate the patient's internal world. Patients who have precarious self cohesion will often react to the slightest misinterpretation of their experience with severe reactions. However, what is primary in these interactions is not the psychopathology of the patient but the failure of the analyst to sufficiently understand his role in contributing to these reactions.

The authors thus conceptualize psychopathology in terms of the intersubjective field. Psychological symptoms are always seen in the context of the patient and his needs interacting with the responsiveness of the selfobjects in his environment. Psychoanalysis represents the field where

needs, wishes, and conflicts are experienced in the transference framework of the analyst whose responses codetermine and influence the patient's subjective world and his responses. The borderline concept is discussed as an example of this. They feel that repeated borderline symptomatology in treatment is often secondary to empathic failures. Thus, when archaic primitive needs of patients are correctly understood and interpreted, borderline features often recede and are replaced by a greater sense of integration.

They then discuss the therapeutic action of psychoanalysis and distinguish between patients who have pathological structures in place and those who have deficient structuralization. One of the mechanisms for the therapeutic action of psychoanalysis is postulated to be an internalization of the analyst's empathic qualities. An empathic vantage point becomes a part of the personality structure of the patient. Structuralization is facilitated by the analysis of the patient's reaction to separations and inevitable misunderstandings which are then corrected. Interpretations can be focused to provide an opportunity to understand how past developmental sequences emerge repeatedly in the transference.

In the third chapter, the authors describe some basic developmental tasks of childhood and give case histories to illuminate their points. They discuss selfobject differentiation, the integration of affectively discrepant experiences, and the oedipal phase. They again apply the concept of the intersubjective field to illustrate the interaction between the subjective experiences of the child and parental caretakers. The child's developmental tasks are understood in the context of the parental attitudes towards the emergence of the child's mastery of these developmental issues. In the clinical cases described, the patients unconsciously establish in the transference a search for qualities in their interaction with the analyst which will facilitate the acquisition of missing structures. They look for the analyst to supply what was missing in their past relationships. The role of the analyst is to understand the specific qualities which are searched for and to interpret the genetic context of the emerging wishes.

In the fourth chapter, they describe the process of concretization — "the encapsulation of structures of experience by concrete, sensorimotor symbols." They discuss neurotic symptoms and symbolic objects such as transitional objects which concretize experience. They discuss enactments, including sexual enactments, and also describe some functions of dreams. They feel one function of enactments and dreams which is ubiquitous is the strengthening and preservation of structural integrity when current structure is felt to be vulnerable.

In summary, the authors have presented a coherent and systematic effort to categorize clinical psychoanalysis and describe therapeutic mechanisms. Their work is a scholarly and thoughtful contribution to psychoanalysis. I do have certain criticisms about some aspects of this book. The first chapter

includes a detailed summary of existential phenomenology including the philosophers Husserl, Heidegger, and Sartre. While each of these philosophers described aspects of the meaning of human experience, the review makes clear that the philosophical concepts advanced are not directly relevant to clinical work. I felt this section was boring and it detracted from the clinical aspects of the other chapters. In addition, on a clinical level, the authors distinguish between patients who present with pathological structures dominating transference configurations and patients who have faulty structures which emerge in the transference. Most of the case vignettes which are presented discuss patients with faulty and deficient structuralization. It would have been helpful to have more case material about patients with pathological structures. Also, almost all the case histories deal with specific issues. These illustrate points the authors are making in regard to concretization, such as enactments or dreams, or to illustrate specific aspects of developmental phases which are revived in analysis. A longitudinal case illustration describing patient and analyst interactions in greater depth would have been an addition to the book.

These criticisms are minimal, however, as the authors provide distinctive and interesting ways of conceptualizing psychoanalysis. I found the book thought-provoking, stimulating, and well written. The authors have great respect for the process of the clinical situation and the need to develop theories which conform to direct experiences with patients. The concepts they discuss represent an advance in the level of scientific discourse. All practicing psychoanalysts will be involved in the continuing dialogue about analytic theory and this book provides a thoughtful contribution to this process.

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BOOK REVIEW

Analysis of Transference
Volume 1 - Merton Gill
Volume 2 - Merton Gill and Irwin Hoffman
and
"The Point of View of Psychoanalysis: Energy Discharge or Person?",
Merton Gill in *Psychoanalysis and Contemporary Thought,* 1983

Reviewed by Lee Shershow, M.D.

Commentators and patients alike often assert that psychoanalysis is dead. But to the contrary, these recent publications of Merton Gill demonstrate that psychoanalysis is very much alive and well. His ideas are as exciting, innovative, and controversial as previous reformulations of psychoanalysis. In fact, his theoretical and technical contributions could potentially become widely influential in the on-going process of re-examining psychoanalytic theory and practice that began with Freud himself.

Gill began his career as a classical analyst, but formed a close association with the analysts grouped around George Klein who questioned the basic metapsychological assumptions of classical analysis in the 1970s. Thus, Gill has been re-examining theory and practice for a long time, moving steadily towards his present focus on transference and psycho-analytic research. In this review I shall focus on Gill's theoretical and clinical ideas on transference; although he has much to say about many areas of psychoanalysis, these ideas are his primary contribution. The two volumes and the journal article summarize previous views of transference, state Gill's own ideas for a "radical revision of transference", defend the new ideas, and provide verbatim transcripts of analytic sessions to support his theories.

Volume I of *Analysis of Transference* is a theoretical monograph. Gill reviews at length the work of all prominent writers on transference, including Freud, Ferenczi, Strachey, Glover, Fenichel, Stone, Greenson, Zetzel, and others, and criticizes many of these writers for their lack of clarity and their confused definitions of transference. He discusses the many types of transference mentioned in the literature—benign facilitating, unobjectionable, obstructing, positive, negative—and concludes that the analysis of transference should be more central than most writers, including Freud, advocate. Gill bluntly and forcefully states that:

> . . . psychoanalysis as it is generally practiced is not of good quality technically. In particular, I mean that the analysis of the transference, allegedly the heart of psychoanalytic technique, is not pursued consistently in practice.

Although the theorizing in Volume I is repetitive, and sometimes confusing or boring in the middle sections, the ideas eventually emerge clearly and powerfully.

For Gill, analysis of transference is the *sine qua non* of psychodynamic therapy. He suggests, for example, that resistance may have many sources, but it can be expressed only through the transference. Consequently, the term "transference resistance" is redundant, although the opposite term, "resistance to transference," is useful. He subdivides resistance to transference into two clinical categories: resistance to awareness of transference, and resistance to resolution of transference. He dismisses "defense" as an intrapsychic concept of little clinical significance, and barely mentions "transference neurosis" or its resolution. Gill argues instead for the ubiquity of transference meanings during all phases of psychoanalysis.

Up to this point Gill is clarifying, but not yet original. Supporters of Melanie Klein, for example, have long maintained that transference analysis should be central at all times. Gill's innovation is to combine this central focus on transference analysis with a rejection of the traditional view that transference and its resulting distortion of reality originates entirely inside the patient's psyche. For example, Gill would deny the validity of Greenson's definition of transference taught to candidates in the Los Angeles Institute:

> Transference is the experiencing of feeling, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present. (Emphasis added)

Instead, Gill believes transference is an interpersonal process, involving both analyst and patient. He thinks that the intrapsychic view stresses only the patient's contribution, as if transference develops in a "social vacuum". Further, Gill believes that the failure to understand the interpersonal nature of transference produces an excessively rigid, dead, or theoretical analysis, in which the analyst is too silent for fear of contaminating the transference, or worse yet speaks from counter-transference needs. He contrasts rigid analytic silence and passivity with Freud's practice of freely intervening in the analysis. Gill concludes:

> . . . that the analyst should have the freer kind of relationship with his patients that Freud had and that the transference can still be properly analyzed if the analyst takes account of the repercussions of his behavior, whether technical or nontechnical, on the transference.

It is beyond the scope of this review to compare Gill's views with those of other analysts, such as Bowlby, object-relations theorists, and Kohut, who have advocated a change in the analytic attitude from intrapsychic to interpersonal. The emphasis on empathy by self-psychologists certainly appears consistent with Gill's views. In addition, Gill's ideas must obviously be added to the growing literature favoring fundamental re-thinking of counter-transference.

In Volume II Gill and Hoffman test their ideas on verbatim transcripts of actual analytic sessions conducted by analysts who do and do not share their views. Whatever one thinks of Gill's ideas, he should be commended for advancing the objective study of psychoanalysis, for it permits the reader to evaluate directly the theoretical conclusions. The cases produce better understanding of Gill's ideas, and a livelier discussion than the pure theory of Volume I. If one is bored by analytic theory, Volume II could profitably be read by itself for the richness of its clinical vignettes. The reader can digest each case in an hour, and Gill and Hoffman's brief comments adequately explain their points of view.

In the introduction to the cases, they re-state their position:

> Instead of the illusory aim of eliminating the analyst's interpersonal influence, we stress the importance of vigilance to disguised references by the patient to this influence, including whatever inadvertent interpersonal effects may stem from the act of interpreting itself.

The cases do support the validity of stressing interpersonal influences. In the first case the analyst fails to attend to interpersonal factors, and says absolutely nothing until the very end of the session, and then only "We'll stop for now." The patient responds with increasingly frantic cries for more contact from the analyst, and finally associates to a dead cat in her past, suggesting to Gill the analysis was dying. In several other cases the analysts seem determined to impose their ideas on the patients, even to the point of enacting the very transference fear being discussed by the patient—that powerful parental figures controlled them in the past or will do so in the present. In one case the analyst gives "an almost unbelievably pat interpretation" of penis envy, which the patient seems to accept but subtly rejects. In another case, the analyst interprets the patient's homosexual fears in such a dominating way that the patient has no choice but to submit to the interpretations. And, as one would expect, in all these cases the patient complies with the analyst, at least consciously, in what Gill refers to as "masochistic surrender."

Volume II also provides contrasting transcribed case examples of analysts who attempt to use Gill's methods. These cases are difficult to summarize, but Gill's methods produce more active analysis that constantly pursues the patient's experience of the analytic relationship, with more freedom in both

the patient and the analyst. These cases demonstrate that the analyst need not impose his or her theoretical point of view on the patient, but should instead examine the patient's experience of the analytic relationship in the hre-and-now. This examination should center on "a thorough exploration of the analyst's contribution from the patient's point of view." In other words, Gill advises the analyst "to look for what in his own behavior makes the patient's experience plausible."

Gill does not disavow the role of genetic transference interpretations, although the books do not focus on their role. In the article, however, he clearly states that the patient's experience of the analyst in the here-and-now must occur first, and only then should the genetic components be interpreted. A long passage from that article is worth quoting:

> The therapist will recognize that the patient's contribution is significantly related to his past and that this past needs to be explored with the same perspective which the therapist uses in his examination of the here-and-now interaction with himself; that is, that the past also took place in an interpersonal context. But he will be ever mindful of a temptation on both his part and the patient's to flee to the exploration of the past from the probably more stressful examination of the present, and he will therefore be biased toward attention to the present rather than the past. In the most general terms a therapist who accepts the perspective I have described will conduct therapy in an atmosphere which differs from what I believe is a prevalently present one in that its emphasis will be more on the examination of the relationship than on the patient as an intrapsychically organized entity, more on the therapist as a participant than an observer, more on the present than the past; and his initial approach to the patient's experience of the relationship will be directed at seeing how it makes plausible sense rather than how it is a distortion of an alleged correctly ascertainable reality.

Gill deserves serious study by psychoanalysts for his work offers solutions to the two most serious problems with analysis. First, he offers a technical method that could soften the rigidity that produces dead analysis and dead analysts. Second, Gill boldly produces the objective data upon which he bases his conclusions and suggests that others reconsider their reluctance to make public what analysts do. At a time of substantial criticism about both the scientific status and therapeutic efficacy of psychoanalysis and psychotherapy, Gill offers refreshing new ideas and new techniques for making psychoanalysis more vital, alive, and scientific than ever.

BOOK REVIEW

The Process of Psychoanalytic Therapy, Models, and Strategy

by Emanuel Peterfreund, M.D.

Reviewed by Samuel Wilson, M.D.

Emanuel Peterfreund joins the ever lengthening list of authors who have attempted the task of refining and re-defining the psychoanalytic process. Recently, the late George Klein, Roy Shafer, Merton Gill, and many others have sought to factor out a more "pure" or phenomenologically based theory of clinical psychoanalysis stripped clean of its metapsychological underpinnings.

In this latest effort, Dr. Peterfreund describes a heuristic psychoanalytic theory of technique which he feels is more phenomenologically verifiable than a psychoanalysis which rests too heavily on stereotypes.

Peterfreund attempts a distinction between clinical theory and a theory of the therapeutic process. This is at times confusing. Peterfreund blurs the distinction that others have made between clinical and metapsychological theory. In defining clinical theory he includes concepts, such as repression, that have been described by others as representing metapsychology. His definition of the theory of the therapeutic process comprises much of what is usually thought of as clinical.

Peterfreund makes a clear differentiation between "stereotyped analytic approaches" and the "heuristic therapeutic process". The former approach involves the application of an accepted body of clinical theory while the latter depends more on the process of discovery.

In describing stereotyped approaches, Peterfreund reports his own supervised work before he developed the heuristic approach. He also discusses cases in the literature that illustrate stereotypes. Such well known psychoanalytic clinicians and theoreticians as Ralph Greenson, Joel Kovell, Gertrude and Rubin Blanc, Jacob Arlow, Charles Brenner, and Phyllis Greenacre are all taken to task by Peterfreund. In these examples, Peterfreund shows how clinical data can be brought in to line with the analyst's preformed hypothesis about the patient's psychopathology.

It could be argued that these hypotheses might also arise from the accumulated wisdom of a body of psychoanalytic knowledge, years of experience, and correct intuition, all leading to a way of focusing and organizing data. Not so according to Peterfreund. His objection to such approaches is that they foster premature closure and molding of the patient by the analyst, who comes too quickly to "an understanding of the patient's pathology". Peterfreund acknowledges that the analyst's hypothesis regarding the patient may indeed be correct. The error is in the manner in which they arrive at such interpretations either prematurely, or with too little or contradictory phenomenological data.

Peterfreund is not attacking "Freudian" analysts as a whole. He considers himself to be included in this group, and is a member of the New York Psychoanalytic Society, known for its adherence to orthodoxy.

Peterfreund illustrates how any theoretical position may be used in a stereotypical manner. As an example he takes up Heinz Kohut's "Two Analyses of Mr. Z" as an illustration of Kohut's change from an earlier "classical" stereotypical stance. He then discusses the possibility of using tenets of self psychology in a stereotypical manner.

Peterfreund lists the components of the stereotypical approach and describes their inconsistencies and tautalogical bases. The concept of resistance is particularly likely to be misused in this way, as it lends itself so readily to rationalization by the analyst, who may always need to be right.

Peterfreund next turns to a discussion of the heuristic psychoanalytic process. He does not claim that this is a new technique, but is rather "one segment of the spectrum of Freudian approaches". He quotes Freud as describing the analyst as one who "sets in motion a process . . . . once begun, it goes its own way and does not allow either the direction it takes or the order in which it picks up its points to be prescribed for it".

In distinguishing a heuristic or learning process from alogorithmic (distinct steps) strategies, Peterfreund illustrates how in the heuristic method one follows only a general outline or direction. The analyst's cognitive and affective processes drift with the patient, much as in the process of free association, which is central to the heuristic method. This free hovering attention is well known as one of the mainstays of the classic technique and is only mined from that body by Peterfreund as a component of his heuristic method.

This is contrasted to stereotyped alogorithmic methods in which the analyst feels he has all the answers before the analysis actually starts. The heuristic approach is pragmatic and empirical. While it is always true that the past influences the present, Peterfreund stresses that it is the patient's memory that is of vital importance, not the analyst's memory of his theories, although these will always be present to some degree. (W. R. Bion has stressed the same basic concept in cautioning against relying on "memory

and desire" while conducting analytic therapy.)

Peterfreund borrows the concept of "working models" from Bowlby. In this paradigm memories are stored episodically and semantically in the central nervous system. The semantic memories are generalizations of specific behavioral episodes. The analyst, using a heuristic approach, must be aware of working from these various "models" of human experience.

Peterfreund also describes "meta models" that represent clinical theories (conflict, repression, oedipus conflict, unconscious processes, etc., and theories of the psychoanalytic process such as working alliance, transference, free association, interpretation, etc.). Another set of meta models is involved with information processing, systems models, neurophysiological models, genetics, chemical and hormonal models, etc.

Peterfreund next turns to a series of case histories in which he lucidly illustrates the heuristic approach.

Peterfreund makes use of the "good hour" to illustrate what he considers the best evidence of correct analysis. In a manner too little duplicated, Peterfreund takes the reader step by step through his thoughts and reactions to the patient's free associations. He candidly discusses his own periods of confusion, disorganization, and uncertainty, together with his temptation at such times to fall back on psychoanalytic stereotypes. His description of the spontaneous empathy that develops within himself during this process provides a rare glimpse into the analyst's experience. In this regard, the analyst's ability to be open to "error correcting feedback" is of vital significance in allowing the process to continue.

Peterfreund next takes up five categories of strategies used in the heuristic approach. The first four involve strategies used by the analyst; general strategies, strategies as participant-observer, strategies related to the patient as participant in the therapeutic process, and strategies related to establishment of meanings. The final category involves strategies used by the patient.

In describing the development of the transference relationship to the analyst, Peterfreund suggests that analysts should educate their patients as to the importance of such phenomena (as Freud did in the case of "The Rat Man"). He feels patients do not understand what is expected of them and need such clarification and direction. He is adamant against using transference interpretations prematurely before the patient has had a chance to experience meaningful transference phenomena. Peterfreund is intent on appreciating the emotional moment of the patient and conveys this understanding, whether it be of transference, constructive, or reconstructive material.

Although Dr. Peterfreund disavows the need for an understanding of information theory to appreciate his present thesis, he does make liberal use of these ideas in the exegesis of the heuristic model. He also borrows

liberally from cognitive theory.

Dr. Peterfreund was greatly influenced by Paul Diesing, a philosopher and social scientist. Diesing's main contribution to Peterfreund's work is in the emphasis on taking a position within the phenomenology of the moment. He suggests that analysts should work their way into the system they are studying, for in so doing they will achieve a new depth of understanding.

In the chapter devoted to the analyst as participant-observer Peterfreund speaks of empathy as consisting of an ability to "follow the patient's emotional line, identify with the patient's experience, and evaluate these experiences." While so doing, the analyst must use himself as the basic model, being constantly open to confusion and tentatively held hypotheses, while attempting to focus, correct, and refine his perceptions.

In discussing a variety of other strategies used by the patient and therapist in the heuristic approach, Peterfreund emphasizes the general working together of the analyst and patient. Although he does not emphasize the concepts of the therapeutic or working alliance, Dr. Peterfreund continually makes reference to the value of the therapist and patient working together to achieve a better understanding of the patient's thoughts and behavior. The emphasis is on the patient's autonomous, unique experience, with the analyst as guide or facilitator of their evolving narrative.

Throughout this section of the book, there are many helpful clinical illustrations.

The final, most interesting and courageous part of the book was the last section, dealing with "evidence, explanation, and effectiveness".

For Peterfreund, the most convincing means of evaluating the effectiveness of analytic treatment is by the presence of what he refers to as good or effective hours. These are described as sessions in which the patient feels understood, expresses his emotions, experiences relief from tension and anxiety, achieves new awarenesses about his life, is an active participant in the process of the therapy, and has corrective emotional experiences. Such corrective experiences are distinguished from the usual understanding of the term in the manipulative sense. The corrective experience occurs naturally as a result of the newly evolving relationship with the analyst as one who can understand the patient, and communicate this in an effective manner.

Dr. Peterfreund exhibits a considerable degree of courage by the manner in which he carried out his post treatment assessments. Six patients were studied in this process. Three patients were interviewed face to face with tape recordings being made. The other patients were interviewed over the telephone and taped. In certain instances questionnaires were sent. Each patient was asked what he or she derived from the treatment, in what ways treatment was meaningful, and in what ways it failed, what was recalled of

the treatment sessions, what stood out, and what made them take the position that changes could be attributed to the treatment and not just to the normal process of growth and development. The analytic cases reported were seen from between seven and fifteen years. The follow-up interviews were conducted after the rest of the manuscript was compiled so as not to bias the earlier description of the cases.

All of the patients involved in the follow-up felt that some positive changes had occurred as a result of their analyses. Two patients felt that the analyst had been too inactive in his approach. One objected to the time consuming, frustrating, nonsupportive nature of the treatment and its disruptive effects on one's outside relationships due to the degree of self preoccupation it stimulated. One patient felt that she needed more specific advice regarding sexual matters, and if in treatment now, would have consulted a sex therapist for these areas of difficulty. Another patient brought out the potential for analysis to overly emphasize the intrapsychic as a replacement for the interpersonal. She describes in a clear and poignant manner how she used the analysis to avoid certain realities of her life, and in so doing, to hide from the world by believing that her distorted perceptions were at the heart of all of her problems. One might point out in this instance that the results of her therapy allowed her to be able to re-analyze these problems following termination. This particularly articulate patient also described what she felt to be a misperception on the part of the analyst in ascribing her sexual problems to conditioned responses resulting from her mother's mistreatment. She now views her inability to achieve orgasm as being the result of a disordered relationship which she was having with her husband resulting from some very real differences between them, her sexual feelings being a summation of the many diverse feelings about her life and her husband. This patient, whose analysis was in two phases, lasting a total of eleven years, was the most negative of those interviewed. She felt the analyst should have resorted more to common sense and less to sophisticated analytic reasoning and tortured meanings.

Another patient, whose analysis lasted fifteen years, was in a chaotic and disintegrated state at the beginning of his analysis, and took ten years to be able to listen to the analyst without feeling grossly disturbed. I felt a sense of awe and admiration for Dr. Peterfreund's ability to sit with this patient, at times six times per week, while he endured the almost constant barrage of insults, screaming, devaluations, and mockery. At one point this patient refused to talk until Dr. Peterfreund restored his potency. Peterfreund interpreted, confronted, and persevered, and finally, little by little, the patient became able to establish a therapeutic alliance. This patient ended up being quite grateful to Dr. Peterfreund for providing the structure, dimension, and honesty that allowed him to become a successfully functioning human being.

Finally, Dr. Peterfreund summarizes the factors which he feels make

analysis effective. These include the effects of time, the impact of new information, expression of emotion, and corrective emotional experience, all leading to healing and the reinstitution of a normal maturational process.

In describing his own evolution as an analyst/therapist, Peterfreund provides the reader with a rare chance to follow the development of the analyst and his analytic instrument.

Many will ask "So what is new about what Peterfreund describes as the hueristic approach?" Certainly many "good" analysts already practice in such a manner. His description of the "stereotypical approach" as representing a caricature of a mythical "classical" position has some merit. Yet Peterfreund provides us with examples of such stereotypes from the writings of leaders in the field of psychoanalytic clinical theory. Perhaps people practice in a way different from their written description of the work. Such possibilities not withstanding, Peterfreund clearly describes what he has found to be a useful clinical psychoanalytic paradigm.

While Peterfreund presents his material in a convincing manner he does not address the issue that lies at the heart of all psychotherapy research. The nature of what actually produces therapeutic change, as always, is defined in terms of the author's theory. What we don't know and what we may never know is if this system is more productive of the mutative response than one that emphasizes a different point of view.

Even as Peterfreund challenges the work of other analysts, how can he or anyone submit evidence that indicates a therapeutic advantage for their own paradigms. No patient can act as his own control; therefore it can never be known how any other set of ideas, analyst-patient combinations, or modes of treatment would have turned out.

What Peterfreund does is to clearly present his own experience in a refreshing, candid manner without attempting to hide his blemishes and uncertainties. For this he deserves our deepest admiration and respect.

SCIENTIFIC MEETING REPORT:

Freud, Female Sexuality, and Masculine Bias

Speaker: Lawrence J. Friedman, M.D.

Reported by: Helen Desmond, Ph.D.

Respected speakers, addressing a compelling topic, drew a full house for the April scientific meeting of the Los Angeles Psychoanalytic Society and Institute. Introduced as "a former obstetrician who grew up as the only boy in a family with eight older sisters and one younger sister," Lawrence J. Friedman, M.D. presented his paper "Freud, Female Sexuality, and Masculine Bias."

Citing "Some Psychical Consequences of the Anatomical Distinction between the Sexes," "Female Sexuality," and "Femininity" as Freud's three major works on female sexuality, Dr. Friedman presented several key quotes from these papers. He noted that Freud's comments on superego formation in women were "a value judgment" which "can be explained only as a sudden breakthrough of man's hostility to woman." He underscored Freud's own awareness of the limitations of his understanding and quoted from the final paragraph of "Femininity:" "That is all I have to say to you on femininity. It is certainly incomplete and fragmentary and does not always sound friendly."

Friedman made the point that a theme contained throughout Freud's theories on female sexual development was that "it is the psychological expression of a developing biological unit." To this he added that the final outcome of this development depends on: 1) our given potential, i.e. phylogenetic inheritance; 2) the vicissitudes of the maturational process; and 3) the environment into which we are born."

Drawing upon history, religion, and mythology, Dr. Friedman next turned his attention to the masculine bias which formed Freud's intellectual and cultural background. "The history of civilization — primitive, ancient, and modern — is full of man's expression of his hostility and envy of woman, and his severe ambivalence toward her." According to Friedman, envy of woman's potentially greater sexual ability and her ability to create a new life is behind this masculine bias. To illustrate this thesis, Friedman pointed out that in the book of Genesis, written by men, man, not woman, is the creator and woman becomes the source of all evil responsible for man's downfall.

Dr. Friedman quoted from Zilboorg, Grotjahn, the American sociologist Ward, and the Swiss historian Bachofen to present the theory that rather than society originating with the killing of the primordial father, there may have been a previous matriarchal society which ended with the rape of the primordial mother. Friedman states that Zilboorg was inclined to think that "woman-envy on the part of the man is psychogenetically older than penis-

envy and, therefore, more fundamental." In Dr. Friedman's view: "Mankind is unwilling to face the thought of its maternal origin and dependency."

Dr. Friedman next directed his comments to the effects of biology in psychoanalytic theories. Freud, dependent upon the biology of his time believed that all original anlage (the beginning of life) was masculine and a female developed if something went wrong in fetal development. More recent studies have shown that the original anlage is feminine. He cites Mary Jane Sherfey's paper, "The Evolution and Nature of Female Sexuality in Relation to Psychoanalytic Theory" as the best demonstration of the extent of the bias against primary femininity. Sherfey "didn't find in any of the works of comparative anatomy any description of the deeper-lying clitoral structures." Friedman quotes Sherfey: "Not only that, they are not even mentioned! But . . . because the comparative anatomists and biologists do such a thorough job on every other body system, including the male sexual anatomy, this total omission of the cryptic clitoral structure is of interest." Dr. Friedman sees a parallel between the conclusions of Zilboorg, Ward, Grotjahn, etc. and Sherfey (who did not include the former in her references). He quotes Sherfey: "To reduce clitoral eroticism to the level of psychopathology . . . is a travesty of the facts and was based on the biological misconception that life begins as male . . . for all mammals, modern embryology calls for an Adam-out-of Eve myth."

Friedman states that Sherfey's studies reveal what the two fifteenth century Dominican brothers who authored Malleus Malificarum (literally, The Witches Hammer - considered to be a scientific study, it became the theological and legal basis for witch-hunts, i.e. burning women alive) knew. In Sherfey's words: ". . . the human female is sexually insatiable." Writes Dr. Friedman: "No wonder man envied her! She made him feel inferior, she was considered dangerous and had to be burned at the stake . . . the stronger sexuality of women had to be suppressed as thoroughly as possible in order to establish and protect family life."

Next followed a discussion of the ways in which man, out of envy of woman, "usurps all the activities and roles in society as exclusively his." To name a few: "the dominance of men in medical schools; the traditional obstetrical practices in child birth; the all too frequent questionable removal of sexual organs in women in the name of preventive medicine; the male tradition of erecting statues to honor military heroes 'usually sitting on a bucking stallion, giving a better view of the tremendous genitals of the horse than of the hero on top of it.' " Dr. Friedman states: "Until man understands his hostility against woman, he will keep on creating bigger and better weapons to wipe out the progeny of other nations and in the long run, himself as well, because of guilt over his hostility."

Addressing the Women's Liberation Movement, Dr. Friedman pointed out that Freud did more than his part in helping women fight for freedom because "he was the first to point out that the most important freedom in

life is emotional freedom . . . and that women should have this emotional freedom as well as men." Friedman stressed that "men and women *are* different — biologically different" and "We must recognize and respect the differences if there is to be real equality." He identified the problem of over-population as the "most important and probably the most dangerous, force against which the Woman's Liberation Movement stands." Consequently, "childbearing — so highly valued until recent times — is rapidly becoming undesirable, even outright dangerous to our planet's survival." Because of the necessity of addressing this problem, Dr. Friedman concludes that "the recognition of woman's ability and place in the economic, political, business and professional activities, previously reserved for the male only, is inevitable." As an important step in the move toward more satisfying relationships between men and women, he suggests that we speak of masculine and feminine rather than men and women, and that we look to the problems and advantages of the development of both potentials in everyone.

As far as coming to an adequate understanding of female sexual development and female psychology goes, Dr. Friedman states: "It will take decades of cooperation among biologists, sociologists, historians, geneticists, and all the others who devote their lives to the understanding of the human agenda, to find better answers." He sees psychoanalysis as holding "the unifying, cohesive force in that joint effort."

Dr. Friedman's stimulating presentation lasted almost one and one half hours. While his lively humor and delivery did much to hold the attention of his audience, Martha Kirkpatrick, M.D. wisely led everyone in some aerobics before beginning her discussion of the presentation.

Dr. Kirkpatrick acknowledged that Dr. Friedman's paper "stimulated so many lines of thought" that her discussion began to be chapterized. She noted that the "overriding theme in Dr. Friedman's paper . . . is that despite the differences in men and women there is an equality of envy which each has for the other." Because of the "damaging effect on human society of the idealization of masculine characteristics and values and the corresponding devaluation of feminine characteristics and values" she states that "deepening our understanding of the development of femininity and masculinity is no longer a scholarly or clinical pursuit, it is a social imperative."

Kirkpatrick points out however, that "the elements of feminine development remain elusive because for one thing, it is hard to distinguish what is intrinsic or potential in femininity from what is the consequence to women of male dominated social arrangements." Dr. Kirkpatrick gives her own illustrations from history, philosophy, and religion of man's "need to see women in a certain way, defective and needy." She notes that Freud "did not seriously consider that femininity could have a source intrinsic to women, independent of men," even though supporters of this view within

psychoanalysis surfaced in the early 1920's. She cited Zenia Fliegel's 1973 article suggesting Freud's reluctance to consider new ideas about women was related to the diagnosis of his cancer in 1923 and his need to consolidate his theories. Dr. Kirkpatrick asked the question: "Did Freud's illness and his impending death, threatening as it did the survival of *his* creative product, psychoanalysis, and perhaps his own struggle with that ultimate merger, death, increase his need to re-assert masculine creativity and centrality?"

Dr. Kirkpatric identifies the post war years as a time when much attention was directed to the defects of mothers and wonders whether this emphasis was in part an out-growth of motherhood envy. She identifies the Women's Movement as being responsible for bringing to the fore questions about the individual woman's development and life experience. She states: "A plethora of studies and data from many disciplines blossomed." However, this literature "is awash with contradictory observations and a plethora of diverse theories each presented with an air of certainty in the style of patriarchal authority."

Kirkpatrick then launched into what she called a "thumb nail review" of this literature. Citing the influence of fetal hormones on neurological development she made the point that brain differences play a part in the organization of early relationships long before genital differences can be noted. In an extensive section on gender identity, she states Stoller "sees girls' feminine gender identity as primary, rooted in the early symbiotic period and therefore more secure than boys." She notes that "Gadpaille suggests male chauvinism results not from motherhood envy but from a denial of this vulnerability (less secure gender identity) of males."

As for "drives, zonal organization and genitals," Kirkpatrick states: "The one genital of childhood appears to be the little boy's misconception, i.e. the vagina is undiscovered only by the boy to whom the female genital and its functions are, and often remain, as Dr. Friedman suggested, a source of mystery and awe." As for penis envy, "Penis envy has been confirmed repeatedly . . . arguments today are around the *significance* of penis envy for gender identity, gender roles and object choice." Though Galenson and Roiphe "see penis envy as *the decisive* event in establishing feminine gender identity *and* the turn to the father," they "also point out that the turn to father occurs only if the previous relationship with mother has been stable enough to allow for separation/individualation to have taken place." Dr. Kirkpatrick continues: "Thus mother's reliable support for her girl's expanding interests is the essential in this move rather than mother's perceived inadequacy as a penis-less person. The question can be stated — does the healthy girl turn to father for libidinal satisfaction or for narcissistic repairs?"

Kirkpatrick states: "Freud's notions of the inferiority of the female superego have been dispelled by Roy Schafer, Doris Bernstein, Carol Gilligan and others." She noted: "They point out that Freud mistook rigidity

— inexorableness — for strength in evaluating the superego. He failed to notice that while the female superego was different in its *flexibility,* and its *object oriented* rather than thing or abstraction oriented values, it was 'quite as adequate for the control of drives and the maintenance of morality, and characterological conscientiousness' to quote Bernstein."

Dr. Kirkpatrick states: "Despite new information and new theories we are still enmeshed in controversy and a long way from agreeing on the weight to give to brain differences, drive and zonal organization, cognitive development, ego development and object relations." She went on to enumerate ways in which she "Had been socialized to be blind: . . . so willing to believe incest was only an oedipal girl's fantasy; . . . so willing to believe rape was a masochistic woman's unconscious wish." She states she believed the "male myth of . . . male rational protectiveness" and thus found statistics of battering and domestic violence shocking. Dr. Kirkpatrick sees more male participation in child-rearing as an opportunity to "facilitate a less counterphobic quality in male identity . . . to change masculine bias to human bias."

Discussion wasn't open to comments from the floor until after ten o'clock. In spite of the late hour, there were several volunteers. Dr. Miriam Williams called attention to Freud's "utterly unresolved transference to his mother" and the conflict which must have been created in his mind over these negative feelings toward his mother. Dr. Rita Spies stressed the importance of the mother-infant dyad in studies of infant development. Dr. Judy Vida stated that although she began psychoanalytic training after the Scherfy paper, she only learned of this paper when she took an elective on Female Sexuality offered by the Southern California Institute. She asked if that paper was in the LAPSI curriculum yet.

Dr. Friedman was delighted with the discussants because he felt they took up where he left off. I was disturbed by Dr. Vida's question. Having just completed four years of seminars, I can answer her. No, the Sherfey paper was not included in my curriculum. Further, I found Dr. Friedman's reaction to Dr. Brenner's book *The Mind in Conflict* particularly apt for a considerable majority of seminars. Said Friedman of Brenner: "He knows only the original unisex approach — what we learned and always questioned — even though in so many other areas he is up to date." In addition, no woman taught a seminar during my four years. Could one then infer from the intensity and direction of this evening's scientific meeting that a course on female sexuality is long overdue in the regular curriculum of this Institute?

LETTER TO THE EDITOR

March 30, 1984

Dear Dr. Wilson:

Your *Bulletin* is a welcome addition to the journals we receive in our Professional Staff Library for the use of our clientele. Current copies are spread out on special shelves to facilitate their use. But I must confess that when your January issue arrived, I took it home rather than adding it immediately to the current journals shelves. I wanted to read Dr. Rodman's interview with Dr. Grotjahn without interruptions and I did for it was about another time, another world.

With all good wishes.

Yours sincerely,

Sherry Terzian

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