

A DESCRIPTION AND CLINICAL RESEARCH APPLICATION OF THE CONTROL-MASTERY THEORY*

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ABSTRACT: An introduction to the key concepts in a new psychoanalytic theory, "control-mastery theory" is offered. The role of the trauma and the resulting development of pathogenic beliefs is emphasized in the etiology of all psychopathology. The clinical interventions therapists can use to help patients disconfirm pathogenic beliefs are described. An empirical study is referred to which demonstrates the power of the theory to predict the patient's immediate reactions to the therapist's termination interpretations (Bush & Gassner 1986).

During the last ten years, we have been members of the Mount Zion Psychotherapy Research Group headed by Drs. Harold Sampson and Joseph Weiss. Our group has been studying the empirical evidence for a new psychoanalytic theory, "control-mastery theory" developed by Dr. Weiss. This paper provides a brief introduction to that theory. A more comprehensive presentation of the theory and research data which support it is available in a new book entitled "The Psychoanalytic Process: Theory, Clinical Observations and Empirical Research" (Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986).

The purpose of this paper is to present a theory of psychopathology and treatment which we believe will be of immediate relevance to social workers. There are a number of features of control-mastery theory which are highly compatible with trends in the social work field. For

*This is an informal term used by the Mount Zion Psychotherapy Research Group to refer to the theory which is presented in this paper. The control portion of the term refers to the hypothesis that patients can exercise some control over their unconscious mental life. The mastery portion of the term refers to the hypothesis that psychotherapy patients are motivated to master their problems in treatment.

example, the theory emphasizes the patient's unconscious motivation to recover, that is to achieve important life goals by gaining control over self-destructive patterns of thought and behavior. The theory assumes that all psychopathology arises in the context of traumatic interpersonal relations. The role of external reality is seen as an important factor which must be understood by the therapist and patient in order that maximum therapeutic progress be achieved.

Although the example cited in this paper refers to a completed psychoanalysis, the control-mastery theory is directly applicable to all types of therapy, including crisis intervention, family therapy, marital counseling, brief therapy, and to all patient populations. Control-mastery theory has influenced the thinking, clinical practice, and teaching of social workers in our geographical area, a number of whom have participated in the research on the theory.

Much of the research presented in the book focuses on the psychoanalytic process of the case of Mrs. C., a woman who was analyzed in a different part of the country by an analyst who tape-recorded the sessions, and who was unfamiliar with control-mastery theory. We shall refer to some aspects of her case to help illustrate the concepts of control-mastery theory. We have participated in the Mount Zion Research Group in part because its mission was to carry out systematic and controlled investigations of the therapeutic process. We believed that objective investigations of psychoanalysis strengthen the scientific basis for our work and promote the vitality, excitement and further development of our field. We viewed such research as a means to clarify theory, and to discover how the data of observation support or refute what theory has taught us to expect. While working as practicing clinicians, we cannot free ourselves from the inevitable loss of objectivity that our theoretical orientation compels. Any theory we use inevitably shapes and should shape our observations and understanding of our patients. We all have the challenge of learning from our theories without dogmatically becoming true believers in these theories.

The systematic study of tape-recorded analytic sessions allows investigators of varied theoretical persuasions and from the various mental health professions to consider how well they can predict or account for what actually transpires in a given treatment. Moreover, such research efforts can be replicated by skeptics and enthusiasts alike. Thus, empirical research enables us to question our assumptions, and to be less exclusively dependent on what our teachers or other authorities claim to be true about human nature.

Now to tell you about the theory. Control-mastery theory emphasizes the importance of trauma in the etiology of all forms of psychopathology. By trauma we primarily mean any experience or ongoing life circumstance which leads an individual to believe that an important

goal, be it an instinctual wish or an ego striving, must be given up in order to avoid the interrelated dangers of damaging one's love objects or being damaged by them. Patients enter treatment consciously and unconsciously motivated to achieve important life goals by mastering earlier traumas which had made these goals too dangerous to pursue.

In keeping with Freud's signal theory of anxiety (Freud, 1926), control-mastery theory assumes that following a traumatic occurrence, anxiety will be experienced whenever an individual unconsciously anticipates that there might be a danger of being retraumatized. Guided by unconscious memories of childhood traumas, people form unconscious beliefs about what constitutes situations of danger and use these beliefs to calculate the potential consequences of gratifying a particular impulse or pursuing a particular goal.

Freud's list of childhood dangers included the loss of the parent, the loss of the parent's love, castration anxiety, and superego guilt. In our work, we consider these dangers to be crucially important, but we extend Freud's list of dangers to include parental failures which give rise to trauma, anxiety, conflict, and defense. Although children are often traumatized by parental weakness and deficiencies, it should be remembered that children may also be traumatized by circumstances where from an objective point of view parents are functioning well. For example, the parents of an ill child may have to inflict painful treatments on the child or seriously restrict that child's activities. Children in such a circumstance may develop irrational ideas to explain why they were treated in these ways and may relinquish important developmental strivings as a result of such beliefs.

We think that a universal reaction to trauma is irrational self-blame which leads to unconscious guilt. Unconscious guilt typically stems from the responsibility one assumes for anything bad that happens to oneself or to the people with whom one is emotionally involved. We assume that children greatly exaggerate how their impulses, feelings, and thoughts as well as their actions may affect others and bring harm to themselves. Children, whose thinking is egocentric, have difficulty understanding that the people around them can have feelings, attitudes, and behavior patterns which are caused for reasons independent of them. Adults under stress characteristically regress to such an egocentric position. It is a commonplace observation that when a loved-one dies, or when a person is diagnosed with a fatal illness, the distressed individual responds with conscious and unconscious feelings of self-recrimination. At times like these, people tend to believe that their fate was deserved. It seems virtually impossible, even for adults, not to experience such traumatic events as deserved punishments. Traumatized adults, like children, fall under the sway of magical thinking. They tell themselves, "if only I had done X, Y, or Z, my child wouldn't

have died" or "the tornado wouldn't have destroyed my home." Because adults have had so much more experience learning about cause and effect relationships, they usually have a greater capacity than do children to recognize the distortions in their reality testing and the irrationality of their feelings of self-blame.

Traumatic experiences give rise to unconscious convictions about how one must or must not behave in order to avoid the dangers of re-traumatization. We refer to these irrational convictions which individuals extrapolate from their traumatic experiences as pathogenic beliefs. Pathogenic beliefs can take the form of powerful, unconscious commands which compel an individual to behave in certain ways or which prohibit other kinds of behavior. This is to say that compulsions and inhibitions can be understood as efforts to avoid the dangers which are foretold by pathogenic beliefs.

Typically, pathogenic beliefs involve irrational explanations about how one's behavior caused the trauma to occur. Sometimes these convictions develop at a later time when the person reconstructs what had happened earlier. The patient is someone who has overgeneralized from his traumatic experience. He believes that he must govern his behavior in accordance with false causal explanations not only in the setting in which the trauma occurred, but more generally in the world at large.

The irrational ideas to which a patient subscribes may stem from a number of sources. They may result from the distorting influences of early childhood cognition. They may result from an identification with the parent's pathogenic beliefs. They may also result from the child's compliance with the parent's interpretation of reality. For example, if a child is traumatized by a parent whom the child experiences as intrusive, the child may out of compliance to that parent develop the pathogenic belief that he or she is unentitled to privacy. Such children may also need to protect themselves from knowing how distasteful they find the parent's intrusive behavior, that is they may use denial to ward off the feelings and thoughts that they have in response to intrusiveness. They may also develop a pathological identification with the parent's intrusiveness and accompanying beliefs which convert the distasteful behavior into a virtue. For example, they may come to believe that intrusiveness is an expression of love.

Children are typically traumatized by the suffering or loss of any family member. For example, suppose that while playing hide and go seek a child's sibling is run over and killed in the street. The surviving child might develop the pathogenic belief that it is irresponsible or dangerous to be too carefree and might come to believe that worry and vigilance staves off disaster. We expect that in most circumstances, the illnesses, weaknesses, and prolonged unhappiness of various family members are traumatic for the child. They stimulate the child to de-

velop causal explanations for the family's misfortunes. Typically, the child develops faulty explanations which take the form of pathogenic beliefs, in which the child erroneously blames himself.

In order to discuss our ideas about how patients work in therapy, let us suppose that a man comes into treatment with a childhood history of having felt repeatedly humiliated by his parents. We might discover that the patient has developed the unconscious pathogenic belief that he would hurt his parents and endanger himself, were he to feel openly proud and dignified. He might also believe that he would hurt his parents and others, were he to be relatively unaffected by their expressions of contempt.

It is quite possible that such a patient has a distorted or exaggerated view of his parents' motives. Whereas his parents may have been trying to provide guidance, the patient may have assumed that they were getting pleasure out of saying things which resulted in his feeling small. Often there are misunderstandings between parents and children which perpetuate neurotic dynamics. If such a patient unconsciously believes that it makes his parents feel important to have opportunities to correct him, he may develop an unconscious need to make himself look foolish. This may heighten the parents' efforts to call attention to and correct their child's foolish behavior. Alternatively, the child may accurately perceive his parents' need to belittle him. From case to case, the relative importance of reality factors and distortions will vary as contributing determinants leading to the patient's interpretation of reality.

We would assume that a patient who, amongst his other problems, suffered from this kind of trauma would be motivated in treatment to overcome its deleterious effects. We would expect that such a patient would want to find a way to feel that in his contemporary relations he was not in such great danger of finding people eager to humiliate him, nor did he have to feel so incapacitated by other people's insults.

In our view, patients are strongly motivated both consciously and unconsciously to gain insight into and work through their neurotic conflicts in a fundamental way, in order to master their problems. Control-mastery theory assumes that patients are capable of working constructively to master their problems and that they attempt to enlist the therapist's help in their efforts to achieve this mastery.

We believe that patients develop "unconscious plans" for how to overcome their problems in therapy. Broadly speaking, unconscious plans refer to ways of achieving therapeutic goals by mastering the effects of childhood traumas and thereby overcoming internal obstructions that interfere with the pursuit of those goals. Unconscious plans contain therapeutic goals as well as unconscious strategies for attempting to achieve these goals. Patients' therapeutic strategies are not fixed or

blindly followed, but rather are tentative and conditional, that is, they are modified and revised as the patient attempts to do that therapeutic work.

Unconscious strategies include as a key component various ways to "test" the therapist in an effort to disconfirm the pathogenic beliefs and the associated dangers that prevent patients from pursuing or achieving their goals. Testing is the most effective means by which patients can reevaluate the reality basis for the dangers predicted by their pathogenic beliefs. Patients test in order to ascertain if the conditions of safety exist for making conscious their pathogenic beliefs and attempting to master the childhood traumas from which they arose.

There are two ways in which patients test the therapist. One is that patients unconsciously turn passive into active. In this process, patients treat the therapist in the very ways in which they felt themselves to have been treated and which they found traumatic as children. Unconsciously, they hope that the therapist will not be traumatized as they were, but will instead be able to maintain a therapeutic stance. For example, if the humiliated patient described earlier tests the therapist by ridiculing him, the therapist might pass such a test by exploring what the patient imagines the therapist's reaction is to being ridiculed. The therapist's lack of defensiveness in reaction to being ridiculed may challenge the patient's pathogenic belief that he should treat ridicule as deserved and feel humiliated.

The other way that patients test is through transference repetitions. Patients relate to the therapist by repeating patterns that characterized their behavior with their parents. They especially repeat those behaviors which they believe were the provocations that led to their being traumatized. In transferring, the patient unconsciously attempts to disconfirm a pathogenic belief by testing to see whether the therapist, like the parents, will respond in a manner which the patient found traumatic as a child.

Passed tests help patients challenge their convictions about the reality of the dangers which their pathogenic beliefs predict. As patients discover that the therapist does not reenact with them the traumas they experienced with other family members, they feel safer to lift their defenses and to begin working through their childhood traumatic experiences. We expect that when a therapist passes a test, the patient typically will become more relaxed, bold and insightful. Often the patient will also bring out new information and sometimes, warded-off memories. It should, however, be noted that while a test is in progress, patients may express negative feelings about the very therapist behaviors which they unconsciously find reassuring.

In addition to passing the patient's tests, the therapist helps the patient by making "pro-plan" interpretations whose import is to make

conscious and implicitly disconfirm some aspect of the patient's pathogenic beliefs, or to otherwise assist the patient in moving towards his therapeutic goals. When the therapist provides the patient with insight into his pathogenic beliefs, it increases the patient's conscious control over the effects of those beliefs as well as their capacity to reality test the dangers predicted by those beliefs. When the therapist fails a test or makes interpretations which confirm the patient's pathogenic beliefs, we expect that the patient will experience an increased sense of danger and become more beleaguered, resistant and un insightful. Following a failed test of an anti-plan interpretation, patients will often give the therapist additional tests or easier tests with the unconscious hope that this will help the two of them get back on track.

Our research group has conducted several studies whose purpose was to ascertain whether there actually existed the predicted correspondence between the analyst's passing tests or making pro-plan interventions and the patient's becoming more insightful and making analytic progress. In a successful treatment, the patient creatively and boldly tests the therapist in ways that have a potential of disconfirming his pathogenic beliefs. As patients feel increasingly safe with the therapist, they are able to lift their defenses, bring into consciousness their warded-off strivings, feelings, and memories, and reflect insightfully upon them. In a successful treatment, the therapist is able to pass many of the patient's tests, make corrections for failed tests, and make pro-plan interpretations which increase the patient's insight and diminish the patient's unconscious sense of danger. When the therapeutic process has these characteristics, patients are able to make progress in disconfirming their pathogenic beliefs and thereby emancipate themselves from the constraining effects of their traumatic experiences.

THE CASE OF MRS. C.

The patient is an attractive 28-year-old woman who comes from an upper-middle-class midwestern family. She had been married for about two years when she first sought analysis. Her husband, like her father, is a successful businessman. Her mother is a housewife who also involves herself in civic matters. The third of four children, the patient has an older and younger sister, and a brother who is six years her junior. At the time the patient sought treatment, she was employed as a social worker in a Catholic agency.

The patient's major presenting problem was her inability to enjoy and unwillingness to have sexual relations with her husband. In addition, the patient described her fear of "simply being a nonentity," of existing as a maid to her husband, and of not occupying an equal position in the relationship. She also complained of feeling chronically tense, self-critical, overly anxious, and unable to relax around people. At work she feels driven by a strong sense of obligation and duty, and feels distant from co-workers.

The opening phase of the patient's treatment was studied by two independent research groups. The formulation which the treating analysis held was consistent with the formulation which had been made by the out-of-town group, a group which consisted of three senior analysts. Their formulation was summarized as follows:

Mrs. C.'s difficulties were crystallized after the birth of her brother when she was six. After his birth, Mrs. C. noticed a marked change in her father's and to a lesser extent her mother's attitude to her. She felt that her parents valued her brother more than they valued her, and that her father in particular shifted his love from her to her younger brother. Moreover, she assumed that her father preferred her younger brother because he had a penis and she did not. She assumed too that because she lacked a penis she was doomed to an inferior position in life.

Mrs. C.'s primary unconscious wish was to redress her castrated state. She envied men, and longed to have a penis. She would attempt both in analysis and in her life either to obtain a penis of her own, or to deny the men in her life their pride in their penises by aggressively withholding admiration and sexual response, or by criticisms and attacks on them.

We did a detailed study of the verbatim transcripts of the first ten hours of the case of Mrs. C. We identified six characteristics of her family life, as she perceived it, which we inferred had been traumatic for her. These were her experiences of:

1. her father's extreme narcissistic vulnerability;
2. her father's sadistic mistreatment of others, and of women in particular;
3. her mother's inability to defend herself or the children against father's attacks;
4. her parents' extreme discomfort with physical and emotional intimacy;
5. her parents' inability to enjoy themselves;
6. the intensely competitive family atmosphere which she believed her parents fostered.

We wrote a case formulation that detailed our expectations and inferences about: (1) the nature of the traumas and the resulting unconscious perceptions of danger they gave rise to in the patient; (2) the pathogenic beliefs which the patient developed as a result of her traumatic experiences; (3) the kinds of testing we anticipated that the patient would do in her efforts to disconfirm her pathogenic beliefs; and (4) the kinds of insights that would help the patient master her traumas.

We shall focus on just one of these traumas, her perception of her father's extreme narcissistic vulnerability, in order to illustrate the application of the control-mastery perspective to clinical work. Mrs. C. reported that her father was easily wounded and became uncontrollably angry if family members disagreed with him. Conversely, he was excessively touched when family members agreed with him. Mrs. C. sensed that her father had an urgent need to be right, to be the final authority on all matters, and to feel superior to everyone with whom he related. She felt that he behaved as if there were only one right answer or one

correct solution to every problem—his answer, his solution. He not only demanded that his children agree with his ideas, but that they also share his preferences, to the point of liking the same flavor of a soft drink. Mrs. C. felt that her father desperately needed his children to demonstrate their loyalty to him by deferring to his authority, by modelling themselves after him, and by having him be the central and most important figure in their lives.

Given Mrs. C.'s perception of her father's narcissistic vulnerability, we inferred that she became conflicted about the following developmental goals: forming attachments to other men, overcoming her dependence on and her incestuous attachment to her father, having her own separate ideas, and exercising her independent judgment instead of deferring to his authority. She compromised these developmental strivings in order to avoid what she perceived to be the consequences of pursuing them, namely to leave her father feeling devalued and repudiated, and to precipitate a frightening attack and loss of control. We inferred that one of her treatment goals was to overcome the unconscious guilt she felt about developing her capacity to assert her own ideas and to enjoy an intimate love relationship with her husband.

In this problem area we inferred that the patient held a set of pathogenic beliefs to which she conformed in order to avoid the dangers connected to her perceptions of her father's narcissistic vulnerability. To be more specific, we inferred that Mrs. C. developed the irrational belief that she had the power to crush or inflame others by disagreeing with their ideas and that such disagreement is necessarily an act of hostility. Conversely, she believed that the way to show love for someone else is to cater to their narcissistic needs by showering them with admiration, imitating their behavior, and idealizing them. She also believed that it was an act of disloyalty to question parental authority, or objectively perceive the deficiencies of other family members, or to have values, opinions and preferences that are different from those of her parents. Similarly, Mrs. C. believed that if she felt equal to or superior to men, she would leave them feeling emasculated. More generally, she believed that she would inevitably threaten anyone, should it be known that she felt superior to them in any regard.

In response to feeling endangered by her father's narcissistic vulnerability, Mrs. C. developed a number of beliefs about how she could protect herself from her father's attacks, and more generally from being demeaned by others. For example, she believed that she should avoid disagreeing with others, not only so as to avoid injuring them, but also to avoid becoming the target for their contempt and rage. In order to protect herself and other people, Mrs. C. kept herself dependent on the approval of others, making them, rather than herself, the final arbiter of her self-esteem.

Testing

We assumed that the paternal transference would be strongly colored by the pathogenic beliefs that Mrs. C. developed in relation to her father and that Mrs. C. would unconsciously test the analyst in an attempt to disconfirm her unconscious belief in her power to injure and provoke him in the ways she felt she had injured and provoked her father. We hypothesized that the therapeutic process would be facilitated by those patient-analyst interactions which led her to infer that these deep-seated fears were unfounded.

We assumed that Mrs. C. would test to see how much power she had to hurt or please the analyst by agreeing or disagreeing with his interpretations. We thought she would also test to see if the analyst needed her to submit to him in the same ways that she had submitted to her father. For example, she might test to see if the analyst could tolerate her feeling that she is in the right and he is in the wrong, or if the analyst would be easily threatened by her acting equal to, superior to or contemptuous of him. Conversely, we expected that Mrs. C. would also test to see if the analyst needed her to feel inferior to him, dependent on him, incestuously attached to him and envious of him. If Mrs. C. tested the analyst by turning passive into active, we thought that she would ask for the analyst's reassurance and approval as her father had done with her, to see if the analyst believed that he would devastate her by not providing these responses.

Finally, we tried to specify some of the crucial insights that Mrs. C. would want to achieve. We thought that she would want to recognize that she has distorted ideas about the narcissistic vulnerability of authority figures, and other people. She sees them as more precarious than most people would in actuality be. Also, Mrs. C. would want to discover that she believes she should sacrifice her own judgment and her right to assert her own ideas in order to avoid wounding or setting off narcissistically vulnerable authority figures. Another insight we identified as important to Mrs. C. to achieve is that she has irrationally envied men and felt ashamed of being female, in compliance to her father who she felt needed to feel superior to females, and also to defend against feelings of contempt for him.

DISCUSSION

We shall now turn to a brief discussion of some of the research that we have been doing. We undertook to investigate the validity of control-mastery theory for when and how resistances—that is, the patient's defensive and testing activities—should be interpreted in order for genuine therapeutic progress to occur. We investigated the hypothesis that pro-plan interpretations make it safer for the patient to work in a more progressive fashion. Conversely, we hypothesized that anti-plan interpretations increase the patient's unconscious sense of danger and are followed by increased defensiveness. Anti-plan interpretations may induce the patient to submit out of guilt, but even if the patient compliantly brings out new material, in this circumstance we expect that she will be unable to master or integrate it.

We assumed that Mrs. C. would work to overcome her resistance to

termination by repeatedly testing the analyst in order to disconfirm her pathogenic beliefs in her power to hurt him by no longer wanting his love or needing his help, by having confidence in her own insights and judgment, by functioning well independently of him, by not being preoccupied with the analyst's approval and options, by enjoying her femininity and not wanting to be a man—like the analyst, by not preferring the analyst to her husband as a love object, and by enjoying sexual and emotional intimacy—things her father did not approve of and could not tolerate in himself and others. Put in slightly different terms, we thought that Mrs. C.'s primary therapeutic goal during the termination period of her analysis would be to overcome the unresolved aspects of the transference neurosis, and especially the father transference. She had taken the analyst's penis-envy interpretations to mean that he needed her to admire him, to feel inferior to him, and to want to be just like him. She had similarly taken his interpretations about how desperately she wanted her father's love, and now wanted his love, as an indication that he needed to feel that he was irreplaceable. She feared that the analyst wanted her to feel helpless, empty, unprotected, and bereft at the thought of termination, and that her termination was actually going to be a very painful loss for him.

The research design was as follows. One group of judges were given the control-mastery plan formulation for the termination phase of the treatment and asked to rate the analyst's termination interpretations on the dimension of plan compatibility, i.e., how much the intervention contradicted or supported Mrs. C.'s pathogenic beliefs. An independent group of raters evaluated the patient's attitude towards termination preceding and following each intervention to see how that attitude was affected by the interpretation. This group was unaware of the content of the interpretations. Each group of raters achieved high reliabilities, indicating good agreement between them.

We found a highly significant correlation between how pro-plan the analyst's interventions were and how much the patient, immediately following these interventions, showed an increase or decrease in her resistance to the idea of termination. Pro-plan interpretations were associated with immediate decreases in the patient's resistance to termination, whereas anti-plan interpretations were associated with immediate increases.

Our finding shows that even though the analyst's formulations were all highly plausible and consistent with the patient's verbal productions, on closer examination we could predict which of these interpretations helped the patient overcome her resistance to termination and which interpretations impeded this effort. A careful clinical analysis of the last 100 hours revealed that Mrs. C. began to make notable progress in overcoming her resistance to termination after the analyst

shifted his interpretive strategy from focusing on her infantile transference wishes to focusing on the patient's irrational belief that she was doomed to an inferior position in life because she lacked a penis.

In terms of the specific hypotheses to which this study was directed, clear evidence was obtained in support of the following propositions: (1) The patient had an unconscious plan for overcoming her resistance to termination; (2) The primary source of this resistance was a deep-seated fear of hurting the analyst by establishing her independence of him and separating from him; and (3) The analyst's termination interventions had a predictable immediate effect on the intensity of the patient's resistance to termination according to whether they tended to reinforce or disconfirm her pathogenic beliefs about his vulnerabilities and her omnipotent power to hurt him.

This study adds support to a series of other studies (Weiss et al., 1986) which have been done within the aegis of the control-mastery theory framework. These studies cumulatively provide strong evidence for the patient's unconscious efforts to master his neurotic conflicts and the importance of the therapist making interventions which support the patient's unconscious work.

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