Developing Practice Guidelines for Psychoanalysis

SHEILA HAFTER GRAY, M.D.

Consensus-based practice guidelines codify clinical intelligence and the rich oral tradition in medicine. Because they reflect actual practice, they are readily accepted by clinicians as a basis for external review. This article illustrates the development of guidelines for a psychoanalytic approach to the large pool of patients who present with depression. It suggests an integrated biopsychosocial approach to these individuals that is useful in current practice, and it offers propositions that may be tested in future research undertakings. Eventually, practice guidelines such as these may form the basis of economical systems of health care that avoid arbitrary, clinically untenable limitations on services.


In this article, I will outline how psychiatrists may formulate practice parameters in a way that benefits our professional development and the care we offer our patients. Practice parameters are strategies for patient management that are developed to assist physicians in clinical decision making. They describe the range of acceptable approaches to diagnosing, managing, or preventing specific diseases or conditions. Because they reflect the diversity of clinical medicine, practice parameters vary considerably in content, format, and degree of specificity. Some are standards; some are guidelines. They may be based on statistical outcome studies or on clinical consensus.

Outcome-based parameters derive their strength but also their weakness from their research foundation. Although there have been several good outcome studies on psychoanalysis, the body of knowledge is inadequate to form the basis of a generally applicable practice parameter. At present, guidelines for psychoanalysis derived from outcome studies alone would be incomplete and difficult to implement.

Consensus-based practice guidelines focus on the experience of clinicians, and they acknowledge the complexity of the individual patient. They codify and integrate existing clinical intelligence and the rich oral tradition.

Received June 8, 1993; revised February 22, 1996; accepted February 28, 1996. From the Department of Psychiatry, University of Maryland School of Medicine, Baltimore, Maryland, and Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC. Address correspondence to Dr. Gray, P.O. Box 40612, Palisades Station, Washington, DC 20016-0612.

Copyright © 1996 American Psychiatric Press, Inc.
in medicine. This makes them better suited than outcome-based parameters for the task of helping the psychiatrist integrate the biopsychosocial aspects of a case. Their delineation of actual contemporary practice also serves the research goal of defining patterns of practice that are appropriate for scientific investigation.

**Toward Developing Guidelines**

Allocating Therapeutic Resources

One ordinarily bases the allocation of therapeutic resources on medical necessity. Peer review is the traditional procedure to monitor this process. When we delineate the knowledge base we implicitly use in this peer review process, we have taken a first step in the development of a practice guideline based on clinical consensus.

The nature of psychotherapy and psychoanalysis requires that this effort to codify be principled, voluntary, and based on broad consensus among practitioners. The guidelines must respect and protect the special doctor-patient relationship that makes psychotherapy possible. They must contain a large measure of appreciation of the individual differences among patients and among psychiatrists. In the absence of definitive knowledge that mandates an unequivocal treatment plan, they must accommodate a range of theoretical and practical approaches to a disorder, and they must state criteria for a successful outcome. They must do all these things not in an ideal space populated with paragon patients, but in a context of clinical reality.

I selected medical psychoanalysis (CPT 90845) as the model psychotherapy to study from this perspective. My earlier work revealed that principles and procedures that support this modality are generally useful for other individual medical psychotherapies (CPT 90844). I selected the specific clinical situation of a patient who presents with depression because the American Psychiatric Association was working on the *Practice Guidelines for Major Depressive Disorder in Adults*.

**Issues Relevant to Constructing Guidelines**

**Important Subject Matter Is Unknown:** Classical psychoanalysis and certain schools of dynamic psychiatry rest on a fundamental assumption that people are motivated by ideas and feelings of which they are unaware and of which they cannot spontaneously become aware. These motive forces are responsible for the formation of symptoms, dreams, and personality. Behavior-oriented psychoanalytic theorists assert similarly that mental disorders contain an important component of disavowed or unacknowledged wishes. We avoid the problem of unknown mental contents by focusing on observable aspects of the patients. These are presented in terms of the formal mental status examination, a full *DSM-IV* diagnosis, and a description of the patients' actions, including their verbal activity in the sessions. This approach lacks metapsychological mystery, but it is accurate and replicable.

Kantor has delineated the diverse findings of the mental status examination in Axis I and Axis II disorders in a way that integrates the biopsychosocial aspects of each case.

**Outcomes Are Unique:** Psychoanalytically informed dynamic psychotherapy focuses on the patient's inner life. Its aim is described by some as the development of insight or self-understanding, or the revision of one's history, or the construction of a coherent and comfortable sense of self. It may involve the discovery of memories of which patient and psychiatrist are, by definition, initially ignorant. Awareness is the anticipated consequence of a process that begins with the establishment of a special doctor-patient relationship, the therapeutic alliance, and goes on through the elucidation of here-and-now transferences to the point at which one remembers or reexperiences the associated past difficulties and reevaluates them in light of contemporary circumstances. One may then
develop a more coherent sense of self, or restructure one's personality, or rewrite one's history, or resume emotional growth. Because the description of these outcomes is unique to each case, to operationalize these variables for an outcome study may at this time be beyond our technical grasp.

The Review Process Always Changes The Case: Each method of review, including a clinician's self-review, has its particular risks and benefits. Each must be scrutinized from the viewpoint of its impact on the clinical psychotherapeutic situation and its specific meaning or meanings to the patient. Lipton, for example, documents the adverse impact on cases of ordinary scientific communication. Because of this phenomenon, psychoanalytic cases are extraordinarily difficult to review.

Writing Notes Degrades Technical Quality: A subcommittee of the Committee on Peer Review of the American Psychoanalytic Association recently studied this problem. It concurred with Adams-Silvan that the process of creating daily notes itself violates the core psychoanalytic technique of listening with even-hovering attention. Notes are therefore not likely to be available as a database for review of psychoanalysis.

Extending Clinical Consensus

Following dynamic treatments over the long term, then, is complicated by the uniqueness of each procedure, by the requirement to preserve the therapeutic alliance, and by the possibility that the review process will sabotage the therapeutic process. In this environment, practice guidelines might be viewed as another ruinous encroachment on the delicate doctor-patient relationship.

I propose that we may mitigate this outcome if we construct guidelines by a process of clinical consensus that reflects the special technical problems of psychoanalysis. In 1975, a group of psychoanalysts of the Baltimore and Washington Psychoanalytic Societies who were members of the Washington Psychiatric Society did just that. The Joint Committee of the Washington and Baltimore-District of Columbia Psychoanalytic Societies for Establishing Peer Review Standards for Psychoanalysis developed guidelines for peer review of psychoanalysis and modified psychoanalytic treatment of adults, adolescents, and children. These guidelines served the District Branch well in its cooperative work with the Utilization and Peer Review Committee of the Medical Society of the District of Columbia and with the American Psychiatric Association's Peer Review Projects. Colleagues tended to heed comments based on these guidelines because they owned them. This report describes an effort to continue this approach at the national level.

Methods

This project stems from an effort to gather facts and opinions on which to base the American Psychoanalytic Association's response to the American Psychiatric Association's Draft Practice Guidelines for Major Depressive Disorder in Adults. I solicited comments from medical psychoanalysts from components of the American Psychoanalytic Association, asking them to focus on how they approached patients who presented with depression. About thirty individuals who had been selected to speak for their local groups offered written contributions. I encouraged the colleagues to tell me what they do and, if they could, why they do it. We also held three small half-day conferences at the scientific meetings of the Association. I used a traditional psychoanalytic methodology, listening to people, understanding the basis of their concerns and their activities, and reflecting this understanding back to them in their own language—the technique of clarification. I tried to abstract from our large psychoanalytic case literature principles that seem to have guided clinicians toward certain interventions and away from others. I set out the process in a logic-driven procedure diagram, which I asked colleagues on the Committee on
Peer Review to test. The aim was to have a set of explicit statements that reflected actual clinical practice.

**Results**

The American Psychoanalytic Association's early guidelines for prescribing psychoanalysis are expressed diagrammatically in Figure 1. The procedure diagram I developed (Figure 2) incorporates these early guidelines. It delineates my best assessment of how good-enough psychoanalysts, to use Winnicott's concept, approach a person who complains of depression. Both diagrams await field trials, based on which there may be further revisions before official action by the Association.

**Psychoanalytic Treatment of Patients Who Present With Depression**

We begin with an undifferentiated group of patients, and in successive steps we isolate those who require and can benefit from psychoanalysis. In this system, psychoanalysis is the treatment of last resort.

*Initial Assessment:* We begin with a rapid assessment designed to answer the question, "Does this individual suffer from a mental disorder?" This guideline is based on the DSM-IV notion of a continuum of depressive disorders from Uncomplicated Bereavement through Adjustment Disorder With Depressed Mood to Major Depression, Melancholic Type. This continuum is a notion based on Freud's germinal work *Mourning and Melancholia.* It is thus congenial to psychoanalysts. It also recognizes that personality disorders may impair the patient's capacity to deal with depression. From this perspective, psychoanalysis represents inappropriate treatment for bereavement and other V-code problems, even when the patient meets criteria for analyzability (see Figure 1). If, however, mourning does not resolve within culturally normative guidelines, the clinician fully reevaluates the individual to decide whether a psychiatric disorder interferes with this ordinary adaptive process or has been precipitated by the loss. In practice, one leaves the door open to these V-coded patients to return if mourning is inhibited or prolonged.

Mental health professionals may present for treatment as part of their education or to enhance their therapeutic skills. They rarely can endorse a true chief complaint, although the prevalence of subclinical dysthymia in this population steers many of these individuals to endorse depression as their problem. Rather than isolate these cases, one asks that they endorse a chief curiosity in lieu of a chief complaint and loops them back into the main stream of psychoanalysis and psychotherapy. This maneuver allows us to monitor the quality of psychotherapies undertaken for training purposes and makes the peer review procedure available to education committees for their special quality assurance work.

This guideline stresses the importance of a full biopsychosocial evaluation. Correct phenomenological diagnosis is essential, but omitting early and conscientious assessment of the dynamic components of a case frequently leads to clinicians' overlooking important aspects of a patient. All psychiatry, and particularly psychoanalytic psychiatry, seems haunted by the DSM-II position that major depression and so-called neurotic depression are mutually exclusive. This colors the American Psychiatric Association's Practice Guideline position on psychotherapy for major depression; it also influences the way older psychoanalytic colleagues think about depressed people. It leads some clinicians to overlook the power of multimodal treatment for patients who function at a neurotic level, and it leads others to underutilize psychotherapy for patients with high-level personality disorders when they present with a severe depressive disorder that clearly requires and responds brilliantly to a biological treatment.

*Trial of Individual Medical Psychotherapy:* A course of brief individual medical psychotherapy accomplishes several functions concur-
rently. It quickly provides the patient with a segment of psychotherapy. It allows the clinician an opportunity to complete a detailed assessment of the case and to complete the initial treatment planning process. For cases in which long-term psychotherapy or psychoanalysis become options, it serves as a test of the patient's capacity to work effectively with the therapist in an insight-seeking mode.

We reassess the patient quickly after three sessions of psychotherapy to verify that the case is stabilizing. We abort the treatment and reevaluate the case if the patient's condition is deteriorating. This is also the point at which we first consider medication. The guideline states clearly that psychopharmacotherapy is an integral element of medical psychoanalysis, and the procedure diagram shows points at which we might consider and administer this. We know that many patients with major depression have a true neurosis and respond well to a combined approach. Several senior colleagues nationwide informed me that the combined approach has been state-of-the-art in their local group for some time. In an unrelated survey, Doidge found that of 641 psychoanalytic patients treated by 237 active members of the American Psychoanalytic Association, 92 (14.4%) were on an antidepressant medication, and slightly more than half of all patients who are treated concurrently with psychoanalysis and pharmacotherapy were medicated by their treating psychoanalysts (Norman Doidge, M.D., personal communication).

At the completion of this module, some patients may require no further treatment or continuing psychotherapeutic management of the biological treatment. Other patients may display either disturbances sufficient to mandate full reevaluation or indications for an intensive insight-seeking treatment. This is a good point for a pre-authorization review. At this time one needs ordinarily to consider a range of treatment options, but I noted that psychoanalysts tended to gravitate toward recommending psychoanalysis or a closely related psychotherapy rather early in this process. This represents a potential weak point that can be addressed by external pre-authorization review. If psychoanalysis is determined to be the preferred treatment, we go to a further brief technical assessment and a clinical trial. This may be followed by a more definitive pre-authorization review based on observations of the patient's actual performance in psychoanalysis. The advantage of this approach is that we have early information about the patient's need for and capacity to work within this demanding modality, and we have optimized the chances for success by having corrected any underlying biological imbalance through medication.

**Trial of Psychoanalysis:** This guideline follows the 1975 consensus of the Baltimore and Washington psychoanalytic colleagues that the treating psychoanalyst should reevaluate a case after 1 year to ensure the appropriateness of the initial prescription. Formal reassessment provides an opportunity to rediagnose, to note progress, and to identify and correct errors in the treatment plan. It also allows patients an opportunity to accept indicated medication that they may have declined earlier. After a successful trial of psychoanalysis we continue treatment and reassess periodically.

**Progress:** Patients demonstrate progress in psychoanalysis in the way they work with the analyst to achieve self-understanding and resume emotional growth. The guideline does not take a position with respect to the nature of these events, leaving each clinician free to define criteria that reflect his or her theoretical views. These subjective criteria are reflected objectively in three places in the DSM-IV diagnosis. The Axis V GAF score will rise dramatically as patients confine their symptoms to the psychoanalytic situation and the transference neurosis consolidates, then rise gradually as treatment goals are realized. Consequently, an external reviewer must guard against disallowing treatment based on an improved Axis V. Our knowledge of how psychoanalysis works suggests that the failure of
FIGURE 1. Determining appropriateness of psychoanalysis. IMP = individual medical psychotherapy (CPT 90844); PYA = medical psychoanalysis (CPT 90845); RX = treatment.

Initial screening interview reveals:

- No mental disorder
  - Terminate process
- Mental disorder present
  - Continue diagnostic evaluation AND
    - Begin dynamic brief IMP
  - 3rd IMP session: Assess progress of IMP:
    - Deteriorating
      - Reevaluate patient immediately
    - Adequate
      - Complete dynamic brief IMP
    - Fair/none
      - Add medication as indicated; complete dynamic brief IMP
- No mental disorder, but person is health professional who endorses a "chief curiosity"
FIGURE 2. Decision tree for psychoanalysts. Patient presents with depression

Patient complains of depression. Begin DSM-IV differential diagnosis:

- No mental disorder/IV code
  - Complete consultation process

- Mental disorder present
  - Continue DSM-IV differential diagnosis AND
    - Begin dynamic brief IMP
      - 3rd IMP session:
        - Assess progress of IMP:
          - Deteriorating
            - Reevaluate patient immediately
          - Adequate
            - Complete dynamic brief IMP
          - Fair/none
            - Complete DSM-IV diagnosis
              - Medicate as indicated; complete dynamic brief IMP
FIGURE 2. Decision tree for psychoanalysts. Patient presents with depression (continued)

1. Assess progress after 3 months:
   - Deteriorating: Revise treatment plan
   - Adequate: Continue PYA
   - Poor: Reevaluate patient
     - Add or change medication as indicated
     - Continue PYA

2. Assess progress at 12-15 months:
   - None: Reevaluate patient
   - Adequate: No change in treatment plan
   - Poor: Revise treatment plan
Axis V to soar should trigger reassessment. In later phases, progress is confirmed objectively by the disappearance of the Axis I disorder and by changes along Axis II that reflect growth in the structure of the patient's personality; Axis II Cluster B disorders will be superseded by Cluster C disorders. At termination, ideally all psychosocial diagnoses disappear and their biological components are in remission.

Complications: This guideline keeps us alert to the possibility that the patient's condition may worsen during treatment. In cases of serious depression, worsening can cause a lethal outcome.

We may view psychoanalysis and dynamic psychotherapy as modalities that offer understanding. Their essential neutrality allows patients to use insight to improve their mental health or to perfect their mental disorder. The negative therapeutic reaction is a special class of complication in which the worsened condition may reflect technical progress in the treatment. This guideline presents an initial attempt to define a way in which the psychiatrist may evaluate such cases and create an appropriate treatment plan for each.

Case Illustrations

The following two cases illustrate aspects of decision making in the treatment of depression without (Case 1) and with (Case 2) the use of the practice guidelines.

Case 1. Wylie and Wylie\(^2\) reported the case of a 39-year-old administrator who consulted a psychoanalyst because she could not establish a satisfactory long-term relationship with a man. She was also anhedonic. She had struggled for many years with intermittent episodes of depression that were refractory to tricyclic antidepressants but responded well to amphetamines. After an initial assessment, the psychiatrist found that the patient met the published diagnostic criteria for anhedonic\(^2\) and instituted psychoanalytic treatment.

Eighteen months into a classical psychoanalysis it was clear that the patient was unable to grasp the special quality of transference relatedness, she was depressed, and she continued to be reluctant to risk an emotional investment in the therapeutic relationship. The history that had been gathered in the course of analysis revealed a severe sensitivity to rejection and a proclivity for self-injurious behavior. At this point the psychiatrist prescribed a monoamine oxidase inhibitor and continued the psychoanalytic treatment.

One month later, the patient spontaneously acknowledged transference feelings within the analytic session. Soon thereafter she was able to collaborate with the psychoanalyst to develop insight; and 2 years later she had achieved her treatment goals. The patient continued to do well at a 10-year follow-up visit (Harold W. Wylie, Jr., M.D., personal communication).

This is one of the earliest published accounts of antidepressant medication used in conjunction with classical psychoanalysis. Applying the proposed guidelines (Figure 2) retrospectively to this case, we note immediately that psychoanalysis was instituted without a trial of psychotherapy adequate to ascertain whether the patient was able to work in an insight-seeking mode. Having failed to establish this point, the psychiatrist continued the psychoanalysis without evidence of progress and without consideration of pharmacotherapy for 18 months. The psychiatrist did eventually come to understand the nature of the problem, reassessed the case, and implemented a treatment plan that resulted in a good outcome in a short time.

Had these guidelines been available at the time this case was treated, the psychiatrist might have recognized early both the need to ascertain that the patient could work in an insight-seeking mode and the importance of considering medication if the initial trial of psychotherapy proved inauspicious. Even if he and the patient had chosen to do only psychoanalysis, it is likely that his early findings would have set the stage for continuous assessment of progress and of the possible use of medication. This process might have shortened the treatment by as much as a full year.
Case 2. A 40-year-old scholar came to me for a second opinion consultation at the request of the treating psychiatrist, who questioned the appropriateness of continuing psychoanalysis without antidepressant medication.

The patient had first consulted the psychiatrist 15 months earlier complaining of unpleasant feelings compounded of anxiety and guilt that had become increasingly intense over a period of 2 years. He viewed them as a response to conflicts related to a parent's suffering and eventual recent death after a long illness. Although he had harbored similar guilt feelings subclinically for years, they seemed to be experienced as background noise that did not interfere with optimal functioning. There had been a course of individual psychotherapy 20 years earlier in connection with discomfort over academic performance. He experienced it as helpful but incomplete.

When the patient first presented to the psychiatrist, depression was the salient clinical finding. He wept often and manifested disturbed sleep patterns, anxiety, irritability, and poor self-esteem. The psychiatrist recommended Individual Medical Psychotherapy (CPT 90844) at a frequency of twice weekly; the prescription explicitly included antidepressant medication. The patient declined the latter.

Three months later, when he had gained some insight but did not achieve full symptom relief and did not seem to be well engaged in the mourning process, the psychiatrist again called attention to the appropriateness of pharmacotherapy. This practice conforms to the guideline for reevaluation of the treatment plan at the completion of brief psychotherapy (Figure 2). The patient again rejected medication and affirmatively requested psychoanalysis. After careful assessment, the psychiatrist agreed. At this point, the plan met guideline criteria because it was developed after appropriate reassessment. They began work in this mode about 1 year before the consultation. They were now at the time of the major reassessment mandated by local guidelines and recommended by this guideline.

The patient arrived precisely on time and settled down to the interview after I made a brief explanation of the function and scope of my inquiry. Pale, flawlessly groomed, and dressed in a well-cut charcoal gray suit, black shirt, tie, and pocket handkerchief, black hose, and black shoes, the patient appeared a picture of continuous, sophisticated mourning. His demeanor was subdued and somewhat apprehensive. He sat directly opposite me in the consulting room and addressed my questions and comments slowly, carefully, and in some detail; yet he revealed very little. He spoke in two voices. One was low-pitched, authoritative, and masterful. The other was higher in pitch; it bore a faint trace of a British academic accent, but the overall impression was of childish vulnerability. The latter voice dominated.

The patient fussed about the formal mental status examination, insisting that the items were too difficult. When I remarked quietly that a demented individual was certainly not analyzable, he quickly tackled the problems, doing well on those that required abstract thought. He endorsed suicidal thoughts in the past; these did not reach the level of a plan. He also endorsed irritability, forgetfulness, and fantasies of vengeance. He denied anhedonia and substance misuse. The patient denied ever having seen visions or heard voices of absent persons; he also denied ideas of uniqueness or of persecution. He had not fainted or had epileptic attacks, including "absences." Social judgment seemed good. Performance on two formal tests of long-term memory seemed impaired by poor concentration; short-term memory seemed adequate.

DSM-IV Diagnosis: Axis I: 296.21 Major Depression, Single Episode, Mild; Axis II: 799.90 Diagnosis Deferred; Axis III: No physical condition that affects the mental status; Axis IV: Death of parent; Axis V: 55 Moderate symptoms of depression and anxiety and some difficulty in social functioning.

The patient may have presented with a major depression, single episode, severe without psychotic features (DSM-IV 296.23). The severity of the disorder abated, but he still endorsed symptoms of a mild major depression. It was not possible to diagnose a specific personality disorder in this single interview. It seemed likely that the anxiety he reported signaled the emergence of an Axis II disorder out of a previously stable and adaptive personality style that faltered in response to the stress of the parent's illness and death.

Although psychoanalysis is very often the treatment of choice in cases where the major therapeutic effort must focus on the personality (Figures 1 and 2), it was clear that after a year of treatment the patient remained mournful. According to the proposed guideline (Figure 2), a trial of medication had been indicated earlier and had
become even more important because he had made inadequate progress without it. In the consultation, I explained to the patient that the presence of an Axis I disorder, even in subclinical form, can and does interfere with the psychoanalytic treatment of an Axis II disorder. Medical psychoanalysis (CPT 90845) that includes psychopharmacology for the Axis I disorder has an excellent chance of success in addressing the biological and psychosocial aspects of the disorder in a coherent and definitive fashion. I supported the treating psychiatrist's prescription of this multimodal approach, recommending the continuation of medical psychoanalysis only if it included the medication component.

DISCUSSION

The effort to establish expert guidelines for a new or revised health care system can lead to conflict with clinicians because expert guidelines favor outcome research over clinical intelligence. Although outcome-based parameters have the advantage of their research foundation, they also have its disadvantages. One is a reliance on statistical studies with problematic methodology. Another is that the present funding environment may have influenced researchers to neglect inquiry into the effect of definitive care over the lifetime of an individual. A third is that because few specific interventions have been studied, practice parameters based on outcome studies are incomplete, and psychiatrists therefore encounter obstacles when they try to implement them in daily practice.

Consensus-based practice guidelines aim to codify the oral tradition in medicine. They are particularly useful in psychoanalysis because psychoanalytic education is grounded in detailed discussion of single cases with a senior teacher. Because they reflect actual practice, they are readily accepted by clinicians.

The development of such guidelines contains a risk of endorsing suboptimal treatment choices. Two pathways are available to mitigate this danger. First, one may use these guidelines as propositions that will be tested in future research. Second, if the consensus process reveals an area in which a professional group did not revise its clinical behavior in response to the emergence of new scientific information, its leaders may use the findings of consensus studies such as this one to develop an educational strategy that targets the particular defect.

As a by-product, these guidelines define a common ground for clinicians and lawyers. Practice guidelines can support the colleague who is sued by providing clear statements about acceptable technique. Detailed discussion of this subject would require another paper.

These guidelines based on emerging clinical consensus help us detect which individuals in the large pool of patients who present with a popular complaint that covers a wide spectrum of psychopathology require and may benefit from psychoanalytic treatment. The guidelines remind us that many patients who have a biological predisposition to depression also have serious neurotic conflict and that we must look beyond medication and support to substantive dynamic treatment for these individuals. Simultaneously, the guidelines help winnow out those patients whose ego structures cannot withstand the rigors of classical psychoanalysis or other intensive psychotherapy. Eventually, such guidelines may form the basis of economical systems of health care that avoid arbitrary, clinically untenable limitations on services.

A different version of this material was presented at the American Psychiatric Association annual meeting, San Francisco, CA, May 24, 1993. The author is grateful for the encouragement and support of the Committee on Peer Review of the American Psychoanalytic Association. Although this article presents some of the Committee’s work, the conclusions and opinions expressed are the author’s alone. This article has not been endorsed by the American Psychoanalytic Association, and it does not reflect its official position. The opinions or assertions contained in this article are the private views of the author and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.
REFERENCES