

## ***Psychoanalysis and Psychotherapy: A Long and Troubled Relationship***

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Recently, Wallerstein (2001) noted: “the complacent certainties about the distinct enough compartmentalizations of psychoanalysis and the psychoanalytic psychotherapies no longer exist. The borders between them are now blurred, and they shift constantly, depending on one’s vantage point and one’s theoretical predilections” (p. xvi). But while many would agree that psychoanalysis is at such a point, the fact is that the distinction was always blurred. Wallerstein’s framing of the issue obscures the interesting fact that while, for most analysts in the past, there were indeed “complacent certainties” about the existence of such a distinction, there was never agreement on what it was, never clarity on where or how the line was to be drawn. As a result, we seem to be in an odd place for psychoanalysts: having resolved or transcended a conflict without understanding what it was about.

Typically, the debates and discussions centered on theoretical or technical issues. Gill (1984) usefully distinguished between formal or “extrinsic” factors, such as the use of the couch, the frequency of sessions, or the training of the analyst, and “intrinsic” factors, the analysis of transference, the use of free association, regression, etc. Arguing that the “intrinsic” factor of transference analysis was the key, however, he did not succeed in persuading most analysts that it was the defining characteristic of psychoanalysis or that it was irrelevant to psychotherapy. More recently, Kernberg (1999) has attempted to stake out definitive boundaries between “psychoanalysis,” “psychoanalytic psychotherapy” and “supportive psychotherapy.” But even he has had to acknowledge not only the formidable counter-arguments to his case but also the fact that the proliferation of psychoanalyses has brought us to the point where his proposed boundaries would necessarily exclude certain contemporary schools of thought.

As a result of what now appear to be insuperable difficulties with establishing clear and valid distinctions, many have backed off the topic, referring, like Wallerstein, to the plurality of “psychotherapies” and “psychoanalyses.” This does not mean that there are not useful or even necessary distinctions to be made, but it does appear to acknowledge

that past efforts for clarity have not led to clear or usable discriminations.

My argument in this paper is that the debates in the past have been contaminated by two covert, underlying issues. First, the debate about psychotherapy was muddied by the fact that, on an institutional level, psychoanalysis did become, as Freud feared, a “mere handmaiden of psychiatry.” The fate he foresaw in On the Question of Lay Analysis has come to pass: “swallowed up by medicine,” psychoanalysis will find its “last resting place in a textbook of psychiatry under the heading ‘Methods of Treatment’, alongside of procedures such as hypnotic suggestion, autosuggestion, and persuasion.” (Freud, 1926, p. 248) Thus the attempt repeatedly to affirm and define the distinction – and the inability to succeed at it -- reflects the fact that psychoanalysis became a form of psychotherapy, in fact, but continued to claim that it was distinctly privileged and different.

I am not speaking here of the “medicalization” of psychoanalysis, attempts to restrict psychoanalytic training and practice to medically trained psychiatrists. That issue, obviously a key focus of Freud’s On the Question of Lay Analysis, has been supplanted by the enormous expansion of psychotherapy in the mid twentieth century, well beyond the boundaries of psychiatry. My point is that psychoanalysts today – whether they start out as psychiatrists, psychologists, social workers, ministers, nurses, or specialists from fields outside the traditional disciplines of mental health – see themselves as providing a psychotherapeutic service. They are “mental health practitioners,” a term that did not exist in Freud’s day, delineating a field that began to be defined in the 1930’s but which robustly came into existence following World War II. In that sense, they are a part of medicine.

The original mission of psychiatry now extends to all forms of mental health service. Psychoanalysts seek reimbursement privileges and insurance coverage, along with other practitioners. Their training is about the treatment of patients, and their professional journals and meetings focus almost entirely on patient outcomes. As a “method of treatment” psychoanalysis may not be in competition with “hypnotic suggestion, autosuggestion, and persuasion,” as Freud predicted, but today it is in competition with cognitive-behavioral therapy, psychopharmacological treatments, group therapy, etc. etc. My point here is not about the issue of “lay analysis,” as it has been traditionally understood; it is about the immense expansion of psychotherapy, what Rieff (1966) referred to as “The Triumph of the Therapeutic” in our culture.

The second underlying issue in the debate stems from the closed and hierarchical nature of psychoanalytic institutions. Historically preoccupied with maintaining the purity of their doctrines and affirming allegiance to Freud, while searching out internal enemies, many mainstream psychoanalysts were averse to modifying their theories and practices in order to adapt to external pressures and demands. Thus, in the post-war era, any attempt to engage with “psychotherapy” was likely to be attacked as a form of psychoanalytic deviance.

In recent times, the issues have changed. As psychoanalysts, less driven by ideological debates, have fewer analysts in their practices, the matter has become more practical. A new hierarchy has evolved out of the old caste system, separating “psychoanalysts” and “psychotherapists,” creating sometimes painful and poignant conflicts among groups within psychoanalysis but also between analytic generations. Moreover, the particular forms of dynamic psychotherapy spawned by psychoanalysis are now themselves under attack, weakened by the same social and economic forces that have weakened psychoanalysis. They are all the more vulnerable to attack as psychoanalytic institutions maintain their aloofness from psychotherapy.

Let me make it clear at the outset, however, that the argument in this paper is in no way meant to imply that psychoanalysis does not have a valuable and potentially important role to play or, even, that it would not be possible to arrive at a definition of what it is. The point is that we have been caught up in conflicts derived from our history that have confused the issues we have been struggling to understand. This paper is an effort at demystification.

### **The Post-World War II Years**

The locus classicus for the debate is Freud’s address to the Budapest Society at the end of World War One. Foreseeing the day when the demand for psychoanalysis would greatly increase but also that, when it did, psychoanalysis would have to be modified to accommodate such numbers, he said: “We shall then be faced by the task of adapting our technique to the new condition. . . . It is very probable, too, that the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion.” (Freud, 1919, p. 167)

It wasn’t until after World War Two that the opportunities – and the pressures -- to develop the “alloy” of psychoanalysis that Freud foresaw arose with any significance. What seemed in 1918 a simple enough

suggestion and a clear enough distinction then became the object of a virtually endless stream of speculation and debate.

Wallerstein has noted that the debate over psychotherapy appears to be primarily an American preoccupation – and for good reason. In America, psychiatry embraced psychoanalysis and psychoanalysis, in turn, conferred on psychiatry a monopoly on eligibility for training. Other countries exhibited similar tensions over the medicalization of psychoanalysis, but it was in America that the strongest alliance was forged. Thus two distinct camps emerged: those whose primary identity was psychoanalytic, determined to preserve the legacy of Freud, and those whose primary identity was psychiatric, determined to take from psychoanalysis whatever it could in the service of developing effective forms of psychotherapy (Hale, 1995; Eisold, 1998). There was superficial agreement between these camps on such issues as “lay analysis,” that is, maintaining the medical monopoly, but the underlying tension repeatedly manifested itself around this issue of psychotherapy.

Interestingly, the pressure to modify or adapt psychoanalysis towards psychotherapeutic ends was spearheaded in America before World War Two by several early émigré analysts such as Alexander, Rado, Horney, and Fromm-Reichman who clearly enjoyed their independence from the orthodox constraints of the institutes in Vienna and Berlin where they had trained. They forged alliances with American psychiatrists such as Adolf Meyer, William Alanson White, Harry Stack Sullivan, Dexter Bullard, and the Menninger brothers in order to develop new approaches to the treatment of mental disorders. On the other side of the conflict were the second generation of American analysts, who went to Europe precisely to get the orthodox training unavailable in America, psychiatrists like Kubie, Hendricks, and Lewin. Later they formed a strong alliance with the second wave of more conservative émigré analysts, fleeing the Nazis, who sought to recreate in America the orthodox and authoritarian institutions they had lost. The tensions between these two camps led to a series of conflicts and schisms (Eisold, 1998) centering on the New York Institute during the war, as a result of which that Institute gradually emerged as the center of a new orthodoxy in the form of ego psychology. The deviants went elsewhere. It was after the war, however, that the tensions erupted into prolonged open conflict, when the “condition” that Freud foresaw in 1918 finally came to pass.

In 1946, William Menninger, former chief psychiatrist of the U.S. Army and newly elected President of the American Psychoanalytic Association, proposed that membership be opened to interested physicians and social scientists and that training programs be established for psychiatrists in psychoanalytic applications of psychotherapy. He argued that the

immense need for psychological help in the post-war population could only be met if some of the resources of psychoanalysis could be bent to this task. Meeting the need required shifting the stress from the “psychoanalyst per se” to the “psychoanalytically oriented psychiatrist” (Hale, 1995, p. 212). Menninger, with his impressive army experience as well as experience in his family’s clinic, was concerned, with the practical issue of meeting a social need. But the Association, swayed by the opposition of Hendricks and Lewin, voted down his proposals, holding to a narrower and more exclusive vision of psychoanalysis as a separate discipline in its own right. Indeed, the American Psychoanalytic Association at that meeting voted to make membership requirements more stringent.

The same year, the Association also approved Rado’s application for a new institute affiliated with Columbia University’s medical school, after having denied it several years earlier. The nucleus of this group, which had formed at the New York Institute at the time Rado was removed as Director of Training (at about the time Horney was stripped of her faculty role), looked for greater academic freedom and opportunities for research which they believed could only be found in a medical school setting, apart from the growing orthodoxy and conservatism of institutes increasingly dominated by the new émigré analysts. This was something of a victory for the liberal psychiatrists. As David Levy put it on the tenth anniversary of the Columbia Institute: its founding was a “protest against authoritarianism in science” (Hale, 1995, p. 218).

Also in 1946, Alexander and French published Psychoanalytic Psychotherapy, the book that became infamous for proposing the “corrective emotional experience.” The outpouring of discussion and debate this produced was clearly less about their specific clinical suggestion than it was about their commitment to psychotherapy and their willingness to consider modifications of standard technique that promised therapeutic gains. The concept of the corrective emotional experience bore the brunt of the attack, but as Stone (1951) put it in his review, the Alexander-French position undermined the very structure of psychoanalysis as “a specific and unique therapy with its distinctive and constant ‘ensemble.’” (p. 218)

Stone’s fear was warranted. In their introductory comments, Alexander and French noted that they had started out attempting “to differentiate sharply between ‘standard’ psychoanalysis and more flexible methods of psychotherapy.” But they concluded: “in every case the same psychodynamic principles are applied for the purposes of therapy. . . . In other words, we are working with the same theories and techniques, the same kit of tools. . . . We therefore regard all of the work set forth in this

book as ‘psychoanalytic’” (Alexander & French, 1946, p. vii). The chief point of the book was what they called “the principle of flexibility,” whereby the psychotherapist sought “to fit the therapy to the patient.”

The book was like a shot fired across the bow of the orthodox establishment, and it was immediately counter-attacked. Jones, Eissler, Knight, Gitelson, Hartmann, Greenacre, Zetzel, Loewenstein, Gill and Rangell, among others, weighed into the battle in addition to Stone. As Wallerstein has commented: “The intensity of the debate stirred up by Alexander’s concept of the corrective emotional experience and the related technical percepts he introduced attest . . . to the depth of the fear that they threatened the very heart of the psychoanalytic enterprise” (1995, p. 55).

That this was not entirely an overreaction is attested to by a report filed by a component institute of the American Psychoanalytic Association in the midst of the debate: “There is unanimous opinion in our group that no sharp demarcation can be drawn. . . . They suggest that all treatment utilizing the basic psychoanalytic psychodynamic concepts in an uncovering insight type of psychotherapy should be considered psychoanalytic therapy” (cited in Rangell, 1954b, p. 736). While this was distinctly a minority point of view within the Association as a whole, it was clear that Alexander was not alone in suggesting that the boundary between psychoanalysis and psychotherapy be dismantled.

Eissler’s (1953) prescription of standard technique, introducing the notion of “parameters,” was the establishment’s more considered response to Alexander’s “flexibility.” The psychoanalytic establishment gradually coalesced around a firm affirmation of correct technique, much as the American Psychoanalytic Association responded to Menninger’s proposals for looser membership boundaries by making them more rigid. The ideological battle was joined.

This is the context in which the debate in America over psychotherapy emerged. The voices of Alexander and others concerned with finding various effective and flexible forms of psychotherapy that addressed a wide array of mental disorders were pitted against the orthodox insistence on correct technique and faithfulness to the legacy of Freud. The American Psychoanalytic Association organized a number of panels on the topic at several consecutive meetings (Zetzel, 1953; English, 1953; Rangell, 1954a; Ludwig, 1954; Chassell, 1955), as did individual institutes (see Wallerstein, 1995, pp. 72-87). Alexander and his allies, of course, lost this battle; and, eventually, even the Columbia Institute gravitated towards the mainstream (Cooper, 1995).

The need for various flexible forms of psychotherapy, however, did not dissipate. Psychiatry could not take the position that non-analyzable patients were beyond help or that those who could not afford analysis did not deserve it. Its professional integrity required it to search out effective treatments. In particular, those psychiatrists connected with residential treatment centers or involved with training residents were under continual pressure to find treatments that worked. On the other hand, the orthodox psychoanalysts, concerned with maintaining the purity of their Freudian heritage, defended it against the deviations that seemed continually to threaten.

Thus the discussion came to have an inevitably tendentious and prescriptive cast. Occasionally, a discussant would note that psychotherapy was not necessarily inferior to psychoanalysis, but usually it was assumed that psychoanalysis was the “pure gold” as opposed to the “dross” or the “copper” of psychotherapy, as Freud’s 1918 metaphor came continually to be misread. Generally it was taken for granted that psychoanalysis was the treatment of choice, but this could not be demonstrated with experimental data. Over thirty years ago, Arlow, noting the repeated warnings he had heard on the Board of Professional Standards of the American Psychoanalytic Association “not to adulterate the pure gold of psychoanalysis with the dross of psychotherapy”, acerbically commented: “In the light of the fact that three or four panels on the program of this Association could not agree on how to distinguish between psychoanalysis and psychotherapy, one can only marvel and envy those who possess so certainly the definitive word on so difficult a topic.” (quoted in Kirsner, 2001, p. 120)

The strain of the conflict permeated the massive study undertaken at Menningers, beginning in 1954 at the height of the debate, reported in Wallerstein’s (1986) Forty-Two Lives in Treatment. The tension between the desire to affirm traditional psychoanalytic methods and distinctions, on the one hand, and the integrity of clinicians and researchers to adapt to the needs of patients and accurately report results, on the other, runs like a leitmotiv through the book. At the end, Wallerstein conscientiously acknowledges the “lesser than expected success of psychoanalytic approaches” (p. 727), and notes: “supportive therapy . . . deserves far more respectful specification in all its forms and variants than has usually been accorded in the psychodynamic literature” (p. 730).

The persistent underlying disadvantage of psychoanalysis in the debate has been that it has not been able consistently to define its aims in a way that differentiates it from the aims of psychotherapy. Continuously bedeviled by theoretical disputes, it could not arrive at agreement. As Rangell put it in 1954, speaking of the work of the Committee on

Evaluation of Psychoanalytic Therapy set up under Menninger's presidency: "In the [five] years of its work since then, it was never able to pass the initial and vexatious point of trying to arrive at some modicum of agreement as to exactly what constitutes psychoanalysis, psychoanalytic psychotherapy, and . . . transitional forms" (Rangell, 1954b, p. 734). The difficulty has not gone away. More recently Gabbard (2001) noted in a special issue of The Psychoanalytic Quarterly devoted to "The Goals of Clinical Psychoanalysis" that there was a disturbing lack of agreement among the contributors, adding: "we had better have some idea of which outcomes are unique to analysis if we are to retain credibility" (p. 188).

Psychotherapy clearly has the upper hand here, with its simple and unambiguous goal of relieving psychological distress. As Schlesinger is reported to have said: "the (external) question that challenges psychoanalytic psychotherapy is, 'Are we getting anywhere?' rather than the (internal) question posed to psychoanalysis, 'Are we getting it right?'" (Wallerstein, 1995, p. 147) Almost certainly he did not mean this as a criticism of psychoanalysis. But his statement does imply that psychoanalysis has been constrained by the rules and prescriptions derived from its theoretical base.

The repetitive and predictable quality of the discussions and debates on this topic over the years suggest strongly that we are in the presence of a "social defense," (Jacques, 1955; Menzies, 1967) an unconscious, collectively elaborated effort to keep anxiety at bay. Persistently and rigidly, the community of mainstream psychoanalysts, split the two entities apart, maintaining "complacent certainties" about a distinction that could not adequately be justified. As Wallerstein suggested, beneath this debate is the fear that psychoanalysis ultimately cannot sustain its privileged differentiation from psychiatry or, in today's world, the larger industry of mental health. One by one, most of those who took up the issue in the past have modified their stance, become more conciliatory, or simply retreated into silence. What Freud feared has come to pass.

Perhaps, now, the only prescription that it is possible to enforce is the rule of frequency, three, four or five times a week. There is virtually no research legitimizing the rules of frequency, and few serious thinkers can be comfortable taking refuge behind the barrier of such an arbitrary seeming regulation. Sensing this, perhaps, our organizations are having difficulty compromising on this point.

## **The Current Scene**

In the post-war years, when the American Psychoanalytic Association rejected Menninger's call to train psychiatrists in psychotherapy, the demand for psychoanalysis was rising. The elitist alternative was a viable option for the profession. But today, most candidates cannot look forward to careers as analysts, that is, with practices of patients who come three, four or five times weekly, and that has profoundly affected the course of the debate.

Hard facts about the decline of psychoanalytic treatments are difficult to come by, but the trend is unmistakable. Informal surveys suggest that most analysts today have between 1 and 2 patients in psychoanalysis; Newell Fischer, former President of the American Psychoanalytic Association, estimates that between 40% and 50% of analysts in the Association have no analytic cases at all (2004, personal communication). According to a task force established by the International Psychoanalytic Association, candidates no longer seek training in the numbers or with the competitive avidity of the past (RHDC, 1995); in 2001, 65 candidates entered training in the institutes of the American Psychoanalytic Association, down from an average of 116 the previous 3 years (Fischer, 2002a), and way down from previous years. Professional organizations face aging members and fewer applicants (Fischer, 2002a).

Today, departments of psychiatry in medical schools turn out few psychiatrists interested in pursuing the arduous additional training psychoanalytic careers require. Professorships and department chairs, once almost uniformly filled by psychoanalysts at the most prestigious medical schools, are now more often occupied by its critics. In psychology, an increasingly small percentage of graduate programs teach psychoanalytic theories to aspiring psychologists, and few graduate students identify themselves as having a psychoanalytic orientation (Norcross, Karg, & Prochaska, 1997). As Bornstein recently put it: "Psychoanalysis is now on the fringe of scientific psychology, accepted by few and ignored by many" (2001, p. 5).

Many psychotherapists, meanwhile, more securely established in our culture, increasingly disparage psychoanalysis. A recent marketing survey initiated by The American Psychoanalytic Association found that groups composed of mental health professionals -- psychiatrists, psychologists and social workers -- associated "psychoanalysis" to words like "rigid," "restrictive," "time consuming," "expensive." Psychoanalysts were seen as "passive," "intellectualized," "uninvolved." Other associations to psychoanalysis were "cult-like," "secretive," "authoritarian," "esoteric." But the most disturbing feature of these

reports was that no one was inclined to recommend it (Zacharias, 2002; Fischer, 2002b).

But though the numbers of candidates are decreasing, many still do come for training, partly because psychoanalytic training continues to be immensely useful to a dynamically oriented therapist, partly because of the continuing prestige of psychoanalysis in some quarters of the mental health industry, and partly because of the lure of the old careers, now curtailed but not entirely gone by any means. Moreover, besides these practical motivations, psychoanalysis retains an intellectual excitement and a spirit of discovery that it lacking in more contemporary “cook book” approaches to psychotherapy. Creative minds are drawn to the opportunities it provides for complex, layered and challenging thinking.

But psychoanalytic institutions, by and large, have not been set up to adapt and change. On the contrary, they are largely closed systems, focused inwardly on maintaining standards, conveying established theories and practices, and thus duplicating themselves. In a period of expansion, they are able to become more exclusive. The hierarchy that ensures control has an easier time recruiting enthusiastic acolytes, maintaining conformity, and guaranteeing its own power. These tendencies in the psychoanalytic training system have been repeatedly commented upon over the years, to little effect (see, for example, Balint, 1948, 1954; Rickman, 1951; Bibring, 1954; Thompson, 1958; Greenacre, 1966; Arlow, 1972; Orgel, 1978, 1990; Kernberg, 1986, 1996).

In the past, the idealization and awe, if not fear, inspired in candidates by their training and supervising analysts, pervaded the governing structures of our institutes as well as social relations around them. Decisions about promotions were often made secretly and without explicit criteria. The senior members of institutes were invested with an aura of generalized competence and wisdom and entrusted with ethical, administrative, and financial responsibilities, often beyond their specific competencies as analysts. The other side of this idealization and presumption of wisdom, psychoanalysts know only too well, is covert hostility and contempt. These tensions have contributed significantly to the rigidity of institutes and their susceptibility to schism (Eisold, 1994), as is the case in any authoritarian system. Nonetheless, training institutes have been able to function because, until recently, there has been enough work for everyone. Those who did not make it to the top still enjoyed significant prestige as well as access to substantial analytic practices.

In the emerging new hierarchy, however, fewer and fewer actually practice long-term psychoanalysis characterized by frequent sessions.

Those managing the training system can hope to analyze candidates in training; the rest will be practicing primarily psychotherapy. Thus the continuing debate about psychotherapy is now about the actual careers that are available to the vast majority of current candidates, the more and less privileged forms of work they can hope for. But everyone is affected by the tensions and strains of these changes: the candidates, the senior faculty, and the administration of institutes and professional associations.

Perhaps the most remarkable fact in the face of this situation is how infrequently it is acknowledged and what little effort is made to adapt the training of candidates to this changing reality. There is little attention paid in training to the problems of shorter or less frequent treatments or adapting standard analytic concepts or techniques to the conditions under which graduates will actually work.

Some institutes have taken the step of setting up separate psychotherapy training programs. This has the advantage of recruiting from a wider pool, appealing to those potential applicants seeking more training but currently ineligible for it or unwilling to make the commitment to full analytic training while side-stepping the objections of current candidates and recent graduates to having their own training “diluted” or “compromised.” These programs are often being justified on the additional grounds that they may attract students who will want to go on for full analytic training. But it remains to be seen if the institutes taking this step will succeed in convincing applicants that their psychotherapy programs are serious good-faith efforts, on a par with their analytic programs, or if the institutes themselves will be able to keep up the necessary level of commitment to both kinds of programs for them to succeed without generating excessive internal tension and conflict.

Even if this strategy works, it still leaves analytic candidates without help in preparing for their psychotherapeutic careers. In a recent chapter on once weekly psychotherapy, Coles (2001) speculates that “there may be therapists, like myself, whose thinking has been muddled by ignorance and prejudice,” believing “that more intensive work was more effective . . . and therefore to become a respected therapist I had to show that I was working with most patients at least three times a week.” (2001, pp 50-51) Noting a number of differences stemming from frequency that she has become aware of over the years of her practice, she has argued cogently: “it is not enough to assume that once-a-week work can be done if one has lain on the couch for four or five times a week. It demeans the once-a-week patient and diminishes the therapist” (p. 61).

On the other hand, candidates themselves are often conservative on this issue, if not silent, fearing the dilution of their training or the lessening of their status. Supplementing psychoanalytic training with attention to psychotherapy can seem to undermine the historic promise of psychoanalytic careers. Similarly, the temptation institutes face of opening training to candidates of lesser status in the mental health professions threatens current candidates with the loss of the status they have worked hard to win.

A second set of problems affects senior faculty. Institutes, once pathways to prestigious and lucrative careers, have less to offer those upon whose labor they rely for teaching and management. Increasingly, senior faculty shy away from assuming responsibility and some even avoid the tasks of analyzing and supervising candidates because of the lower fees they are often required to charge. Far more troubling, under these conditions, it is becoming more and more difficult to induce senior members to take on the increasingly onerous burdens of leadership (Dick Fox, personal communication, 2004).

From the perspective of the younger generation, the seniors are vulnerable to the charge of having failed in their guardianship of the profession, a charge that sometimes takes the form of a grudging recognition of their less vulnerable position. The senior analysts for their part often note that candidates are “not what they used to be.” Moreover, training and supervising analysts are reluctant to change the system by adapting to the social and demographic changes that are occurring because that would lay them open to the charge of further undermining the profession of which they are guardians. It is not difficult to see how this situation contributes to a pervasive sense of demoralization as each side, refraining from blaming the other but stalemated in talking about the limited options they face, can feel increasingly disengaged.

As a result, fewer graduates appear to seek the forms of higher certification that professional organizations offer, and some institutes are beginning to question the value of continuing to implement them. In addition, there is a leakage of membership from our graduate societies and professional organizations. Our institutional leaders, often preoccupied with the effort of putting out local fires, which frequently derive from these underlying tensions, as well as the immediate survival issues of recruitment and fund raising, are also hampered by a lack of experience in managing such complex, tension-ridden enterprises. In the days when institutes could simply continue on in traditional ways, the minimal skills required to manage them were relatively easy to absorb. But the problems facing institutes and professional associations today

require a sophistication about groups and systems that traditional psychoanalytic training does not provide.

One positive outcome of this situation is that, increasingly, institutes have sought consultation to cope with their difficulties, bringing in outsiders with more knowledge about management as well as greater detachment from the specific issues affecting particular institutes. (see Maccoby, 2004.) Paralleling the role of the analyst with an analysand, consultants can offer not only insights and observations to clarify disputed issues, but also help to create a reflective space allowing institutes to step back from their own internal conflicts.

Meanwhile, there are serious issues about psychotherapy in need of clarification. The impossibility of establishing a clear and firm boundary between psychoanalysis and psychotherapy does not mean that there are no differences in the effects of various techniques and strategies, or variations to consider with particular patients or under different circumstances. Clearly, different frequencies of treatment have different effects, on the therapist as well as on the patient, and different mental disorders may ideally benefit from differences in intensity. The use of the couch has received only impressionistic commentary, while the question of strict adherence to the analytic frame, though arousing much discussion and controversy, needs far more systematic study than it has received. It has been discussed to be sure, and certainly many practitioners have learned a great deal about how to vary these factors in their work, but a climate of ideological conflict has made it difficult to approach these issues in a dispassionate manner.

This goes for the “intrinsic” issues as well: the focus on transference, regression, free association, abstinence, and so forth. So many traditional concepts are so linked to specific theories that they are difficult to operationalize; indeed, it has seemed at times that, as theoretical winds shift, certain clinical phenomena disappear from view. Clearly, it would be useful to try to delineate such concepts more sharply and to study when and where they are useful. Indeed, it might even be possible to understand them better if they could be discussed free from the preoccupation of which technique belongs to which modality.

### **The Situation Elsewhere**

This discussion has focused on the situation in the United States, but the relevance of these issues is worldwide. Different political, cultural and historical situations have produced wide variations in the institutional

life of psychoanalysis, and yet these issues have affected our institutes and professional organizations to some degree everywhere.

As psychiatrist-psychoanalysts throughout the world brought psychoanalysis into their psychotherapeutic practices, they often felt the strain between their psychoanalytic identities, based on the rules and the codes of their psychoanalytic professional associations, and their medical identities, based on their ties to their medical associations, their patients, and the various organizations representing patients. Moreover, hospitals and clinics, insurance companies, and government agencies, when involved, tend to insist on treatments that are demonstrably effective, that relieve suffering, regardless of how pure or venerable the methods used in achieving that goal may be. Psychoanalysts and psychotherapist not medically trained will feel this differently, but the underlying tension is still there so long as psychoanalysis and psychotherapy are viewed as medical procedures, aimed at treating mental illness.

In Germany, for example, where psychoanalysis has enjoyed an unprecedented degree of official recognition since 1967, when coverage for psychoanalysis was first included in health insurance plans, state control over the provision of psychotherapy benefits has gradually led to an erosion of the status and security of psychoanalysis as an autonomous profession. At first, other forms of psychotherapy, such as behavioral treatments, were included in the plans. Then, in 1991, undermining a long standing compromise, patients were restricted in applying their benefits to four-times-weekly treatments, because the benefits of such frequency lacked empirical evidence. Danckwardt and Gattig (1998) noted: “health care systems regulated by the state tend to stabilize and ossify in rigid systems of regulation. Ideological distortions have again and again imposed an additional burden on the necessary debate between the parties.” Bell (2001) concluded, more harshly, that today: “the standard psychoanalytic procedure is not possible in the health service context. Only psychoanalytic psychotherapy is possible” (p. 14)

This situation has exacerbated long simmering tensions between the DPV (Deutsche Psychoanalytische Vereinigung) which is recognized by the IPA, and therefore obliged to hold to its four-times-weekly standard, and the DPG (Deutsche Psychoanalytische Gesellschaft), not recognized by the IPA, and which has held to a lesser frequency, more in line with the new regulations (Cremerius, 1999). But, perhaps more important, according to Cremerius: additional new “quasi-state training regulations define the training institute’s curricula – including those of the DPV. The DPV institutes have to offer the following contents in training, though the IPA states they are ‘foreign to analysis’. . . . the psychology of learning, group and family psycho-dynamics, theory and methods for short courses of

therapy, psychotherapy, behavioral therapy, group psychotherapy and Balint groups, as well as psychological testing” (1999, p. 26).

Psychoanalytic training institutes have the option of rejecting such regulations, of course, and operating outside the established health care system. But that puts them at a disadvantage with patients who have come to expect or who may need to use their insurance benefits, and it increasingly puts their graduates at risk of lacking the competitive advantage of training in the range of psychotherapeutic modalities that other practitioners will have. The longer range risk is that those providing treatments lacking evidence of efficacy will lose their state licenses. Kutter put it mildly when he wrote: “it was overlooked that the psychotherapy agreements gave the medical authorities influence on the psychoanalytical process; for example on its frequency and duration” (1992, p. 121). Korner’s view is more dire: “To the extent that we can foresee the future today, incorporation into the German Act on Psychotherapy and the regulations for specialist doctors will lead to the profession of the psychoanalyst disappearing as a professional title” (1999, p. 101).

There are other effects of this primary orientation to health care in Germany. Kurzweil (1989) noted that, “therapy appears to have gained momentum at the expense of research” (p. 215). More recently, Kachele and Richter (1999) have agreed: “the development of psychoanalysis has been largely hampered by the situation in the psychoanalytic institutes” which have failed “to maintain the inseparable bond between therapy and research” (p. 59). Here as elsewhere, the pressure of clinical service tends to absorb resources.

Within institutes, the political and social orientation of psychoanalysis has been neglected as well, a situation that has elicited more comment and controversy in Germany perhaps than elsewhere, given the fact that memories of collaboration and the holocaust are so pervasive and, indeed, so implicated in the institutional revival of psychoanalysis in the post war era (see Goggin & Goggin, 2001). “The ‘social critics’ would like to apply the lever of psychoanalysis to society, whereas the ‘therapists’ see the challenge of their work primarily in the analysis of the psyche of the individual” (Kutter, 1992, p. 124). But in this divide, the therapists clearly have the upper hand. As a result of this trend, no doubt, the German membership in the IPA has grown to the point where it is second only to that of the United States. Research and social applications, on the other hand, have been conducted largely outside psychoanalytic institutes.

The official recognition of psychoanalysis in Germany in 1967 was a major achievement, a milestone of acceptance. But it does seem, in retrospect, that this began a process that contributes to the present beleaguered stance of psychoanalysis as a separate discipline. From the medical point of view, no doubt, psychotherapy has been enriched by its connection with psychoanalysis, and many if not most clinical psychoanalysts have profited from their roles as psychotherapists under the health care system. Moreover, it is at least arguable that the population has benefited from the diversification of mental health services that have become available.

But traditional psychoanalysis is on the defensive. The German experience illustrates that if psychoanalysis is primarily a treatment for disorders of mental health – in Freud’s terms, a “handmaiden of psychiatry” – it will inevitably be subject to the expectations, standards and controls that increasingly govern medicine. Kurzweil has put it somewhat more ominously, no doubt mindful of the loss of the critical spirit that can also be a feature of this ambiguous success: “the reimbursement policies mandated by the German government have been functioning as a benign big brother” (p. 313).

In England, the links between psychoanalysis and psychiatry have not proven so decisive. Though Jones worked hard to retain psychoanalysis as a medical specialty in the 20’s and 30’s, opposing Freud’s position on lay analysis as much as his loyalty allowed, in the post-World War Two era that issue subsided. The British Psychoanalytical Society did not seek to play a role as a provider of mental health services to meet an expanding need. As in the American mainstream, it maintained a distinctly elitist position. Indeed, throughout the wartime “Controversial Discussions”, both sides insisted on the disinterested “scientific” nature of psychoanalysis, its value as a method in the search for truth rather than as a treatment for neuroses (King and Steiner, 1991).

The role of applying psychoanalysis to a larger social need largely fell to the Tavistock Institute, viewed by Jones and Glover as the “poor relation” of the British Society (Rayner, 1991, p. 267). Many psychiatrist-analysts, returning from their wartime experience, found there an institution eager to apply their new ideas to the burgeoning social need for psychotherapy, group and marital psychotherapy, as well as other applications of psychodynamic thinking. The Tavistock Institute joined the National Health Service; the British Society did not. There the divide was institutionalized, though increasingly analysts could move back and forth between the two institutions (see King & Holder, 1992).

Other institutions responded to the need to provide various forms of psychotherapy and relevant training programs: The Cassel Hospital, The Portman Clinic, The British Association of Psychotherapists (founded in 1951), The London Centre for Psychotherapy, The Lincoln Institute, and others. The British Psychoanalytical Society was thus freed from pressure to modify its position outside the NHS and respond to this social need; it could maintain its single-minded commitment to classical psychoanalysis. Many of the newer programs and services sought out its graduates to staff its programs and to supervise its trainees. Some of them, in fact, require that their trainees be supervised only by “psychoanalysts,” meaning graduates of the British Society as no one else in the UK is entitled to call him or herself a “psychoanalyst.”

Thus a society-wide caste system has emerged in Great Britain with many obvious as well as subtle effects. Among the more obvious consequences of this system is that training to become a “psychoanalyst” is simply unavailable outside London. Those in Scotland, for example, who train at the Scottish Institute for Human Relations have no choice but to accept the lesser designation of “psychotherapist.” Experienced and competent as they may be, their lack of access to properly trained “psychoanalysts” and analytic supervisors ensures their lesser status. Moreover, those who train at the various psychotherapy courses available in London requiring supervision by “psychoanalysts” could not until recently aspire to become supervisors at their own institutions; those positions most often are still occupied by outsiders, a form of professional colonialism that appears to have effects on graduates who tend to feel second class.

Another effect: the British Society, as a result of its status, has little incentive to modify its programs or procedures. Thus it can hold to the “strictest” five-times-weekly standards, despite the difficulty it experiences in finding cases for candidates; and it can be equally strict in its demands upon and responses to candidates, though the pool of applicants is diminishing. While high standards do have some marketing appeal, it remains to be seen if it will provide immunity from the world-wide decline in the numbers of psychoanalytic candidates, patients, and training cases (see RHDC, 1995).

One of the more subtle effects of this system is a pervasive sense of inadequacy among those who have the “lesser” trainings. Coles (2001), for example, cited above, was speaking of her experience as a graduate of the Lincoln Institute in London. Though she wrote of being “muddled by ignorance and prejudice,” appearing to blame herself for her confusion and sense of inadequacy, it is clear she is a product of the system that trained her. The idea that to “become a respected therapist” she had to

show that she “was working with most patients at least three times a week” clearly derived from the caste system she was embedded in.

It may well be that, in England, the strength of the social class system makes such distinctions easier to accept. Working under foreign masters, subject to external rules, tends to make one a harsh judge of oneself and others, if not, alternatively, rebellious. There are a number of other training programs in the UK spread throughout the country, however, developed by a Joint Committee of Higher Psychiatric Training, programs that have a strong if not exclusive psychoanalytic influence. Since as Pines (1999) has observed, “very few analysts could be persuaded to leave London to work in the provinces” (pp. 19-20), such programs may be freer from self-deprecating tendencies.

Identifying with the aggressor is by no means a purely English trait. Outside the UK, those who have had psychotherapy training apart from the training systems of psychoanalysis may not suffer as intensely from a sense of inferiority. They may feel that psychoanalytic training is valuable and useful, perhaps even superior, but if they have not been identified with the “dross” of psychotherapy, they need not judge themselves for not being better than they are.

Meanwhile, in England, increasing government involvement in the provision of psychotherapeutic services appears to be intensifying this divide: “Psychotherapists are now having to audit their work and attempt to show they are efficient in their administration and efficacious in their work.” According to Pines, “The Tavistock Clinic is leading the way in setting up comprehensive audit programmes within all its departments” (1999, p. 24). Such audits will not only increasingly satisfy the government and consumers but can also help therapists assess the benefits of their work. Psychoanalysis, so far, stands apart from this development, though recent efforts by the government to regulate the use of the term “psychoanalyst” may force greater involvement (Casement, 2004).

In retrospect, comparing developments in Germany and the UK suggests that neither pathway solves the problem of psychotherapy for psychoanalysis. Becoming part of the health system, as in Germany, leads to increasing governmental regulation and interference, compromising the ability of the psychoanalytic profession to set its own standards. On the other hand, maintaining a more elite apartness, as in the UK, does not prevent the increasing marginalization of psychoanalysis, while it also produces its own pervasive discontents. These results are far from conclusive, but they suggest that there is no

easy escape from the dilemmas of the uneasy relationship between psychoanalysis and psychotherapy.

### **The Future of Dynamic Psychotherapy**

For psychoanalysis, psychotherapy has come to appear as the powerful threat that could absorb and annihilate its distinctive features. But even if psychoanalysis could disentangle itself from the professional project that has embedded it in the specific concerns of mental health, psychotherapy will continue to turn to it for insight and guidance. Conversely, psychoanalysis will need psychotherapy, for sure, as it will be hard to imagine it without patients and without treatments for mental disorders.

For that reason alone, psychoanalysts will inevitably become more alarmed over the precarious future of dynamic psychotherapy. There are many reasons for this threat: An increasingly competitive culture that places a premium on immediate results, the development of other, simpler approaches, and a spiraling crisis in health care cost that have brought about the draconian remedies of managed care.

These profound pressures have already moved dynamic psychiatry to a crisis point. As Luhrmann, a medical anthropologist, has observed in her recent study of psychiatry in the United States: “Faced with the fear that psychiatric care would not be reimbursed, many psychiatrists, psychiatric lobbies, and patient lobbies . . . have argued that psychiatric illness is a medical disease like any other any other and deserves equal coverage or ‘parity.’” But, she adds, “as the debate continues, it encourages psychiatrists and nonpsychiatrists to simplify the murky complexity of psychiatric illness into a disease caused by simple biological dysfunction and best treated by simple pharmacological interventions” (Luhrmann, 2000, p. 250).

This trend is more advanced in treatments for the more seriously disturbed. Speaking of hospital residents in psychiatry, she notes, “the more time they spend on the phone with insurance agents negotiating for a six-day admissions to be extended to a nine-day because a patient is still suicidal, the more admissions interviews they need to do, the more discharge summaries they need to type, the less the ways of thought and experience of psychodynamic psychiatry fit it, the less they seem relevant or even real, and the more psychiatrists are willing to fall back on the ideological position that the cause and treatment of mental illness is biological and psychopharmacological.” As she summarizes: “it is not just managed care but managed care in the context of ideological tension that is turning psychodynamic psychiatry into a ghost.” (2000, p. 238)

These developments help to account for the decline in psychodynamically oriented residency programs as well as the recent struggles and relocation of the Menninger Clinic and the closing of Chestnut Lodge. This is all the more unfortunate as it is just at this moment that a new vision of an integrated psychiatric treatment is emerging. As Gabbard has put it: “There is irony in the polarization of psychiatry into a biological and psychodynamic approach because we now stand on the threshold of embracing a sophisticated understanding of the interaction between the brain and the environment that can lead to truly integrative treatment strategies” (2000, p. 16)

Training in psychology is undergoing a similar decline of interest in psychoanalytic and psychodynamic ways of thinking. As Bornstein (2001) recently noted: “Treatment approaches that do not conform to today’s emphasis on biochemical and time-limited cognitive-behavioral interventions are no longer valued in most graduate training programs” (p. 16). In 2000, only 4% of APA-approved graduate programs emphasized psychoanalysis, reflecting a steady decline, while 21% were behavioral, and 76% cognitive-behavioral (APA, 2000).

More immediately, most practitioners in the United States notice that in their private practices managed care has put increasing obstacles in the way of patient benefits, encouraging psychopharmacological interventions and behavioral treatments, subtly inducing doubt in patients about the value of the long term talking treatments no longer underwritten. Many of us may not realize how widespread this trend is – or how dangerous to the future of psychodynamic treatments. The downward trend in reimbursements means, as well, that increasingly those less well trained are moving into psychotherapeutic roles, a trend exacerbated by the increasing tendency of analysts to refuse to participate in managed care. An interesting recent development is towards the licensing of “Psychoanalysts” in the U.S., a category aimed to cover “lay analysts,” those who are not already licensed providers of mental health services such as psychiatrists, psychologists and social workers. It is too early to know how this trend will play out, and it is likely to be somewhat different in each state; but there is the danger – and the irony – that newly licensed “psychoanalysts” could be held to a lesser standard (see Appel, 2004).

In the long run, it seems implausible to think that dynamic psychotherapy, including psychoanalysis, will be extinguished. Certainly in the large cities where it has been well established, the profession, battered as it is, carries a great deal of internal conviction, a conviction shared by large numbers of patients who have directly experienced the

help it can provide. The accumulated weight of anecdotal evidence is formidable.

But the kinds of statistical evidence that carries weight in hospitals and academic settings, that impresses insurance companies and government agencies, is still sadly lacking. There is some evidence of our effectiveness, to be sure, but a strong case for the positive outcomes for our brands of dynamic psychotherapy cannot now be made. As Cooper warned some years ago: “Even if we do not feel impelled by our scientific and theoretical curiosity, we might respond to the demands of a society that will not forever allow us to practice clinical psychoanalysis without evidence of its efficacy” (1984, p. 259).

It seems unlikely that the learning that has grown out of the clinical experience of psychoanalysts over the years could disappear entirely, but it may be that psychoanalysis as a distinct profession will become increasingly marginal. What it has discovered to be of enduring value might well survive, absorbed into the practice of psychotherapy; the rest could fade away. But it would be ironic if our response to the “condition” Freud foresaw at the end of World War One leads us into further internal strife and immobility.

The opportunity to develop and test the alloys of psychoanalysis may slip away.

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