NEWSLETTER

FROM OUR PRESIDENT

Elizabeth Waiess, Psy.D.

You are a psychoanalyst or psychoanalytic clinician who probably gets several calls a month from individuals seeking therapy for themselves or their children. A few minutes into the initial call comes the question, “Can you take my insurance?” You have reached one of the “make-it or break-it” obstacles to treatment. Are you paneled, in-network, out-of-network, and do you bill insurances at all? (continued on page 2)

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FROM OUR PRESIDENT

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The practical question is rarely about whether psychoanalysis and psychodynamic therapy have been proven to bring about change, but whether the individual can rise to the challenge of affording what we know is so helpful. For some, this is a non-issue; though they have insurance, they opt not to use it because they do not want a medical record about their diagnosis and treatment, and they can pay out of pocket. Others don't even mention insurance and can easily afford to put down the full fee. Probably the majority of Americans, however, have learned to expect to use their insurance for any medical problem and will not even consider paying out of pocket. If the provider cannot get reimbursed by the insurance company, the person looks elsewhere, apparently without awareness of what they might be walking away from by limiting their options in this artificial way. Then, as we all know, the middle-class is diminishing; and it is not because citizens are moving into the upper classes. A large percentage of Americans do not even have health insurance, or they have insurance with such high deductibles and copays that they do not want the insurance billed. This is the world we are living in right now, and it is going to be that way for a while.

There are a few doctoral programs that award a degree in psychoanalysis in the United States and a few more which are psychoanalytic in orientation. In Michigan, we have Madonna University and the Michigan School of Professional Psychology which are psychoanalytic in their approach. In regards to exposure to psychoanalysis, the average American gets none or very little. The adolescents whom I have worked with get a smattering of Freud in high school psychology classes. Undergraduates who are required to take Psych 101 also get a version that is greatly out of date, a peculiar rendering of the theory, or outrageous. In the words of one of my students, "I heard that Freud said that it doesn't hurt kids to have sex with their parents". This student had learned that from a previous psychology instructor. Then there are the graduate programs. We all know that psychoanalysis is not in vogue in the psychology and social work graduate programs in Michigan. Psychiatry students who want to learn how to do psychotherapy must wait until they have completed their education or imperil their status in their medical schools. How frustrating is this: knowing how effective a treatment is, yet having it bypassed by the majority of schools of higher education, both public and private?

My program was psychodynamic, and I was able to start working as a clinician in a community clinic. Clinicians were routinely allowed to see patients more than one time a week. I do recall when this changed around 1986, and the push came to see more patients and thus less frequently. Now, it is very difficult for a new graduate to get a clinical job in a community setting where he/she will actually be doing one-to-one therapy for the majority of the day. And the required mode of treatment is first going to be biological. I have noted the increasing move toward "privatization" of community services, which seems, in actuality, to mean grant-supported clinics staffed with underpaid and overworked clinicians. Therapists working with adults and children have increasingly come under pressure from third party payers to prove treatment's necessity and efficacy. The amount of paperwork involved in documenting has always been onerous in clinics. This has entered the private practice as has the mandatory setting up of treatment goals and date of expected

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MEMBERSHIP NEWS AND NOTES

On October 22, 2012, at the Somerset Inn in Troy, **Alvin Curtis Spindler, M.D.** co-directed and co-presented with E. J. Spindler, M.D., a 3-hour course at the Annual Scientific Meeting of the Michigan State Medical Society titled, "The Musical Genius and the Medical Ass: Understanding Our Difficult Patients through an Interactive Case Study of Our Mystery Composer and His Music." At the same conference, he co-presented with E. J. Spindler, M.D., a powerpoint on "Mirror Neurons and Empathy" and co-directed the course "Obesity: the Body Speaks" with C. Klyman, M.D., (MPI psychoanalyst) and E.J. Spindler, M.D.

On September 21-22, 2012, at the Campus Inn in Ann Arbor, **Evangeline J. Spindler, M.D.** co-chaired and co-moderated with Andrew Barnoffsky, M.D. (UM Hospital Ethics Chair/E.R. specialist) and Stanley Wolfe, M.D. (bioethicist/cardiologist) the Michigan State Medical Society Foundation's Annual Bioethics Conference titled "Will the Patient-Physician Relationship Survive?"

She also co-authored with Alvin Curtis Spindler, M.D. and Robert E. Weinstein, M.D. a paper (in press in the upcoming MPC Bulletin) titled "Trauma and Mastery through Music: Beethoven, His Deafness and His Symphonies."

Just Released: Introduction to Child, Adolescent, and Adult Development: A Psychoanalytic Perspective for Students and Professionals, by **Ivan Sherick, Ph.D.** Available from Amazon and Kindle.

A new book by **Ellen Toronto, Ph.D.** will be available on Amazon.com in early 2013. Entitled *Family Entanglement: Unravelling the Knots and Finding Joy in the Parent-Child Journey*, the book strives to present complex relational psychoanalytic concepts in terms that are accessible to a lay audience.

Dr. Toronto, drawing from her experience parenting four sons and her training and professional expertise, explores the concept of the core or authentic self, the influence of childhood on the reactions and behaviors of the parent, the complexity of familial bonds, and the redemption and forgiveness needed to address our imperfections. Her book considers the feelings of bewilderment, stress, and exhaustion that new parents face. She shares a glimpse of what happens in real families behind closed doors.

While frankly discussing the psychological issues parents encounter, the text presents a parenting model that can reduce family conflict and create an atmosphere of harmony in the home. *Family Entanglement* takes readers through the familial arc beginning with the early years of sleep deprivation, moving through the middle years of school and homework, the teen years of sexuality and new-found autonomy, and finally to the bittersweet era of grown children leaving home.

Dr. Toronto is a founding member and past president of MPC. She and her husband have four sons and ten grand-children.

STARTING A PSYCHOANALYTIC PSYCHOTHERAPY PRACTICE

Edward P. Schmitt, Psy.D.

The high turnout of early career psychotherapists for Michael Rudy's MPC presentation in October, "The Business of Psychotherapy: Your Greatest Financial Risk is Not Knowing Your Risks," was exciting and enlivening. It confirms significant interest among early career professionals in starting and working in private practice and the need beginning therapists have for accurate information about how to do it. More than two decades ago, while completing my internship at one of the nation's top 25 hospitals, I was told that private practice was dead, or at least nearly impossible, and that having a psychoanalytic practice was almost certainly not workable unless one did short term or CBT treatment and tracked patients' progress by administering weekly outcome measures. Fortunately, I had other advisors, like Bertram Karon, who told me that it could be done, was being done, and that there were people I should talk to who were actually doing it. I didn't fully believe him; but, because I trusted him, I followed his guidance and tried it. This is how I began the somewhat unusual path of entering private practice at the beginning of my career. Dr. Karon and others taught me the simple axiom that if you want to learn something you should consult with someone who has done it and/or is doing it rather than someone who has not. Simple advice, but true. It continually surprises me just how often otherwise intelligent people forget this.

My clinical supervisors and advisors at internship and in academia were well meaning, committed, and decent people; but, they could not teach me what they did not know how to do. Instead, I joined MPC and began learning to be a good psychoanalytic psychotherapist by the standard method: getting my own therapy (up to three times a week), learning via psychoanalytic supervision, and taking courses offered through this organization. As a result, my skills and practice grew and developed. I now counsel early career and beginning psychotherapists that the surest way to fail in private practice is to listen to the conventional wisdom that you need to do only Cognitive Behavior Therapy, or Short Term Therapy, and need to document your treatment success with checklists. If I had followed this advice, I am certain that I would have failed. Instead, I did the best psychodynamic work I could (given my own level of personal growth and self understanding at the time), and I continued my education via MPC.

Now, over 25 years later, I have a thriving practice, enough referrals to support myself and my wife (Dr. Marie McKay) in full-time private practice, as well as send excess referrals to the 6 colleagues who practice with us.

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Dr. Edward P. Schmitt, Psy. D.

WHY TRAIN TO BE A PSYCHOANALYST IN AN "EBT" AGE?

Michele Rivette, L.M.S.W., A.C.S.W.

Periodically, colleagues who are not in the psychoanalytic community ask me why I was attracted to psychoanalytic training, especially as a clinical social worker. Psychoanalytic training is long (4-7 years, depending how aggressively one manages the requirements), expensive (particularly the personal analysis and clinical supervision), and perceived by some as a treatment modality that has fallen out of favor in the managed care and "evidence-based therapy (EBT)" culture that is our mental health care system today. Certainly, during the 23 years that I have been in practice and teaching graduate students, social work, psychology and psychiatry programs have gradually decreased coursework and clinical placements that would expose trainees to psychodynamic/ psychoanalytic theory and practice, thereby denying new graduates/trainees a chance to come to their own conclusions about psychoanalytic theories and clinical practice. This has been directly related to the rise of so-called EBTs which are preferred by managed care organizations and insurance companies for reasons that are beyond the scope of this article, but certainly include the fact that they are more amenable to more symptom-focused treatment plans and brief treatments. Many social workers not familiar with contemporary psychoanalysis have a stereotyped perception of the psychoanalyst as a patriarchal figure of the Freudian tradition who acts upon the patient with interpretations as his or her primary strategy for uncovering unconscious material. In this vein, there are still negative characterizations of psychoanalytic clinicians as being motivated to keep their patients in therapy or analysis to endlessly pursue deeper material (the "navel-gazing" metaphor). I would like to offer my own thoughts and experiences about why I chose to undergo psychoanalytic training, particularly through MPC. I can only offer my perspective as a clinical social worker, but I imagine that colleagues in psychology and psychiatry may have similar motivations and experiences.

My only exposure to psychoanalytic theory in graduate school was a half semester in which we read "An Elementary Textbook of Psychoanalysis" by Charles Brenner, M.D. It was a good basic text in terms of learning about classical psychoanalytic concepts, but this limited exposure did nothing to dispel my own perception of psychoanalysis as being a bit dry and intellectualized. For my own counter-dependent neurotic reasons, the idea of practicing long-term, intensive therapy was not my goal at that time. My focus in graduate school was social work in the public health and healthcare realm, as I was intending to take pre-medicine courses afterwards and apply to medical school. I was working in a psychiatric emergency room at the time, and I remember saying to my colleagues that I liked intervening with people during times of crisis, then sending them on to work with their therapists because I had no desire to "take care of" people in that extended way.

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NEWS FROM THE VICE PRESIDENT OF CERTIFICATION: SONYA FREIBAND, PH.D.

In the past few years, MPC has certified a number of new psychoanalysts who were candidates in our program. Certification by MPC involved having completed a prescribed course of study through our training program, having satisfied the requirements of supervision and personal analysis, and having written a paper suitable for presentation or publication. We are very proud of the following graduates from our program:

Michele Rivette, MSW, ACSW (May 2011, Adult Psychoanalyst)

Reena Liberman, M.S. (March 2012, Adult Psychoanalyst)

Marybeth Atwell, LCSW (May 2012, Adult Psychoanalyst)

We are also pleased to have certified a number of psychoanalysts in the past few years who were not trained at MPC. These analysts have met equivalent requirements from other institutions and were seen as bringing other talents and viewpoints to our organization which would enrich us as a whole. We have been happy to welcome the following analysts as certified analysts in MPC:

Maria Slowiaczek, Ph.D. (January 2011, Adult Psychoanalyst)

Michael Singer, Ph.D. (March 2012; Adult, Child, and Adolescent Psychoanalyst)

Ivan Sherick, Ph.D. (November, 2012; Adult, Child, and Adolescent Psychoanalyst)

In addition, we have had one graduate from our training program in Psychoanalytic Psychotherapy, which involves an elective course of study, supervision, and personal psychotherapy. We awarded certification to:

Sheila Wasung, LMSW, ACSW (May 2011, Psychoanalytic Psychotherapist)

We are pleased to have the following clinicians currently in our Adult Psychoanalysis training program:

David Freiband, MSW, Ph.D.
William Gaines, Ph.D.
Cynthia Hockett, Ph.D.
Ralph Hutchison, Ph.D.
Michael Rudy, MSW
L. Kay Sorrell, MSW

We have one new candidate in our Psychoanalytic Psychotherapy training program:

Laura Pierce, Ph.D.

Sonya Freiband

Michael Singer

Marybeth Atwell

Reena Liberman

OPEN DIALOGUE

Rebecca Hatton, Ph.D.

You may have heard about Finnish Open Dialogue, a method of family therapy used in W. Lapland, Finland, that has reduced the prevalence of schizophrenia by over 80%. These outcomes have been accomplished with minimal use of neuroleptics (19-28% use antipsychotics long term). Recent outcome studies are suggesting that Dialogue may be lowering the *incidence* of psychotic crisis as well, perhaps due to the fact that about half the residents of W. Lapland have taken part in "network dialogues" since the implementation of dialogic practice 25 years ago. A high level of trust is generated by Dialogue that is highly accepting, egalitarian, and non-pathologizing.

Open Dialogue was developed by psychoanalysts and family therapists in Finland in the 1980s and '90s. It has roots in the work of American and German analysts such as Harry Stack Sullivan, Frieda Fromm-Reichman, and Bert Karon (a member of Michigan Psychoanalytic Council) who worked successfully with people having 'anomalous experiences'. Finnish psychologists consulted with Dr. Karon in the process of developing Dialogue. A key researcher, Jaakko Seikkula, told me that Dr. Karon "is always with me in my heart when I am working". Another foundational resource were family therapists, again primarily American, who explored communication in families experiencing psychotic crises (Gregory Bateson, Jay Haley, etc). A Soviet philosopher, Mikhail Bakhtin, developed dialogical concepts, ironically while working under conditions of severe censorship, that were integrated with clinical methods to form dialogical therapy approaches.

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NEW TO MPC:

Carole Symer recently relocated her private practice as a neuropsychologist and psychoanalyst to Ann Arbor from East Hampton, New York, where she served as a consultant to local schools as well as to the medical staff at Southampton Hospital. In recent years, as an adjunct faculty member at New York University (where she trained at the doctoral and postdoctoral levels), Carole taught doctoral students in clinical assessment; continues to serve on the Committee on Ethnicity, Race, Class, Culture and Language; and helped to found NYU's Postdoctoral Program in Psychotherapy and Psychoanalysis. In Ann Arbor, Carole is a family consultant at Allen Creek Preschool where she is scheduled to give a talk in January 2013 on "Raising Socially Responsible Kids" and an in-service training later this year on the psychosocial considerations when teaching and treating the bilingual child. (continued on page 9)

STARTING A PSYCHOANALYTIC PSYCHOTHERAPY PRACTICE

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I have learned that, although few patients are willing to pay $125 per hour for CBT or Short Term Therapy, many are willing to pay for treatment focused upon helping them truly understand themselves in a deeply meaningful way, both consciously and unconsciously. Although I have found that I need to take the time and initiative to educate them about psychodynamics and what "unconscious" means, they are very willing to learn. This includes teaching them to understand the effects of events during their entire lives from childhood to adulthood.

People who are hurting hunger for this kind of understanding and currently can find few places where they can obtain this help. For example, despite the existence of a very large, non-profit, Christian Mental Health Organization in my area with many therapists and numerous outpatient clinics, they do not offer this high quality psychodynamic or psychoanalytic psychotherapy. However, our practice has thrived because we do.

Because I practice in West Michigan, the heart of the Christian Reformed Sect, I was told that many in my area seem to avoid self understanding, and instead turn to God, church and prayer, and I was discouraged from opening a practice here. Nonetheless, I did, and my practice has grown over the years, requiring four moves to increasingly larger offices. In this working class, western suburb of greater Grand Rapids, there were no private practices; because everyone "knew" that the people here were not psychologically minded or sophisticated. Nonetheless, I survived and eventually thrived by doing good psychodynamic and psychoanalytic work. Because this was what my patients required to resolve their most difficult human conundrums and conflicts when the other therapists they had seen had failed. It can be said that the non-psychodynamic or non-psychoanalytically oriented therapists in my area helped me build my practice by not having the skills to help their patients. Many of their ex-patients would eventually find their way to our office for another go at treatment, and we had the uncommon skills to help them. To summarize then, my advice to the many early career therapists who attended Michael Rudy's informative presentation is to join Michigan Psychoanalytic Council and continue to learn from the many experienced therapists who make up the MPC membership, as I did. The Michigan Psychoanalytic Council, is an organization whose members know how to build, maintain and be successful in the private practice of psychoanalytic psychotherapy and psychoanalysis, they can teach what they know and are eager to do so. Just ask them. I will close with an offer to assist any of you who are interested in starting or growing a private psychodynamic or psychoanalytic practice. Just contact me, and I will do my best to pass on what I have learned. Good luck, you are in good company.

The MPC Newsletter

All material for **The MPC Newsletter** should be submitted as follows: (a) through an attachment in email as a Microsoft Word or Pages document, or (b) as text in an email.

The Editors reserve the right to edit material submitted for purposes of clarity and length.

The Editors and the MPC Board of Directors retain the absolute right to accept or refuse to publish any material submitted to **The MPC Newsletter**. Publication in no way implies MPC's endorsement of or agreement with the published material.

Advertising

Full Page $300; Half page $225

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Per Line: $7 per 50 character line (including all characters, spaces, punctuation, etc.), 2 line minimum.

Letters to the Editor: up to 300 words long and may be edited for brevity.

Submit materials, articles, or advertisements to:

Barbara L. Gamble, MS
202 East Washington Street, Suite 308
Ann Arbor, MI 48104
734-646-6406, BarbaraLGamble@gmail.com

The Michigan Psychoanalytic Council (MPC) was formed in 1988 as an organization dedicated to the study of classical and contemporary psychoanalytic concepts, and to the training of psychoanalysts and psychoanalytically oriented psychotherapists. Founding members were interested in creating an organization that would run on egalitarian and gender sensitive principles. The formal training program offers certification in Adult and Child Psychoanalysis to qualified individuals, as well as in Psychoanalytic Psychotherapy. MPC also offers regular scientific meetings and other programs for professionals in psychology, psychiatry, social work, and related fields. Courses are offered in Ann Arbor, East Lansing, Metro Detroit, and Grand Rapids.

Carol Symer
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Carole welcomes conversations with other analysts and evaluators who share curiosity about understanding the interplay of neuropsychological issues with dynamical components in our clients' stories. She finds current conversations within neuropsychology, philosophy, and psychoanalysis vital to contemplating questions such as what it means to be human and how we build more play into learning, especially for people of all ages with acquired and developmental disabilities, including relational trauma. Carole finds dialoging with other analysts helpful in addressing the challenge of 'other minds' in fostering therapeutic action, in working through relational impasses, and in enhancing the potential for a shared 'we' space in which both analyst and analysand are free to recognize, relate and imagine the Other out into the world.

In addition to spending time with family and friends, Carole enjoys yoga, cooking, going to concerts, and studying Mandarin.

FROM OUR PRESIDENT

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achievement. Of course, psychoanalysts do not work or think that way. In the words of one of my patients, he "wants to enjoy his life." How does one quantify that or set the date of achievement? And is that even an acceptable goal to a third party payer? Of course not. On the other hand, not that long ago psychologists and social workers were not permitted to conduct psychotherapy in the United States and practicing independently was unthinkable. Today these privileges are not under attack, though how to conduct the treatment is obviously coming under increasing scrutiny and increasing restrictions if third party payers are involved.

These are serious challenges faced by psychoanalysts and psychoanalytic clinicians every day. The psychoanalytic community has become essential in a new way: as a source of shared energy, where we leave meetings feeling supported and uplifted, fueling our work in the consulting room. We want and encourage students at all levels to approach with respect and curiosity---to be there to learn. We want and encourage our instructors of all levels to do likewise.

MPC is in the process of coming together in a new way. We are becoming a community of professionals trained through MPC, trained elsewhere, and some not formally trained but having a passion to learn about psychoanalysis. We can study how to turn this into wealth. You are in the enviable position of helping to make to make MPC the psychoanalytic community you need it to be to assist with your work and the newest demands in our field. I hope we will all help to make MPC a community of support and intellectual stimulation.

Our editor has put together a very fine edition of our Newsletter. I hope that you will find something of interest and assistance to you in these pages and perhaps comment on our listserv.

MPC PROGRAMS
Sundays, 11am to 1pm

01-20-13 *Cancer and the Couch: Personal and Professional Reflections.* Patricia Plopa, Ph.D., University Club, East Lansing

02-17-13 *Psychological & Musical Perspectives on Ambiguity.* Julie Nagel, Ph.D., Ann Arbor City Club, Ann Arbor

03-17-13 *Developmental Lines and Neurotic Conflict: A Case Illustration of an Adult.* Ivan Sherick, Ph.D., University Club, East Lansing

04-21-13 *The Developmental Partnership in Psychotherapy & Psychoanalysis.* David Klein, Ph.D., Providence Hospital, Southfield

05-19-13 *Masochism Expressed in Non-Verbal Behavior: Thoughts on the Masochistic Object.* Michael Shulman, Ph.D., Ann Arbor City Club, Ann Arbor

SAVE THE DATE: Our 3 year retreat will be held in East Lansing at the University Club May 31, June 1 & 2, 2013

TRAINING IN AN "EBT" AGE

(continued from page 5)

Like many people who end up being attracted to psychoanalytic work, my real introduction to the heart and soul of it was through my own psychotherapy. Honestly, had I realized my therapist was training to be a psychoanalyst at the time, I might not have been attracted to working with her in the beginning. However, as my work with her deepened and my relationship with her stimulated strong transferential feelings and attachment, I was both a bit anxious and curious. What was most powerfully healing to me was the relationship we developed over a period of five years, increasing the frequency from one to five times per week, and how she actively listened to me and worked with me to develop narratives for feelings and experiences that had previously been handled (or not) on my own. She weathered the affective storms when they came, and I felt the safety of her resiliency and non-judgmental attitude that freed me from the perception that I needed to always be the person who was strong and invulnerable. Over time, I learned that she was a candidate at MPC and I grew interested intellectually in what exactly we were doing that I was finding so moving and helpful for me. I will be forever grateful for the intimacy and safe holding environment that she provided in our work together, and far from being the stereotypic "distant" analyst figure, she made herself emotionally available to me during a particularly intense transference experience and a very significant loss in my family, which was devastating for me at the time. It was through this therapy experience that I worked through my own conflicts and fears about the idea of engaging in intimate relationships with patients that might bring intense feelings of love, hate, desire, dependency, envy, competition, and so forth.

I share my personal story because, unlike some of the negative stereotypes, I find psychoanalytic practice to be very consistent with clinical social work values and ethics related to self-determination and meeting the patient where s/he is. The psychoanalytic process of helping is couched in an attitude of active listening, honoring the patient's self-expression, and doing something *with* rather than *to* the patient. Contemporary psychoanalysis is focused on the patient-therapist relationship, and most analysts I know are far more interested in ideas with which their patient's disagree than in having patients be passive recipients of their interpretations. Sigmund Freud is still viewed as the revolutionary that he was in developing this process for understanding patients at a time when clinicians typically sought to advise, persuade, and even coerce their clients (Alexander & Selesnick, 1966). However, contemporary psychoanalytic training offers exposure not only to classical theory, but to ego psychology, object relations, inter-subjective, and self psychological theories with in-depth attention to personality development, internal identifications (includes race, gender, sexual orientation, social class, etc.) and attachment theory.

In recent years, I have had more opportunity to experience gratitude for my in-depth training in psychoanalysis as a by-product of providing consultation to hospital-based clinicians who are trained in EBTs and from teaching and supervising graduate students in a psychoanalytic Ph.D. program for clinical social workers in Chicago. In both settings, the clinicians--

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TRAINING IN AN EBT AGE
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students are trained in EBTs (cognitive-behavioral, dialectical behavioral, prolonged exposure, etc.) and have had little to no exposure to psychodynamics, even basic concepts of transference, resistance, defense mechanisms, or internal conflict. What I have noticed is that these EBTs require the patient to be *at least* contemplative, but even better, determined to *act* on behavior change at the start of treatment (referencing the motivational interviewing model, which is another of the popular therapeutic concepts out now and essentially a model for working through resistance in psychoanalytic practice). These treatments are action-oriented with assigned homework and overt demands for specific, measurable treatment goals that narrow the focus of treatment, usually around symptoms and behavioral problems. So what is a young EBT therapist to do when their patient(s) are pre-contemplative (don't see that they have a problem) or terribly conflicted and stuck in a contemplative, ruminative state that is a barrier to behavioral change in the near term? In the hospital setting, what seems to happen is the patient is determined by the treatment team to be "not ready" for the EBT treatment and are discharged from the program. On the therapist side, feelings of frustration and blaming the patient can arise when the underlying assumption of what will help the patient relies upon a "student" who actively participates and practices the skills provided by the therapist-manuals. I have also been dismayed to find that many of the EBT therapists have had little intensive training in their treatment modality beyond a conference or two and reading the training manual. I'm sure there are exceptions to this, but it seems to me that the research "evidence" that supports the efficacy of these treatments is conducted in ideal settings where therapists are thoroughly trained in the model and receive clinical supervision and group consultation from other clinicians who are specialists in the model. I am not intending to dismiss that many patients can benefit from the manual-based EBTs, but I am trying to make the case that there are many patients who do not, and worse, end up feeling judged or like they have "failed" treatment because their internal resistances (based on fear, mistrust, attachment issues, masochism, for example) got in the way of benefiting from the EBT – and the model does not allow for a focus on the therapist-patient relationship and working through defensive strategies in the way that a psychoanalytic therapist or analyst would have not only the skills, but the motivation and pleasure in doing so. In the Ph.D. program, I have been curious what motivated the students to make a commitment to an expensive, explicitly psychoanalytic program, almost blindly. The themes that have been shared have included a feeling on the therapist side of "inadequacy" or "failure" when patients are not able to benefit from the EBT; an experience of "boredom" over time at the repetitive and didactic nature of the treatment interventions/ modules; and these experiences in combination with feeling that their master's programs did not provide any depth of training or exposure to the EBT models they graduated to practice, much less to psychodynamic theories.

If colleagues reading this article are interested in psychoanalysis enough to affiliate with the MPC community through membership and attending
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OPEN DIALOGUE

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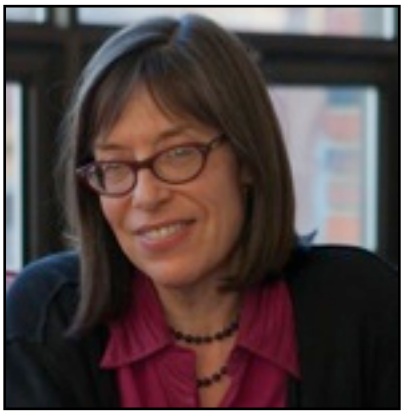
Open Dialogue is known as the Keropudas Model, named in Finland, after a psychiatric hospital no longer in use since crises are responded to in-home, at times with the support of staff who can stay with families overnight. People are seen an average of three weeks after initial signs of psychosis appear, an indication of the high level of acceptance families perceive among professionals. Family members and other supportive people are welcomed into dialogical meetings. Psychosis is viewed as a process that exists among a group of people rather than in the brain or neurochemistry of an individual. The same group of professionals (such as a psychologist, psychiatrist, and nurse) meets with the family each time throughout treatment. Initial meetings may occur daily for a week or two until a crisis stabilizes, then shift to weekly or monthly. Consults or discussions that occur without the family present focus on therapists' reactions and experience, not on the family.

Dialogic therapists strive to hear all voices (physically present or not), including one's disparate inner voices, and to hear the weakest voices especially. Therapists speak in order to hear more, rather than listening in order to speak. We strive to reduce the 'clinical gaze,' the judging and inadvertently distancing approach many of us learned in training. Feedback is often given in the form of reflective conversation among colleagues so it does not appear as a challenge to the family's way of being, but as affirming or alternative voices.

Psychotic symptoms are often found to be responses to 'unspeakable' experiences. Dialogue searches for the meanings a person conveys in the form of symptoms. The crisis tends to resolve as 'symptoms' recover a shared or consensual meaning.

Open Dialogue is a spontaneous process that does not try to 'fix' or change a family. An example of its present focus is the way international conferences are organized. The conference begins with a general meeting where everyone is asked, "what do you hope to gain from this conference?" These are written on large boards, and attenders then vote for their top six topics. Attenders who are specialized in these topics then meet to prepare learning in their areas. My colleagues who have attended these conferences described the process as "life changing" in the way that it speaks to the concerns of the moment with immediacy and energy.

As a member of the first group of Americans training in Open Dialogue, I have been traveling to Massachusetts to meet with a psychologist, Mary Olson, and Finnish and Belgian developers of dialogical methods. My creative and gifted classmates include four psychiatrists, several people recovered from 'chronic schizophrenia,' and nationally known activists in the recovery movement. Classmates in MA and NYC have begun working as teams and report that it is immensely rewarding. A challenge for those of us outside Massachusetts is to form dialogical teams in our local communities. I've begun to think in terms of "Open (Source) Dialogue" and am forming a study group of colleagues intrigued by these ideas seeking to create space for Dialogue in Michigan. If you are interested, please email me at rebecca.hatton1@gmail.com.



TRAINING IN AN EBT AGE

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meetings, but perhaps have not taken any classes or considered committing to a training program in adult or child psychoanalysis or psychoanalytic psychotherapy, let me conclude with a summary of the reasons that I and a number of colleagues have experienced as the benefit of making that commitment, specifically at MPC:

- MPC was founded as an independent institute and has explicit by-laws that emphasize a non-hierarchical training structure and feminist principles. This has meant trainees have more flexibility to choose their own analyst from within or from without MPC, and new graduates become "training analysts" right away, allowing them to treat psychoanalytic candidates, supervise, and teach in the training program. Also, psychoanalytic candidates take courses alongside colleagues who are not in formal training (exception: case conferences).
- Clinicians interested in taking courses can do so without committing to a training program right away. This allows for a clinician to take courses of interest and should s/he decide to enter a training program later, those courses count toward the requirements.
- Coursework, a personal analysis, and clinical supervision make the work so much more interesting and enlivened. Psychoanalytic training deepens the treatment and helps clinicians to develop skills in freely associating during sessions and paying attention to meta-communication in the transference and counter-transference to connect with less-obvious possibilities of what is going on in the moment.
- Training improves the clinician's ability to have a deeper understanding of their patients' dynamics and tolerate affective storms and therapeutic impasses when they occur. It helps us understand our own reactions to patients and identify contributions we may be making when things feel "stuck" or enacted.
- Case conferences and supervision require close process recording notes on specific cases, which is laborious, but allows for an in-depth look at session-by-session clinical work and helps to synthesize the learning from courses and the personal analysis.
- Although training is expensive, many trainees find that they develop a better ability to grow their practice from within. We learn strong skills in clinical diagnostic formulation and how to recommend more intensive treatment (increased frequency of sessions) when it will help a patient to achieve their goals and well-being more effectively and quickly. These skills contribute to a more stable and financially successful practice over time while also offering a thoughtful effective treatment

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TRAINING IN AN EBT AGE

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recommendation to our patients.

- Trainees are encouraged and supported in publishing and presenting their work to our community during monthly clinical programs.
- Finally, MPC has a very diverse, open community of colleagues who are passionate about contemporary psychoanalysis and seek to offer courses and programs that offer intellectual stimulation, emotional support and collegial community. This helps to reduce the isolation that can be experienced in private practice. Trainees develop a particularly close bond over the course of years in taking classes together.

I, and others, have found that after graduation, there is an on-going practice of the process of synthesizing what was learned over the course of the training program. During the course of it, one often hears the voice of his or her analyst or supervisors when sitting with patients, but the day comes when those voices are integrated into one's own analytic identity. I am grateful for all the many years of training and mentors who offered their experience and talents that contributed to the clinician-teacher I am today.

Michele Rivette, L.M.S.W., A.C.S.W. is a psychoanalyst in private practice in Ann Arbor and a Consultant at the Institute for Clinical Social Work in Chicago.

This edition of the MPC Newsletter was edited by Barbara L. Gamble, MS, with much appreciated assistance from Lynne Tenbusch and Reena Liberman.