THE PRACTICE OF PSYCHOANALYSIS:
A SPECIALTY OF CLINICAL SOCIAL WORK

A Position Statement of
The American Board of Examiners in Clinical Social Work

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Executive Summary

The American Board of Examiners in Clinical Social Work has published a position statement that is intended to be definitive and comprehensive in its treatment of Psychoanalysis as a specialty within the overall practice of Clinical Social Work. With more than 180,000 practitioners in virtually every city and county of every state, clinical social workers make up the nation's largest group of providers of mental-emotional healthcare services.

The statement offers a new interpretation of what constitutes the advanced practice of psychoanalysis in the clinical social work profession. In highly detailed groupings of professional knowledge and skills, it identifies the specific characteristics of practice by which a clinical social worker psychoanalyst may be recognized for competence.

These characteristics (summarized in section V of the statement), and other relevant considerations addressed in the statement, serve as the source material for a new credential in the specialized practice of Psychoanalysis, in conjunction with the general-practice certification of Board Certified Diplomate in Clinical Social Work.

The statement also addresses the pertinent psychoanalytic literature in the following areas:
- its salient features as a method of treatment,
- its history and contemporary standing, and
- its nature as a specialty of clinical social work
- principles of intervention
- research
- cultural competencies
- major theories of psychoanalysis
- issues affecting the analyst and analysands.

In an effort to be as accurate and inclusive as possible, the statement's authors submitted it in various drafts to leading practitioners and academics, who responded in detail. Many of their comments were incorporated into the final version, which is fully annotated as to sources and references, and is intended to meet high levels of scholarly and empirical scrutiny. A bibliography is included.

Purpose of Psychoanalysis

In clinical social work, psychoanalysis is conducted by an experienced and skilled clinical social worker who treats those experiencing disturbances in affect, thought, and behavior. Analysts draw on a well-defined knowledge base derived from research, theoretical constructs, applied practice methodologies, and a highly developed set of specialized practice skills and activities.

Nature of Psychoanalysis

Psychoanalysis is defined as the psychotherapeutic application, by trained analysts, of psychoanalytic theory in order to ameliorate disorders that interfere with the analysand's satisfactory functioning. It is conducted with frequency and intensity, and seeks to bring unconscious mental elements and processes into the analysand's awareness, where they may be explored and understood.

Generally, psychoanalysis is conducted with the analysand lying on a couch and talking to an analyst who is out of the analysand's line of sight. The unconscious material that has been brought into awareness is addressed by the analyst and analysand through various techniques, including exploration, clarification, confrontation, and interpretation.

Approaches to Psychoanalysis

Although once informed by a unifying theory in the work of Sigmund Freud, psychoanalysis has evolved over the years and now has many models and encompasses a wide variety of theoretical approaches. Section IV of the position statement identifies the organizing principles of the four paradigms that dominate psychoanalytic theory: Drive Theory, Object Relations Theory, Ego Psychology, and Self Psychology. Theories of human motivation, the nature of anxiety, and the causes of psychopathology, are considered, as are Jungian, Kleinian, and Lacanian schools.

As practiced by a clinical social worker psychoanalyst, the different models all have a core set of principles (developed by social work schools and organizations and by regulatory bodies) for the analyst to follow: ethical and legal practice; a commitment to advocate for improved human services programs and social policy; respect for culture and diversity; and recognition of the analysand's rights to privacy, confidentiality, informed choice, and self-determination,

Psychoanalysis as a Specialty of Advanced Clinical Social Work

In clinical social work, psychoanalysis is a specialty area of practice that is pursued through advanced training, years of experience, and mastery of a range of competencies (identified in detail in the position statement). The clinical social worker's training and education begin in master's program at a school of social work, and continue for at least two years of post-graduate entry-level practice under clinical supervision. During these years, the neophyte practitioner absorbs the theory and methodology of clinical social work, and applies it to the treatment of clients. After this, clinical social workers may engage in autonomous practice; however, if they choose to specialize in psychoanalysis, they will re-enter a period of rigorous training and education which will last for a number of years. In most instances, this process is undertaken through a psychoanalytic institute. It is intended to produce deep, detailed expertise in psychoanalytic processes and their emotional, psychological, cognitive, and behavioral aspects.

Once established as a psychoanalyst at the advanced level, the practitioner will continue to receive supervision or consultation and will keep learning through continuing education or certificate programs, reading current literature, attending professional conferences, and self-observation and reflection on interactions and their outcomes. The advanced practitioner will apply evidence-based best practices when possible, and will practice legally and ethically. Ethical practice, among many other things, requires that the practitioner who chooses to use psychoanalysis has a high degree of expertise in psychoanalytic theory and practice, without which he/she should refer interested clients to clinical social worker psychoanalysts who do have such expertise.

Competencies of the Advanced Clinical Supervisor

A proficient psychoanalyst should be practicing at an advanced level of competency. The analyst understands theoretical concepts and how to apply them flexibly to practice, and has practice wisdom gained from years of experience in this field. The analyst monitors his/her own direct practice, pursues professional development, and knows when to seek consultation and/or supervision. The analyst may also serve as mentor or consultant to colleagues, and may model and teach what is needed for practice. In determining the competence of the analyst, nothing is more telling than the level of competency in professional knowledge and practice skills, which can be measured by detailed characteristics of practice (listed in detail in position statement) as they are related to the following terms:

- **Assessment and Diagnosis**

- **Treatment Considerations**

- **Intervention**

- **Outcome Evaluation**

- **Supervision, Consultation, Training, and Writing.**

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Introduction

This paper was produced by the American Board of Examiners in Clinical Social Work (ABE), a certifying organization for the field of clinical social work. ABE's mission is to conduct national certification at the advanced level and to set uniform advanced practice standards.

As a position statement on the advanced practice of psychoanalysis by clinical social workers, this paper seeks to be comprehensive and definitive in describing the main characteristics of clinical social work practice of psychoanalysis, and in identifying various approaches used by clinical social workers in this specialty. It was developed because there is no such document that aspires to describe and identify the characteristics and approaches of this important area of practice. The American Board of Examiners, as a standard-setting organization representing advanced clinical social work, is committed to identifying the characteristics of advanced practice in various specialty areas. Beyond its function as a position statement, the paper will serve as a source for developing standards for an ABE certification to be offered to advanced practitioners in the specialty area of psychoanalysis.

I. Background of Clinical Social Work Psychoanalysis

A. Rationale as a Practice Specialty

Psychoanalysis is an effective method of treatment for those who experience disturbances in affect, thought, and behavior. The clinical social worker psychoanalyst masters a specific knowledge-base and applies a highly developed set of specialized practice skills and activities through which the analysand (client/patient) and analyst work together toward helping the analysand (see section V., The Summaries: Professional Competencies of the Clinical Social Worker Psychoanalyst).

The knowledge base for this specialty is derived from theoretical constructs, applied practice methodologies, and findings from supervised practice and other areas that have been the subjects of research. Mastery of the knowledge base and treatment skills for the competent practice of psychoanalysis is achieved through a rigorous, extended program of study and training. While psychoanalytic theory and certain psychoanalytic treatment methods have informed other types of clinical social work practice, psychoanalysis remains distinct as a treatment method. Its unique process and capabilities are neither replaced by nor interchangeable with any other method.

A competent analyst is the product of rigorous training and education. The hallmark of the competent analyst is a deep, detailed expertise in psychoanalytic processes and their emotional, psychological, cognitive, and behavioral characteristics. The non-specialist, who may have a general understanding of psychoanalytic processes, cannot practice psychoanalysis ethically and effectively. With regard to techniques and treatment methods, specialists are distinguished by the extensive experience and high levels of practice proficiency that enable them to apply specific psychoanalytic techniques adeptly and to consider many alternatives before emphasizing certain aspects of intervention as being in the best interests of the analysand.

The practice of psychoanalysis is mastered only at the post-graduate level, primarily through the training programs of psychoanalytic institutes. Education and training with a less formal curriculum are found at some university-based graduate schools of social work, and in workshops and seminars. The three pillars of analytic institute training are the following: personal analysis of the candidate, didactic curriculum (including theory, development, psychological health, psychopathology, and technique), and supervised clinical work (The Psychoanalytic Consortium, 2002).

Clinical social workers must practice within the limits of their competence and must be well-informed about the knowledge-base and about the diagnostic and treatment approaches they employ. This form of practice requires that clinicians have a high degree of expertise in psychoanalytic theory and practice. Lacking this, they should refer interested clients to clinical social worker psychoanalysts who do have such expertise.

B. Brief History of Clinical Social Work Psychoanalysis

Today, as in the past, many advanced clinical social workers—not only those who specialize in psychoanalysis—draw on psychoanalytic theory in their efforts to understand human motivation and behavior and to practice effectively.

In 1918, the first psychoanalytically oriented school of social work, Smith College School for Social Work, was founded to teach students about Sigmund Freud's ideas and their application to practice, particularly in the treatment of WWI veterans' "war neuroses." Freud's appeal was great for many reasons, but greatest for his discovery of how best to conduct the helping process itself: by listening, by honoring the client's self-expression, and by doing something <u>with</u> rather than <u>to</u> the client. These attitudes were revolutionary at a time when clinicians typically sought to advise, persuade, and even coerce their clients (Alexander & Selesnick, 1966). In these and other ways, psychoanalysis, formerly seen as the province of psychiatrists, made such a profound impact on social work that many practitioners were recognized by the title Psychiatric Social Worker (note: the term "psychiatric social worker" was supplanted in the 1970s by the term "clinical social worker," since clinical social work is now practiced in a broad array of settings).

In the 1940s and 1950s, several events occurred that were important to the development of social work and psychoanalysis. Social work schools incorporated psychoanalytic ideas into their curricula, based on the influence of the published work of psychoanalytic social workers. Psychiatric social workers treated a wide array of clients, including those in hitherto-neglected settings like family agencies and child-guidance clinics (Feldman, 1982; Garrett, 1949, 1972; Hamilton, 1947, 1954; Hollis 1939, 1958). Psychoanalytic training and certification programs arose in major cities throughout the United States but generally excluded psychiatric social workers and other members of non-medical disciplines. While some individual social workers were able to provide non-certified psychoanalytic services, the institutes' discriminatory policies generally prevented clinical social workers from achieving recognition for the practice of psychoanalysis.

Informally, a few psychoanalysts did provide training and supervision to social workers; and in 1948 social workers were first accepted at the psychoanalytic institutes of the National Psychological Association for Psychoanalysis, and the Postgraduate Center for Mental Health, both in New York. Other doors began to open and, by 1964 in New York City alone, thirty such institutes accepted clinical social workers (Wallerstein, 1996). Organizations such as the American Psychoanalytic Association gradually dropped their prohibitions against admitting social workers.

In 1980, in New York, the first organization for clinical social worker psychoanalysts was founded. It subsequently became a national organization and is known today as the National Membership Committee on Psychoanalysis, affiliated with the Clinical Social Work Federation, Inc. The Committee participates in The Psychoanalytic

Consortium with the American Academy of Psychoanalysis, the American Psychoanalytic Association, and the American Psychological Association's Division on Psychoanalysis (Division 39). Clinical social workers have been accepted since 1988 as members of the American Psychoanalytic Association, and are also accepted in its Fellowship Program and in many institutes affiliated with that Association. Nationwide, clinical social workers constitute a large number of students in many institutes (Perlman, 1995); and they serve as presidents, deans, faculty, and curriculum chairs.

C. Contemporary Context of Clinical Social Work Psychoanalysis

1. Practice Issues

Clinical social worker psychoanalysts now form a relatively large part of the U.S. psychoanalytic community. Employing a bio-psycho-social approach to mental-emotional healthcare, these practitioners integrate their work as both clinical social workers and psychoanalysts, and consult with clinical social workers in other practice areas to benefit from their insights and to share psychoanalytic knowledge that can help their clients.

Today, clinical social worker psychoanalysts still apply many of Sigmund Freud's concepts, such as respectful listening, the importance of the unconscious and the irrational, transference and counter-transference, the repetition compulsion, normal and pathological mourning, masochism and sadism, the processes of identification, and defense mechanisms. At the same time, these analysts make use of more recent psychoanalytically based discoveries about the processes of development, especially pre-oedipal and female development. Recently, the domain of psychoanalysis has been greatly enriched by the findings of infant research, neurology, and gender studies (Richards & Tyson, 1996).

Analysts' involvement in the mainstream of modern practice has led them to grapple with managed care systems and with other challenges, including the need to incorporate into treatment the new findings about biological aspects of bipolar disorders, major depression, panic disorders, and obsessive-compulsive disorders, in which medication may be required as an adjunct treatment. Clinical social worker psychoanalysts have long been aware that physical illness and physical handicaps have an impact on emotional and personality development. In recent years, they have better understood the influence of organic and environmental factors on brain development and brain function. Peri- and post-natal influences, temperamental differences, genetic and heritable factors, cognitive and emotional deficits—each contributes to the maturing infant's interaction with the environment, and the environment responds differentially to the infant's needs. Analysts demonstrate a basic understanding of the effects of diet and environmental toxins on children's development. They possess an awareness of the limitations imposed by a variety of physical, cognitive, and emotional handicaps.

Financial constraints (including lack of reimbursement under third-party insurance

and managed-care systems) can keep potential analysands from obtaining services, although low-cost psychoanalysis is sometimes available through training clinics. In working with agencies and clinics, clinical social worker psychoanalysts bring the value of psychoanalytic and developmental theories that enhance the treatment of those who, though perhaps unsuitable for psychoanalysis, can benefit from consultative contributions to their therapists. Freud (1919), who envisioned outpatient clinics providing psychoanalytic treatment to all, stated that people who were poor should have just as much right to mental health treatment as to surgery.

2. Education and Training

The clinical social worker psychoanalyst's education in this specialty may begin in social work graduate schools that offer courses with psychoanalytic content (psychopathology, casework treatment, human development, etc.). After graduate school, the prospective analyst traditionally has pursued a three-pronged course of study: seminars, supervised practice, and personal psychoanalysis. While this education may be obtained independently, customarily it is offered through institutes. Psychoanalytic institutes offer an intensive course of study and supervised practice, and award certification in advanced practice (although not in psychoanalytic clinical social work per se). Clinical social workers form a sizeable portion of the psychoanalytic institutes' student bodies as well as of their membership corps. The less-formal types of education are found in workshops, seminars, and other continuing-education presentations, as well as readings in journals, discussions among peers, training tapes, and on-line list-serves, all of which serve to refresh currency of knowledge and practice. Some of these supplemental offerings focus on the socio-cultural domain, and the issue of how what's "outside" gets "in" and vice versa—the so-called fourth leg, which, some have argued, must be present in all analytic training.

Many institutes also offer training in advanced psychoanalytic psychotherapy for those who are not analysts but seek to broaden their treatment skills and conceptual understanding.

3. Clinical Social Workers' Contributions to the Field

Clinical social work has had an effect on the field of psychoanalysis, as many practitioners have brought to it their practice skills and their social work values, ethics, principles, perspectives, and specialized education and training. Collectively and individually, clinical social workers have made enduring contributions, some of the most notable of which are in the areas of working with children and families, in ego psychology, in divorce and its developmental impacts on children, in deprivation, and in infertility and adoption issues.

Among other areas of psychoanalytic practice, clinical social workers are noted for prevention and early intervention with infants, older children, and their families, and for applying psychoanalytic developmental theory to the design of programs for multi-problem

families, abusing mothers, and blind children and their parents (Fraiberg, 1987; Shapiro, 2001). Prevention and early intervention is also a clinical social work focus, as at The Mother's Center Program (Edward, Ruskin & Turrini, 1992), whose model is replicated in the United States and abroad.

In many other areas of psychoanalysis, clinical social workers make a major impact as theorists, authors, instructors, and practitioners—an impact that cannot be adequately addressed within the narrow scope of this paper. Among clinical social workers whose contributions are especially well-known are: Selma Fraiberg (1987) for prevention and early intervention and for books that have become part of the larger popular culture; Ruben and Gertrude Blanck (1974), for theory and practice of ego psychology; Judith Wallerstein (2000) and Janet R. Johnston for studies of divorce and its developmental impacts on children; Ellen Sarasohn Glazer (1998) for studies of the impacts of infertility, the use of reproductive technologies, and adoption . Rudolf Ekstein, Jean Sanville, Joyce Edward, Carolyn Saari, Pascual Gargiulo, Herbert Strean, and many others, have made and are making major contributions in psychoanalysis.

II. *Nature of Psychoanalysis as Practiced by Clinical Social Workers*

A. Definition of Psychoanalysis as Practiced by Clinical Social Workers

Psychoanalysis is the psychotherapeutic application of psychoanalytic theory by analysts in order to ameliorate the emotional, mental, cognitive, and behavioral disorders that interfere with the analysand's satisfactory functioning. Psychoanalysis, which is conducted with frequency and intensity, is further defined as "a specific form of individual psychotherapy that aims to bring unconscious mental elements and processes into awareness in order to expand an individual's self-understanding, enhance adaptation in multiple spheres of functioning, alleviate symptoms of mental disorder, and facilitate character change and emotional growth" (The Psychoanalytic Consortium, 2002, p. 1). Typically, psychoanalysis is conducted in person between the analysand and analyst, several times a week, and aims for intensity of engagement (compromise may occur if limitations are present i.e. analysands who are physically handicapped or live and/or work a considerable distance from the analyst).

Psychoanalytic technique varies according to the analyst's theoretical orientation and according to the analysand's needs. Generally, psychoanalysis is conducted with the analysand lying on a couch, talking to an analyst who sits out of the analysand's line of sight. This helps to engender states of regressed transference that foster the analysand's "process" (verbal productions) and that permit the analyst and analysand to gain access to unconscious conflicts, the resolution of which can ameliorate the analysand's troubles. In some instances, analysis is conducted with the analysand sitting up.

Unconscious material is dealt with by the analyst and the analysand through a variety of techniques, among them exploration, clarification, confrontation, and interpretation. Exploration, which helps to establish a context out of which the material becomes more meaningful, also serves as a conduit for elaboration and for factors such as coexisting contradictory ideas.

In clarification, a high degree of analyst-analysand empathic attunement is required. The analyst typically invites the analysand to respond to questions about the process material in order to understand it better and to advance the treatment and to enhance meaning. Frequently, the analyst will restate the material so as to highlight contradictions, new information, or cognitive and/or affective connections to other process material.

The technique of clarification may include an element of confrontation. Confrontation is most frequently used when the analysand is prone to potentially damaging or dangerous "acting out" (meaning the projecting of internal and unconscious conflicts onto his/her environment) or other forms of injurious behavior. Interpretation, which originally referred to the analyst's explanations to the analysand about the meaning (when finally understood) of the process material, has been reconceptualized to mean a dialogue in which analysand and analyst mutually arrived at meaning (Cooper, 1998).

The analyst's theoretical orientation helps to determine the nature and frequency of use of techniques. Generally, the more classical the orientation, the greater the professional distance between the two participants and the more likely the emphasis on relationship-repeating aspects of transference. Practitioners with less-classical orientations tend to conceive of the analyst-analysand relationship less as a repetition and more as a mutual creation. Indeed, they see the engagement between analyst and analysand as "the very fulcrum of and vehicle for the deep characterological change psychoanalysis facilitates" (Mitchell, 2000, p. 125).

The main (but not the only) goals of psychoanalysis are the following: improving the analysand's adjustment, reducing maladaptive solutions, enhancing strengths, enhancing relationship capacities, helping the analysand to gain insight, achieving mastery and competence, alleviating suffering, and restoring progress along developmental lines.

Psychoanalysts believe that psychoanalysis is distinguished from other modalities by depth and intensity and by frequent treatment sessions over a long term, all of which, they further believe, can be more helpful for the analysand than can other, briefer treatment methods.

Psychoanalysis encompasses a variety of theoretical approaches including, but not limited to, the following (alphabetically arranged): attachment, conflict, ego psychology, interpersonal psychology, inter-subjectivity, Jungian, Kleinian, Lacanian, object relations, relational, and self psychology (see section IV. *Major Psychoanalytic Theories/Perspectives*).

B. Contemporary Research on Psychoanalysis

Since the early years of psychoanalysis, several major studies have attempted to examine its effectiveness (Bachrach, Galatzer-Levy, Skolnikoff & Waldron, 1991). The early research generally focused on the control cases of psychoanalysts in training. Problems in those studies, which produce systematic bias, have been noted in the literature as including retrospective accounts, un-validated rating scales, insufficient data, findings reliant upon post-analysis interviews with the analysts, and the use of inexperienced trainees as treating analysts and the use of a limited spectrum of patients (Jones, Caston, Skolnikoff, 1992). Contemporary research has a different basis than did the efforts from the 1930s to the 1950s, in which the analysand subjects presented with more severe psychopathology and had less likelihood of improvement (note: more recent work of this nature is reported in Kantrowitz, et al., 1989; Kantrowitz, Katz, & Paolitto, 1990 a, b, c; Kantrowitz, 1993).

Today, most published research about psychoanalysis is in the form of single-case reports, which, while rich in clinical material, do not provide cumulative data from which to generalize, as in large-scale outcome studies, efficacy studies, or comparative-methods studies. Often, these cases are chosen for publication because they are atypical; and many articles report the case-content selectively. While randomized clinical trials are preferred in empirical study design, such trials generally are not applicable to psychoanalysis, since it is not chosen by most people as their treatment method (due to its demands on money, time, and commitment) and since it is unrealistic to assign people randomly to psychoanalysis or an alternate psychotherapy. The unsuitability of psychoanalysis for large-scale research is addressed by Jones, et al. (1992), while Waldron (1997) and Luborsky, et al. (2001), report that new research methods may profitably be applied to psychoanalysis.

The interface between psychoanalytic theory and neuroscience (Saporta, 2000, 2002) is proving fruitful for researchers. In their findings, psychoanalysis, with its roots in the neurological sciences, is seen in rapprochement with a greater understanding of human development, personality, psychopathology, and therapeutic treatment. In such areas as memory and trauma in early childhood, this new work may enhance our understanding of the processes of recovery from trauma and may cast new light on such controversial topics as repressed memories. Among other contributors in cognitive neuroscientific research are Wilma Bucci (2000, 2001) in sub-symbolic versus symbolic forms of information processing, and Marcel Mesulam (2000) in the integration of sensory information into multi-modal representations and conceptual knowledge.

C. Cultural Competence in Psychoanalysis

The concepts of culture as they interact with psychoanalytic theory have existed at

least since the publication of Freud's *Totem and Taboo* (1919/1960). In the United States, the "culturalist" writings of the European immigrant psychoanalysts like Horney and Fromm created much interest in how psychoanalysis could enhance the understanding of other cultures as studied in anthropology. In the 1930s, despite a "chilly" reception for such theories, rapprochement was initiated between cultural anthropologists and culturalist psychoanalysts (Manson, 1988). Psychoanalytic thought influenced the anthropological studies of personality in the writings of Mead (1962, pp. 115-149), Sapir (1934), and Benedict (1934). Abram Kardiner presents the terms and concepts of applied psychoanalysis (the energic point of view, in particular), as quoted in Henderson (1994):

> Each specific culture creates different values, different necessities and specific defenses. The specificity of each culture depends upon which impulses it chooses to curb, how it curbs them, what compensations it supplies, how it deals with the stresses created by these repressions, what avenues of discharge does it promote, and as a result of the whole picture what emotional values in the form of ideals, objectives and life goals does it supply. (p. 123)

Later writings shift direction: there is less concern with how psychoanalysis enhances the study of culture, and more with how understanding culture enhances the skill with which analysts treat their patients. Ethnocentrism is viewed as a potential pitfall for all psychotherapists, including analysts; and unexamined ethnocentrism, with its insensitivity to culturally based fears and beliefs, may antagonize the analysand and lead to premature termination of treatment (Henderson, 1994).

The concept of identity, crucial as it is in psychoanalytic theory, can be profoundly affected by the analysand's cultural language (Henderson, 1994). For example, European languages assign a private identity to individuals through the use of one pronoun each for the first- and second-person pronouns (e.g. "I" and "you"). In contrast, Japanese first- and second-person pronouns vary according to the situation: if speech is public or private, if one is speaking to a male or female or to one of higher or lower status, etc.

In actual practice of psychoanalysis, the following principles apply. The components of culture in an analysand's life are analyzed, as are all other life components, according to their effects upon that person's psychic structure. The patient's ethnic, racial, geographic, ethnographic, political, social class, and religious demographics are all considered, as are the related distinctions of age, gender, and sexual orientation, according to the patient's assigning of meaning both conscious and unconscious. Of particular therapeutic importance is the analyst's ability to glean the metaphoric content of such productions as they are revealed through venues such as the recounting of dreams or free association. Issues putatively relating to culture via these venues may serve as a means by which specific and personal experiences are brought to light and analyzed as to their effect upon the analysand. The psychoanalytic techniques of exploration, interpretation, and clarification, are thus used to process the patient's cultural material in a way similar to that

used to process other patient productions. The requirement of analytic neutrality is always appropriate (Blanck and Blanck, 1974), and must be maintained while investigating cultural material. While not sufficient per se, the analyst's capacity for empathy must be deep enough to permit understanding of the impact of cultural effects in the therapeutic relationship, in the patient's relationship to the environment, and in the patient's relationship to him/herself.

Training institutes tend not to emphasize academic investigation of the components of culture; but analysts need more than empathy to understand the potentially profound effects of an analysand's cultural milieu (Henderson, 1994). Better than analysts from other disciplines, clinical social worker psychoanalysts appreciate the effects of culture on the analysand, due to social work's context of cultural recognition and appreciation. Zayas (2001) noted that matters of racism, which influence the formation of the racial and ethnic identity of youth, also have effects upon treatment within the transference and the treatment alliance. Shonfeld-Ringel (2001) explained how cross-cultural issues shape the working alliance.

Clinical social workers, upon entering psychoanalytic training institutes, tend to have two traits that enhance cultural competence. First, they are likely to have the social worker's distinctive interest in the cultural factors of the human experience. Second, they have been required, in graduate school, to take course-work pertaining to cultural factors. Thus, clinical social workers tend to sensitize the psychoanalytic community to cultural factors. Guided by social work ethics, clinical social worker psychoanalysts seek to examine their own personal beliefs and values regarding the culture of their analysands, to educate themselves about the cultural traditions of a diverse clientele, and to offer treatment techniques that reflect their understanding of each analysand's culture.

The experience of psychoanalysis can also affect the analysand's experience of his/her culture. The analysand might alter his/her relationship to culture due to an alteration in internal mental representations, or might experience cultural context in a deeper or more complex way. The culturally competent psychoanalyst is better able to help the analysand to understand parental influences by differentiating culturally bound child-rearing practices from those arising from parental personality characteristics separate from culture. It is generally understood that the impact of the environment and culture are present both inside and outside the patient, in that the external environment is internalized and understood within internal mental representations. The culturally competent analyst would ensure the integration of both internal and external manifestations of culture into the whole psychic structure of analysis.

D. Ethics and Training Standards

Psychoanalysis, as practiced by clinical social workers, is informed by the ethics codes of the clinical social work profession and of any professional organizations to

which the practitioner belongs (ABE, 2002, November; CSWF, 1997; NASW, 1999). It is understood that the practitioner maintains state licensure/certification, current and in good standing, at the highest level recognized by the jurisdiction(s) in which they practice.

Standards for psychoanalytic training have been promulgated by the Accreditation Council for Psychoanalytic Education, whose board of trustees includes, among others, the National Membership Committee on Psychoanalysis in Clinical Social Work. The latter's National Study Group (Phillips, Speicher, Goldner & Kaplan, 1994) has promulgated standards for programs that train clinical social workers to be psychoanalysts, summarized below:

a. Candidate engages in personal analysis, conducts analytic cases under psychoanalytic supervision, completes comprehensive psychoanalytic curriculum;
b. Program imparts a variety of contemporary theoretical approaches;
c. Candidate exemplifies integrity, maturity, advanced intellectual ability, capacity for deep self-reflection, and clinical aptitude.

Training should be directed toward mastery of the analytic process. One formulation of this process includes (1) bringing unconscious mental elements into awareness; (2) recognizing the importance of developmental, social, cultural, familial, and interpersonal influences in determining symptoms and personality; (3) working with transference and counter-transference phenomena and with specific techniques aimed at expanding the analysand's self-understanding; (4) facilitating the process of adaptation in multiple spheres of functioning; (5) alleviating symptoms of mental disorders; and (6) facilitating character change and emotional growth (The Psychoanalytic Consortium, 2002).

This training is usually (but not necessarily) imparted in post-graduate programs offered at institutes, which teach the theory and process of psychoanalysis through the following modalities:

1. Personal Analysis

In order to use the self in a disciplined way in the service of the psychoanalytic process, each psychoanalyst must have a personal psychoanalysis characterized by depth, frequency and intensity. The candidate's psychoanalyst (known as a training analyst) must have had at least five years of postgraduate experience in conducting psychoanalysis in all of its phases. He/she must be formally recognized by an institute as a training analyst (or as meeting the criteria to function as a training analyst) or be able to demonstrate equivalent expertise through certification by a body independent of an institute. "The psychoanalysis of a candidate is expected to be conducted in person at a frequency of 3-5 sessions per week, on separate days, for a minimum of forty weeks during a year, and for a minimum of three hundred hours. The Accreditation Council for Psychoanalytic Education

expects that the personal analysis of a candidate be consistent with the training experience and orientation of the institute; but in no event shall these be at a frequent of fewer then three sessions per week." (The Psychoanalytic Consortium, 2002, p. 4-5). Recognizing the inevitability of personal blind spots and being willing to self-reflect are parts of the analyst's responsibility to continue self-analysis throughout one's professional life.

2. Course Work

Psychoanalytic candidates must take didactic courses that include the following areas:

a. The history of psychoanalysis;
b. Psychoanalytic theory (beginning with Freud and including later theoretical contributions from other key figures in the profession);
c. Normative and pathological psychological development;
d. Psychoanalytic technique, taught through didactic study of specific elements of technique and through continuing clinical case conferences;
e. The effects of the social, cultural, and other environmental factors on the analysand.

3. Supervision

Candidates will undertake the supervised analysis of two or three adult cases, characterized by the same frequency and intensity as experienced in his/her own personal analysis. One or more cases will be supervised for at least two years and one case for one year; and at least one case will be supervised to termination (before or after graduation). A minimum of 150 hours of practice will be supervised by a training analyst who meets the criteria set forth in the Personal Analysis section above. The Accreditation Council for Psychoanalytic Education expects that a candidate's supervised analysis be consistent with the training experience and orientation of the institute, and not less frequent than three sessions per week (The Psychoanalytic Consortium, 2002). Unlike supervision, consultation is generally not utilized to oversee the conduct of the entire case.

III. Principles of Therapeutic Intervention

A. Assessment and Diagnosis

The clinical social worker is responsible for ensuring that each client receives an adequate assessment. Such an assessment takes place in a face-to-face meeting to gather information about the client's biological, psychological, environmental, and cultural qualities and conditions (ABE, 2002, March). In the psychoanalytic process, assessment (recognized primarily as a social work term) refers to a wholistic evaluation, as in the term "bio-psycho-social assessment."

Diagnosis is considered to be an ongoing conceptual evaluation of the analysand's personality structure, including the analysand's capacity to bring unconscious mental elements into awareness, as well as the analyst's recognition of developmental, social, cultural, familial, and interpersonal influences on symptoms and personality. The diagnosis guides the analyst in his/her work with transference (the analysand's redirection of feelings and desires and especially of those unconsciously retained from childhood toward the analysts) and counter-transference (the analyst's reactions to the analysand's transference) (Mish, 1996). The diagnosis also serves as the analyst's guide in the use of specific techniques aimed at expanding the analysand's self-understanding, facilitating the process of adaptation in multiple spheres of functioning, alleviating symptoms of mental disorders, and enhancing character change and emotional growth.

Psychoanalysis makes it possible to understand the meaning of the analysand's symptoms, psychological patterns, internal conflict, adaptations to trauma, self-deficits, deprivation, and other conditions. Psychoanalytic approaches may interpret the meaning of behavior and symptom-formation differently from the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders; APA, 2000), which is the most commonly used method of classifying mental disorders.

B. Psychoanalytic Treatment Considerations

Psychoanalysis is typically conducted with the analysand lying on a couch and the analyst out of the line of sight. It is characterized by frequent sessions over an extended period of time, in order to promote depth, intensity, and access to deeper levels of awareness, unconscious needs, and impulses. These then emerge in the treatment as transference manifestations, in which there is a reliving and reworking of earlier needs, unresolved traumas, conflicts, and deprivations. There is an elucidation and working-through of defenses and pathological adaptations that leads to new and constructive adaptations to life. Throughout the treatment, the analyst maintains a state of evenly suspended attention, characterized by empathy and non-judgmental interest.

The analyst invites the analysand to say whatever comes to mind, without self-censoring, and pays attention to the content and to the emotional trains of thought, associations, dreams, and slips of the tongue, all of which help make connections to past events of which the analysand may not be consciously aware. In this process, which is facilitated by the analyst and the analysand, the analyst makes empathic comments, shares impressions, expresses feelings about the process, and encourages the analysand to explore the underlying meanings of and connections among comments, feelings, or actions that emerge. The analyst also helps the analysand to identify and overcome resistances against exploration of these meanings and connections. This process continues, with the goal of helping the analysand experience ever-greater insight into the way the mind and emotions operate together.

The analyst understands dreams to be symbolic expressions of the analysand's inner life, both in the present and as related to the past. While there are many variations in the process, it is typical for the analyst to listen to the description of the dream and then ask the analysand to share associations to the dream and its elements. These associations, together with the dream material, help to uncover the analysand's deeper wishes and fears, and, through the analyst's interpretations, to help the analysand understand what has hitherto been unconscious to him/her.

In fostering interaction with the analysand, the analyst creates a situation that produces transferences in the analysand and also counter-transference in the analyst. Both transference and counter-transference offer further understanding of the analysand's psychic structure and experience. In interpreting enactments, which are instances of the analysand's transference-related experiences and behavior, the analyst primarily helps to increase the analysand's self-understanding. Secondarily, analysis of enactments enables the analyst to become more self-aware and therefore more clinically skillful.

In describing psychological defenses to show how they guard against anxiety, the analyst helps the analysand to appreciate the impacts of maladaptive defenses and to adopt more effective ways of managing anxiety. Defenses are not always maladaptive; indeed, we all use defenses to manage the environment's influence upon our inner lives. For example, people suffering from breast cancer frequently utilize the defense of denial, which, depending on pervasiveness and impact on health behaviors, can exert either adaptive or maladaptive effects on coping and quality of life (Wool, 1986; Wool & Goldberg, 1986). The analysis of defense requires enhanced priority when the analysand has an insufficient repertoire of defenses or when defenses totally prevent personal insight or thwart intimate relationships (Polansky, 1991).

The psychoanalytic process gradually helps the analysand change in the following ways: developing an enhanced function for self-reflection; achieving a greater sense of mastery and competence; adapting more effectively; and progressing developmentally toward greater structure-building of personality. The psychoanalytic treatment process is conceptualized in phases: assessment and diagnosis, working–through of issues, and resolution, in which the progress and achievements of the process are reviewed before termination occurs.

C. Special Issues

1. Characteristics of Those Who Can Benefit from Analysis

While a psychoanalyst may look for certain characteristics in a prospective analysand, current thinking emphasizes the importance of a good match between the analyst and the analysand for effective treatment. Suitable candidates for psychoanalysis tend to be interested in and capable of exploring deep levels of their personality, and able

to make logical connections and to draw cause-and-effect conclusions. Besides these cognitive capacities, their ego capacities include the use of the treatment relationship to foster self-reflection, patience in allowing processes to unfold, and the ability to remember and explore dreams and to contain and verbalize comfortably a range of affects as unconscious aspects emerge within the transference.

Current thinking about psychoanalysis suggests that it can help a broader range of people than had once been the case. Even in those whose capacities for psychoanalytic work are impaired, modifications of the techniques can assist with development (Blanck & Blanck, 1986; Gedo & Goldberg, 1973).

2. The Place of Medication Consultation in Psychoanalytic Practice

Clinical social worker psychoanalysts, like other psychoanalysts, utilize the services of physicians (ranging from internists to psychiatrists) for medication, when necessary; and they should have the knowledge and skill to treat analysands who are on psychotropic medication. When involving a third party for psychopharmacologic consultation, the analyst carefully monitors the implications and impacts of such a referral on the transferences and other crucial aspects of the treatment. In some instances it is unethical to refrain from making the referral for a medication consult. For example, a person who suffers greatly from the symptoms of depression or anxiety should be afforded a referral for medication, as should those who have illnesses such as bipolar disorder or schizophrenia, in which there is risk to the analysand or to his/her environment.

3. The Place of Psychological Testing in Psychoanalytic Practice

Sometimes an analysand's symptoms are so complex or confusing that the analyst may use testing as a means to achieve clarity. There are many psychological and neuropsychological tests designed to measure various factors (intelligence, job suitability, motivation, etc.). The most widely used projective tests, designed to illuminate unconscious thoughts and feelings, include the Rorschach and the Thematic Apperception Test, which are administered by psychologists. In discussing any such test with the analysand, the analyst must be highly aware of the possibility that the introduction of the test could negatively affect the therapeutic alliance.

4. Child Psychoanalysis

With regard to psychoanalysis for children, clinical social workers have long been intensely involved as practitioners and theorists and as students and faculty in post-graduate training programs. Child psychoanalysis addresses the internalized and unconscious conflicts engendered within children before they have become entrenched in the adult personality.

Typically, children in analysis express their internal conflicts by engaging in play as

a form of free association. The child and the analyst usually sit on the floor or at a table; and the analyst at times participates in the play, using toys to interpret or express empathic attunement. Frequently the child directs the analyst's actions with the toys as if he/she were the director of a play. At other times, the analyst does not play but comments on the child's play. The decision as to how to participate varies according to the analyst's theoretical orientation, the child's varying needs, or some other dynamic such as the child's capacity for or interest in interactive play.

5. Limits of Confidentiality

Rules and legal mandates affect an analyst's ability to guarantee confidentiality to the analysand. All states mandate that mental health professionals must report suspected child abuse and/or neglect to the authorities, even if the suspicion is based on material from an analysand within the analytic session. Likewise, the ruling in the case of Tarasoff v. Regents of University of California (1976) made it clear that mental health professionals have a "duty to warn" if there is reason to believe that the analysand represents a danger to self and/or a credible threat of harm to an identifiable victim.

There are many situations in which some level of disclosure is required. Federal HIPAA (Health Information Portability and Accountability Act) regulations now govern the transmission of electronic data about clients (and to them). When psychoanalytic treatment is covered by third-party payors, analysts must provide a certain amount of disclosure (a DSM-IV-TR diagnosis and dates of service, at least; often much more). Some states have rules requiring that the practitioner reveal certain professional information to clientele, such as the institutions and dates of education and training.

IV. *Major Psychoanalytic Theories/Perspectives Used by Clinical Social Worker Psychoanalysts*

The corpus of analytic theory is vast and constantly evolving. *The Complete Psychological Works of Sigmund Freud: The standard edition* should be read as a history of the evolution of his theory and his conceptualizations of the nature of the human mind. This section is arranged to identify the organizing principles of the four paradigms that dominate psychoanalytic theory: Drive, Object Relations, Ego Psychology and Self Psychology. In addition, there are other major analytic schools. Flowing through each paradigm are the theories of human motivation, the nature of anxiety, and the causes of psychopathology. While this presentation is not intended to describe the many principles and concepts that exist within psychoanalysis, it does serve to organize the central ideas of the major theories.

A. Drive Theory

Psychoanalytic thinking began with Sigmund Freud, author of the first psychological theory concerned with what things mean to a person. Paying serious, specialized attention to the patient's various communications was a new concept in the treatment of mental illness.

Frustrated in his academic career as a neurophysiologist, Freud turned to the clinical practice of neurology and became interested in the findings of two leading neurologists, Charcot and Bernheim. After observing their work on hypnosis and hysteria, he and his colleague and mentor, Josef Breuer, studied a series of hysterical patients. This work led Freud to develop a theory of the unconscious and how its meaning was demonstrated in everyday life. The basic theme is one of inner conflict. The mind, Freud posited, may be seen from five metapsychological viewpoints: Topographic, Dynamic, Economic, Structural, and Genetic. The Topographic view (Freud, 1900) examines the mind as analogous to a geographic model with its conscious, preconscious and unconscious layers. The Dynamic view posits the existence of aggressive and libidinal instincts, also known as the drives. In the Economic view these same drive energies are studied as quantitative forces that may be increased or decreased for tension reduction or expression. The Structural perspective (Freud, 1923/1961) describes the agencies of the mind, in which the id is primal. The ego and superego then develop out of the id as a result of object identifications and the resolution of internal conflict. Freud's Genetic viewpoint was the first theory of psychological development. It proposed the oral stage (0-18 months), the anal stage (18-36 months), and the phallic-oedipal stage (3-6 years) (Freud, 1905); and it posited that the "past persists into the present."

Freud initially felt that all areas of motivation and anxiety, and all causes of psychopathology, could be explained through the five viewpoints—a conclusion that he later adjusted. He believed that human motivation was based on the pleasure principle, a seeking of pleasure and an avoidance of un-pleasure resulting from increased levels of stimulation. Since death is the ultimate lack of stimulation, the pleasure principle required a counter-balance, a life instinct opposing the death instinct. Thus, he devised the constancy principle, which states that people try to keep energy at a low, optimal level. He added the reality principle, in which a certain amount of tension is tolerated in the service of adaptation. Therefore, one could seek discharge of pent-up tension via sexual gratification and aggressive drive expression. The insistence of these principles leads to repetition in order to maintain the pleasure state (Freud, 1920).

Freud posited that anxiety was caused by intra-psychic pressure due to lack of sexual gratification and to the mind's intolerance of unacceptable wishes (Freud, 1894). Later, he replaced this very physical explanation with one in which anxiety was seen as arising from the pressure of unacceptable wishes that threaten to break through the repression barrier. Since the strength of instincts is an inherited trait in classical theory, anxiety may also result from too much or too little sexual or aggressive drive, threatening

the balance. These sources of anxiety can lead to psychopathology because of excessive or inadequate repression of drives or wishes or because of insufficient means of achieving gratification (Freud, 1926/1977).

Because maturation in Drive Theory occurs by movement from narcissistic love to object love and via conflict resolution by identifications, the loss of an object or the object's love also creates anxiety. At the oedipal phase, rivalry for the object leads to castration anxiety or guilt/fear because an overly strict superego develops. Psychopathology occurs when a fixation of instincts and early developmental arrests prevent a mature, genitally based sexual organization. This is a drive/defense theory: the symptoms of psychopathology are viewed as compromise formations, intended to mediate internal forces with the external world as experienced by the analysand.

While Drive Theory continues to influence psychoanalysts, few of them adhere solely to this somewhat mechanistic approach and most draw on concepts included within some of the following theories.

B. Object Relations Theory

There are a number of different Object Relations theories, generally categorized as either part of the American School or of the British School. Prominent American Object Relationists are Edith Jacobson, Margaret Mahler, and Otto Kernberg. Leading British theorists include Melanie Klein, W.R.D. Fairbairn, Harry Guntrip, and Donald Winnicott. The theorists and schools vary, but also have commonalties. For the purposes of this document, Object Relations Theory is defined as an organized explanation of personality development, its motivations and anxieties, and the evolution of psychopathology based on the creation of internalized mental representations of interpersonal relationships. Whether or not the theorist adheres to a basis in Drive Theory, he or she believes that growth is not the result of conflict and defense against it, but of a psychic structure evolving toward autonomous function based on successful differentiation of self and object (Summers, 1994).

Attachment Theory, originally a subset of Object Relations Theory, was first propounded by John Bowlby (1980), who believed that a person's mental-emotional state is a function of the "accessibility and responsiveness of the principal attachment figure" in childhood. There are several patterns of infant attachment: secure, insecure-avoidant, insecure-resistant, and disorganized. (Ainsworth, 1978; Main & Hesse, 1990, pp. 161-182). Attachment Theory has been advanced by the work of Ainsworth, Slade, Sroufe (1996), Stern, and especially Peter Fonagy, who holds that secure attachment is a necessary precursor of the ability to regulate affect and to reflect on the emotional functioning of self and others (Fonagy, 2001). Although not a psychoanalytic model itself, Attachment Theory enhances other psychoanalytic models.

In Object Relations Theory, the motivation for maturation begins with the creation of a tie to the maternal object and a desire to sustain that attachment. From the mother-infant bond comes the capacity to tolerate frustration by the creation of an interaction characterized by consistent availability, response to cueing, and mutual attunement. Progress relies on the mother's capacity to respond to needs and to allow optimal frustration and separation as a baby matures and wishes to move away and explore. As development proceeds, a sense of independence and autonomy grows simultaneously with the capacity to be dependent and maintain intimacy in the relationship. This is contingent on the attainment of object constancy, or the capacity to remain in a constant relationship with the same object who frustrates or gratifies, loves or is angry, is present or absent. The evolving potential for awareness of self and object allows for an expansion of interpersonal relationships (Mahler, Pine & Bergman, 1975; Stern, 1985). It should be noted that this primary union is most frequently between the mother and the infant, but that any primary caregiver can serve the function as the infant's primary object, if the mother does not fulfill that role.

Anxiety becomes acute if the environment fails to be dependable or, per Winnicott, to be "good enough." Attachment to the object is primary, so loss of that object or its love at a very early time, or failure to achieve secure object attachment, may evoke the deepest anxiety, known as annihilation anxiety (Winnicott, Shepherd & Davis, 1989). A similar loss during a later phase will also provoke anxiety, but since the interference is at a different point in development, a different psychopathology is created. While premature separation is painful and frustrating and interferes with development, the infant is also provoked to anxiety by excessive intrusions and is made to experience interference with proper boundary development by refusals to allow any separations.

Developmental arrests are fixations at different sub-phases of the separation-individuation process. The result of these frustrations or intrusions by care-taking objects leads to psychopathological symptom formation (Kernberg, 1976). Failure to achieve object constancy leaves the ego unable to tolerate the incompatible feelings of both loving and hating the primary object. Thus, ambivalence and anxiety are so intense that bad, hostile feelings for the internalized representation of the primary object dominate the positive ones and prevent identification with the good object. Splitting and regression are the consequences of too much early disappointment, helplessness, and narcissistic injury.

While each theory differs, psychoanalytic work utilizing any Object Relations Theory focuses on the internalization of interpersonal relationships for psychic development and mental health.

C. Ego Psychology Theory

Ego Psychology grew out of Freud's evolving theory. In it, the conceptualization of the ego is based on the recognition of limitations of Topographic theory in explaining the

complexity of mental life and the unconscious function of defenses. In his 1923 paper, *The Ego and The Id*, Freud laid out what later became known as Structural theory, which posited the id, ego, and superego as the three agencies of the mind. Central to this was the recognition that the ego and its defenses played a greater role in psychic life than the early analysts had previously thought. Anna Freud's (1984) *The Ego and the Mechanism of Defense* is an elaboration of the ideas of the Ego and the Id as well as an explication of the prevailing ideas in Freud's inner circle regarding defenses and their dynamic properties. In the United States, analytic theorists continued to elucidate the role of the ego. Hartmann, Kris, and Lowenstein made prolific contributions, as did clinical social workers Gertrude and Rubin Blanck and Selma Fraiberg (Hartmann, 1958/1964; Hartmann, Kris & Lowenstein, 1946, 1949; Blanck & Blanck 1974, 1992; Fraiberg, 1959).

Motivation in Ego Psychology centers on the development of the ego and its complex functioning in mental life. Primarily, the ego works to protect its own integrity and boundaries, and develops an efficient array of defensive operations (Hartmann, Kris & Lowenstein, 1946). The central function of these operations is to enable the individual to achieve optimal drive gratification and to recognize that we live in a social matrix that makes external demands requiring an optimal adaptation to the environment (Hartmann, 1958/1964). The ego also strives to help the individual achieve mastery over both internal drive demands and the increasingly complex challenges we face as we mature, from love-attachments to parent-hood and functioning in the larger society. Ultimately, the ego functions to negotiate the demands of the id and the injunctions of both the superego and external reality (Freud, 1923/1961; Freud, A. 1984).

Anxiety in Ego Psychology again centers on the ego as a structure that has an array of operations: its function, its internalized objects, and pressures from internal sources. The most basic anxiety centers on the very integrity of the ego and its boundaries. Related to Freud¹s earlier formulation regarding the role of internalized "objects" and a developmental "hierarchy" of anxiety related to them, ego psychology organizes anxiety around the loss of the object, the loss of the object's love, castration or physical harm by the object, and, finally, the loss of the object's regard or superego condemnation (Freud, 1923/1961, 1926/1977). The ego mediates anxiety as it is evoked internally as the individual negotiates his environment.

Psychopathology is conceived as being related to the functioning of the ego as it mediates internal and external demands. Just as an insufficiency of defenses leaves the person vulnerable to being overwhelmed by drive demands or breakthroughs of primary process material, so rigidity (defensive excess) constricts the person's ability to function in an unencumbered manner. As to its more generalized operations, the weaknesses or inadequacies of ego functions, as produced by over-stimulation, excessive frustration, inadequate internalization, or constitutional deficits, are seen as sources of problems in human functioning (Hartmann, Kris & Lowenstein, 1946, 1949; Blanck & Blanck, 1974, 1992).

D. Self Psychology Theory

The theory of Self Psychology was developed over a number of years and continues to evolve. Its primary theorist was Heinz Kohut, who, in a radical departure from Freud, offered that narcissism has its own line of development. Developed primarily out of Kohut's work with narcissistic analysands, and part of the larger analytic trend to develop theories applicable to more-disturbed personalities, he offered that early narcissistic structures needed to be "re-ordered" and that "narcissism ultimately transforms into ideals and ambitions with the qualities of creativity, empathy, transience, humor, and wisdom" rather than object love (Kohut, 1966). Key ideas of this theory are narcissistic or selfobject transferences and the self as a central structure (Kohut & Wolf, 1978). Arnold Goldberg, Paula and Anna Ornstein, Marian and Paul Tolpin, and Ernest Wolf, have made major contributions to this theory, as have the clinical social workers Miriam Elson (1988), Constance Goldberg (1996), Linda Chernus (1988), Joseph Palombo (2001), and Crayton Rowe (1989).

Motivation in Self Psychology focuses on the development and maintenance of the Self. The Self strives for cohesion, continuity and agency and the regulation of self-esteem (Siegel, 1996). Central to development is the achievement and maintenance and preservation of self-selfobject bonds and the internalization of their functions (1996). Selfobjects are distinguished from the traditional conception of objects. Selfobjects are not separate objects that are targets of drives and wishes; instead a selfobject is the experience of a function provided by an object, and thus is a part of the Self. Selfobjects are understood in terms of their function in the maintenance of the Self and are delineated by three functions: idealizing, mirroring, and twinship. Rather than viewing development in terms of increasing autonomy, Kohut felt that individuals needed to maintain selfobject ties over the life cycle but with increasing flexibility and tolerance for fluctuation in their availability (1996).

Kohut viewed anxiety as caused by threats to self-cohesion. Rather than a regression to earlier levels of libidinal organization, anxiety is fear of self-fragmentation or a threat to the self's very existence. Loss or disruption in selfobject bonds is a central threat resulting in fragmentation anxiety. Other sources of anxiety are depletion, the threat of over-stimulation, and threats to the self's boundaries. Anxiety is seen as a threat to the self's organization and integrity rather than as a breakthrough of earlier drive organizations (Tolpin, 1997).

Psychopathology is conceptualized as the result of developmental problems. Individuals may suffer from arrests at early forms of self-selfobject experiences secondary to traumatic disruptions in ties with the mirroring or idealized selfobject (Kohut & Wolfe 1978). These disruptions result in a failure of transmuting internalization, which, had they not failed, would have resulted in the gradual transformation of narcissism into mature structures. This in turn can lead to a failure to develop a cohesive nuclear self, which thereby leaves the self vulnerable to fragmentation, excessive demands for selfobject

experiences in an effort to ward off the threat of fragmentation, or excessive repression or splitting off of self needs in an effort to maintain a sense of cohesion (Kohut, 1971, 1977; Siegel, 1996).

E. Other Major Analytic Theories and Schools

Like all fields of inquiry, psychoanalytic theory continues to evolve as it incorporates new thought and findings.

Research in neuroscience is increasingly integrated into the practice of the clinical social worker psychoanalyst. This new scientific research lends support to Freud's belief that neurobiology can be used to explain the operations of the mind. The capacity to understand human beings is greatly enlarged by the bridge between biology and psychology, and the existence of brain structures that participate in affect and that influence memory, language, and experience. This capacity is rooted in comprehension of the brain as it relates to mind and mind's relation to brain. The interface of the brain's neurobiological workings and the psychodynamics of the mind create an unfolding context for scientific exploration and the creation of a living and growing body of knowledge (Edelman, 1992; Carter, 2000; Damasio, 2000; Ledoux & Hirst, 1986; Wallerstein, 2002).

The British School of Object Relations differs from the American School by its elaboration on aggression and the aggressive drive (Klein, Melanie, 1952) in contrast to the earlier, classical emphasis on libidinal conflicts favored by the majority of the American School. The British School was particularly concerned about the question of "lay" analysis —psychoanalysis practiced by non-medical professionals—and the development of child analysis, both of which issues have turned out to be of great influence on contemporary psychoanalysis. The British Independent School, exemplified in the work of Christopher Bollas, Roger Kennedy, and Jonathan Parsons, emerged from the British School of Object Relations and continues to elaborate on the role of aggression, particularly in the internalized mental representations of objects. The Independents, while standing apart from the limitations of any particular theory (Kohon, 1986), have integrated much French analytic thinking.

Led by Jacques Lacan and, more recently, André Green, French analytic theory has its own line of development. These analysts encourage the awareness of philosophical underpinnings in psychoanalytic thought and have incorporated linguistic principles into their work. Lacan, who advocated a return to Freud and the exploration of the deepest parts of the unconscious, proposed that the unconscious is structured like language. In his Symbolic Order, the order of language, words became arbitrarily chosen signifiers in linguistic chains that can be traced back toward signifiers, or unconscious concepts evoked by sound (Berger, 1996, pp. 83-98). Like the British, the French maintain a general interest in aggression, and more specifically in the death instinct as it is conceived as a part of the aggressive drive. Green's contributions on the "work of the negative," the presence of

absence, etc., are provocative in the French movement and in general (Green, 1993/1999).

Jungian Psychology, developed by Carl G. Jung, is concerned with individuation (referring to personal development over the life-span), transformation of the personality (not just adaptation), and connection to archetypal dimensions. Jungian analytic practice covers a wide range of perspectives, from an analytic focus on the archetypal dynamics in dreams and fantasies to a clinical emphasis on developmental disturbances or deficits of early life and, for most Jungian clinicians, to a clinical stance that combines both elements. A significant aspect of Jungian practice is to foster awareness of the conscious and unconscious, of the personal and archetypal, of individual and collective dynamics, and to create an approach to life in which all of these psychological dimensions are considered (Samuels, 1985).

Intersubjective and Relational Theorists have borrowed and re-formulated some self-psychological concepts. Robert Stolorow and George Atwood, Donna Orange, Jessica Benjamin, and Irwin Hoffman retain the discipline of psychoanalysis but require that "the analyst also engage with the patient in a way that is sufficiently self-expressive and spontaneous so that a bond of mutual identification can develop between the participants" (Hoffman, 1994; Stolorow, Atwood & Brandchaft, 1995). Integrationists like Stephen Mitchell and Allen Schore are attempting to synthesize the major concepts of analytic theorists and to find common ground among them. Among Narrative theorists, Carolyn Saari (2003) addresses the ways in which underlying psychodynamic development is expressed and accessible in practice, and finds that clinical social worker psychoanalysts have a particular affinity for relational theory because it is more aligned with their "practice wisdom" and traditions than is classical analysis (p. 217).

V. The Summaries: Professional Competencies of the Clinical Social Worker Psychoanalyst

At the level of advanced specialty practice, the clinical social worker psychoanalyst must have mastery of the knowledge base and practice skills specific to that specialty area. In addition, the analyst endorses core clinical social work values, expressed and amplified by the following convictions:

- to honor the dignity and well-being of the analysand and his/her right to self-determination, privacy, confidentiality, and informed choice
- to advocate for analysands in service provision, access to care, and program evaluation (although analysands, by virtue of certain social and cultural characteristics, may tend not to need advocacy in the ways that other clients do)
- to practice ethically and legally, with competence and integrity, and with respect for culture and diversity (age, ethnicity, gender, and lifestyle)

- to contribute to a society that offers opportunities to all of its members in a just and non-discriminatory fashion
- to deliver the most appropriate treatment and level of care, according to the analysand's needs and informed consent

These core values connect the clinical social worker psychoanalyst to other clinical social workers and help him/her to maintain professional identity. The analyst's knowledge and skills are informed by these values, and by a vigilant professional self-awareness and a disciplined bio-psycho-social approach to the practice environment. Therefore the following principles apply.

1. The analyst attains self-awareness through clinical supervision, personal psychotherapy, personal psychoanalysis, self-observation, and reflection on interactions and their outcomes. Ongoing reflection is facilitated by periodic consultation. Self-awareness increases the analyst's capacity to understand analysands and to avoid imposing onto the analysand one's own unresolved issues.

2. The analyst recognizes the importance of a bio-psycho-social perspective and the environment (client-settings, institutions, and community resources) in which treatment is conducted and which the analysand inhabits. The analyst does all in his/her power to understand the barriers to treatment so that the analysand is given the highest degree of care. In psychoanalysis, advocacy is addressed by interpretation of resistance; however, in extreme circumstances (e.g. danger to self and others), the analyst, being reasonable, prudent and lawful, will exceed traditional parameters and intervene.

In determining the proficiency of the clinical social worker psychoanalyst, nothing is more telling than his/her competency in the areas of Professional Knowledge and Practice Skills, whose characteristics may each be measured in the following specific terms: Assessment and Diagnosis; Treatment Considerations; Intervention; Outcome Evaluation; and Supervision, Consultation, Teaching, and Writing.

A. Professional Knowledge

The clinical social worker psychoanalyst has a knowledge of psychoanalysis that encompasses a thorough grasp of theoretical concepts, an ability to apply theory to practice, and a practice wisdom gained from years of experience in this field. Examples of such knowledge include expert diagnostic skills; understanding of the centrality of unconscious mental processes; familiarity with defense mechanisms, transference, counter-transference, and resistance phenomena; recognition of the limitations of psychoanalysis with certain populations; and the experience of having been psychoanalyzed. The analyst has the knowledge and skills to integrate these elements into his or her practice and to

work unsupervised. (See Tables 1-5 for a detailed listing of the characteristics of Professional Knowledge.)

B. Practice Skills

The clinical social worker psychoanalyst has the skills to apply theory effectively and has the competence to monitor his/her own practice, to pursue professional development, and to know when to seek consultation and/or supervision. A mature, flexible interpretation of theory is a hallmark of the advanced level of practice, in which the advanced analyst may serve as mentor or supervisor to colleagues. (See Tables 1-5 for a detailed listing of the characteristics of Practice Skills.)

Table 1
Professional Competencies of the Clinical Social Worker Psychoanalyst

<u>Assessment and Diagnosis</u>

"Characteristics of Professional Knowledge"	**"Characteristics of Practice Skills"**
▪ Determines the analyzability of the analysand and the ability to symbolize and self reflect	▪ Performs a comprehensive evaluation of the analysand's strengths and weaknesses, cultural influences, interpersonal influences and environmental stressors as part of the assessment process
▪ Uses advanced knowledge base and bio-psycho-social framework to arrive at a conceptual diagnostic assessment of the personality structure of the analysand	▪ Considers interplay of internal and external stressors, conscious and unconscious motivations, and past and present experiences in diagnostic formulations
▪ Has knowledge of factors relating to culture, ethnicity, gender, age and lifestyle and is aware of limitations of theory in addressing societal problems	▪ Conducts ongoing assessment of the analysand's capacity to bring unconscious mental elements into awareness
▪ Uses multimodal assessment process taking analysand/ family/peripheral resources into account	▪ Identifies physiological and other variables (e.g. medical instability, substance abuse, learning disabilities) that require collaboration with other professionals
▪ Has deep, broad diagnostic knowledge and applies it in treatment	▪ Independently employs standard diagnostic classification system to make differential diagnoses, ruling out other diagnoses and evaluating for comorbidity
▪ Has knowledge of specific categories of emotional disorders and disturbance (as in the DSM-IV-TR) and of when they need to be addressed separately from the analytic process	▪ Continually uses analysand's associations and other indicators/connections to refine the conceptual assessment and diagnosis
▪ Familiarity with mastery of multiple treatment modalities and their appropriate applications for assessment and diagnostic purposes	▪ Systematically analyzes the multiple contexts affecting the analysand's functioning, including constitutional, developmental, historical, psycho-physiological, socio-cultural, religious, economic and political forces

Table 2
Professional Competencies of the Clinical Social Worker Psychoanalyst

<u>Treatment Considerations</u>

"Characteristics of Professional Knowledge"

- Forms verifiable professional opinion as to the appropriate clinical approach including the type of intervention, based on the diagnostic assessment

- Determines treatment based on factors like the nature of the analysand's problem (duration, severity, and environmental contributions), and the nature and degree of intrapsychic difficulty, as well as respect for the analysand's autonomy

- Integrates theory in the treatment approach based on the needs of the analysand, including the need for a consistent and coherent conceptual framework

- Is attuned to the analysand's language, interests, and culture in order to facilitate communication and maintain a therapeutic alliance

- May develop referral base and broad professional contacts to increase treatment options

"Characteristics of Practice Skills"

- Bases treatment recommendations on assessment and diagnosis and, if required, on consultation with professions in related disciplines, availability of collateral resources, specific treatments needed for focal problems, and socio-cultural factors

- Educates and prepares analysands with information about treatment and participation, including the rationale for psychoanalytic treatment and about the nature of this process

- Establishes clear parameters regarding treatment plan, including setting, time and frequency of sessions, fees for services, goals and objectives

- Maintains sufficient self awareness to factor in (analyst's) own issues

- Considers adjunctive therapies, such as medical and pharmacological treatment

- Collaborates with the analysand in determining treatment goals

- Tailors interpretations and clarifications to analysand's psychological needs and level of development, and considers analysand risk

- Incorporates responses and observations of analysand to refine intervention strategies

- Demonstrates ability to appreciate the similarities and respect the differences of the analysand (e.g. gender, sexual orientation, ethnicity, culture, etc.)

Table 3
Professional Competencies of the Clinical Social Worker Psychoanalyst

Intervention

"Characteristics of Professional Knowledge"	**"Characteristics of Practice Skills"**
▪ Has sufficient knowledge and practice experience to independently conduct the psychoanalytic treatment	▪ Implements treatment interventions based on psychoanalytic model of treatment
▪ Has the ability to form a professional opinion justifying choice of psychoanalysis as method of treatment employed and intervention utilized	▪ Carries out treatment with a high level of expertise and works effectively with a broad range of affect, behavior and cognition
▪ Is knowledgeable about the theory and technique of psychoanalysis	▪ Permits and is informed by expression of intense affect states, both positive and negative
▪ Understands the concept of the therapeutic alliance with analysand and respects the centrality of the therapeutic relationship	▪ Applies psychoanalytic theory and technique to develop creative and flexible treatment strategies
▪ Understands and monitors the process of transference and countertransference as to advance the treatment without crossing boundaries	▪ Adeptly sustains a therapeutic alliance with the analysand, utilizing empathic responses to the analysand to increase mutual understanding of their needs and conflicts
▪ Understands the psychoanalytic process of termination	▪ Facilitates the process of adaptation in multiple spheres of functioning
	▪ Demonstrates respect for and empathy with the analysand's style of communication, including readiness to reveal thoughts, choice of activities, and silence
	▪ Works with the transference and countertransference configurations as a central focus in the understanding of the mental life of the analysand
	▪ Is continually alert to impasses and/or disruptions in the treatment and works to repair them
	▪ Understands the process and use of dream interpretation
	▪ Recognizes psychological significance of the termination process and can assist client in dealing with the issues it evokes
	▪ Assesses readiness for termination in collaboration with analysand in terms of treatment and level of functioning
	▪ Terminates treatment in consultation with the analysand in a responsible manner

Table 4
Professional Competencies of the Clinical Social Worker Psychoanalyst

Outcome Evaluation

"Characteristics of Professional Knowledge"

- Understands the relationship of the development of the transferences to the phases of treatment

- Is aware of indicators of intrapsychic change such as recognizing changes in organization of memory, ability to manage relationships, and capacity for affect regulation

- Has knowledge to evaluate the need for adjunct services (i.e. medication, couples therapy, marital therapy, child therapy, etc.) and arranges for them when indicated

- May have sufficient knowledge to develop treatment-outcome evaluation

- Understands own knowledge deficits and seeks consultation as needed and continuing education regularly

"Characteristics of Practice Skills"

- Monitors own practice, identifies own problem areas, and addresses them with intervention strategies, including consultation or referral, when indicated

- Considers both formal and informal feedback from analysands in evaluating clinical efficacy

- Can define limitations and effectiveness of various approaches to care and can differentiate realistic from unrealistic goals

- Evaluates with the analysand the achievements of treatment and remaining work

- Monitors and evaluates transference and counter-transference in the psychoanalytic treatment process

- Consults with peers as needed regarding ongoing transference/counter-transference issues and problematic cases

- May develop or contribute to new outcome evaluation models/measures

- Bases termination on goals to which the analysand has agreed (post-termination consultation is available)

Table 5
Professional Competencies of the Clinical Social Worker Psychoanalyst

Supervision, Consultation, Training and Writing

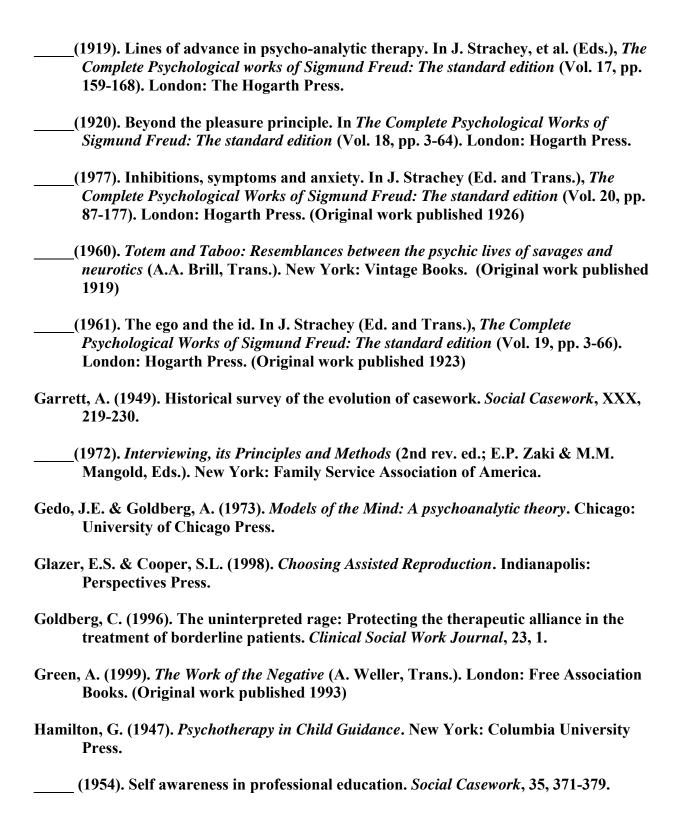### "Characteristics of Professional Knowledge"

- Recognized as an expert clinical social worker psychoanalyst or clinician by peers and the professional community

- Has acquired sufficient knowledge to provide consultation, supervision, and education about psychoanalysis to less experienced and non-analytic practitioners

- Has sufficient knowledge to provide education, consultation, and training to other professionals and to the public

- Imparts knowledge to others with objectivity and respect

- Stays abreast of scientific and professional literature

- Engages in activities which promote increasing professional knowledge base such as courses in supervision or the functional equivalent

- Pursues continuing education and seeks out consultation to keep abreast of emerging theoretical thinking and treatment approaches

- Able and willing to recognize the need for supervision and consultation and be willing to seek it out

"Characteristics of Practice Skills"

- Recognized as expert by colleagues as demonstrated by referrals and consultation requests

- Provides and uses supervision/consultation to refine psychoanalytic knowledge and technique

- May participate in research projects, outcome studies, and continued scholarship

- May exercise leadership as a clinical social worker psychoanalyst by writing, speaking, teaching, researching, and/or publishing

- May assume political and educational positions to further the field of clinical social work psychoanalysis

- May publish in the field of psychoanalysis

- May serve on professional boards or provide community service representing the discipline of clinical social work and the specialty of psychoanalysis

- May participate as evaluator of services or programs, serve on advisory or service boards

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The Supplementary Bibliography of this paper, containing non-cited references, may be found on the American Board of Examiners web site: www.abecsw.org

Publisher's Note with Acknowledgments

This paper is the intellectual property of the publisher, American Board of Examiners in Clinical Social Work (ABE).

The final version of this paper was produced by the ABE Work Group on Psychoanalysis, facilitated by ABE staffer Dianne Moran and composed of Barbara Berger, Ph.D., BCD; Elizabeth Horton, MSW, BCD; Crayton Rowe, MSW, BCD; Dennis Shelby, Ph.D.; Howard Snooks, Ph.D., BCD; Janet Vogelsang, MSW, BCD; and Margaret Wool, Ph.D., BCD. The paper was circulated in draft to a number of expert readers*, whose comments, in some instances, were incorporated into this published version, which was co-edited by Howard Snooks and Robert Booth.

An earlier draft of this paper was prepared at the direction of the ABE Specialty Credentials Committee, chaired by Howard Snooks, and was delivered in February, 2002. That draft was produced by the ABE Specialty Credentials Subcommittee on Psychoanalysis, whose chair was Cecily G. Weintraub, Ph.D., BCD, and whose members were Chad Breckenridge, MSW, BCD; Cathy Krown Buirski, MSW, BCD; James Engelbrecht, M.A., BCD; William Meyer, MSW, BCD; and Margaret Wool, Ph.D., BCD. The subcommittee's consultant was Joyce Edward, MSSA, BCD.