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"A Psychotherapy for the People": Freud, Ferenczi, and Psychoanalytic Work with the Underprivileged

Abstract. The development of psychoanalytic technique can be traced in part to the dialogues between Sigmund Freud and Sándor Ferenczi, dialogues that took place in the context of psychoanalysis's encounter with poverty and destitution in the wake of World War I. These dialogues, which served as precursors to contemporary, especially Relational, psychoanalysis, also inspired Freud's call for greater psychoanalytic engagement with the poorest and most vulnerable. This inspired the early psychoanalysts to "sharpen in all directions the sense of social justice" by engaging in political activism, experimenting with clinical technique, and by promoting short-term, more affordable treatments. The relevance of this history for clinical work with diverse populations will be discussed, and aspects of contemporary psychoanalysis (countertransference, enactment, new relational experience) will be understood in light of Freud and Ferenczi's responsiveness to the underprivileged.

Keywords: Ferenczi, Relational psychoanalysis, social justice, short-term therapy, underprivileged, active therapy

FREUD'S (1918/1955a) DISTINCTION between the "pure gold" of analysis and the "copper" of direct suggestion is often invoked to mark the boundaries of orthodox psychoanalysis, and separate it from the more "base" elements of supportive psychotherapy. The "pure gold" of psychoanalysis refers to a long-term, interpretive approach in which abstinent analyst and repressed analysand meet more than twice a week in an open-ended therapy. The "copper" of direct suggestion traditionally refers to any and all therapeutic methods that fall short of this "gold standard," such as the supportive elements of the therapeutic relationship, interventions spanning the gamut from Relational/Interpersonal psychoanalysis to cognitive-behavioral therapy and different varieties of short-

Contemporary Psychoanalysis, Vol. 48, No. 2. ISSN 0010-7530

term therapy. These alternative therapies are defined as "other," denigrated in relation to the idealized method of cure. This application of Freud's words, however, ignores the context in which he coined them, and the two-sided and conflicted purpose for which they were developed. The context of these terms is his 1918 keynote at the Budapest Congress, "Lines of Advance in Psychoanalytic Therapy," in which he explored the modification and application of psychoanalysis to poor and underprivileged persons who, until the 1920s, were generally marginalized from psychoanalytic treatment. The purpose of distinguishing between "pure gold" and "copper," in turn, serves a double function of both exclusion and inclusion, segregating psychoanalysis from the pragmatic realities of psychotherapy, while calling for their integration in order to forge what Freud referred to as a "psychotherapy for the people."

The context of this article is the ever-changing face of psychoanalysis in the United States. Recent developments in psychoanalysis in the United States have fostered the growth of Relational theory and practice, which highlights the interpersonal context of the analytic relationship as well as the role of the analyst's subjectivity in the transference-countertransference dance (Greenberg & Mitchell, 1983; Aron, 2001; Wachtel, 2008). Increasing economic and political pressures (especially from managed care companies) have led to the proliferation of short-term psychodynamic therapies that take place once a week over the course of 12 to 40 sessions, and emphasize greater therapist activity and the formulation of a focus to guide treatment (Crits-Christoph, Barber, & Kurcias, 1991; Messer & Warren, 1995; Tosone, 1997). Finally, clinical work with diverse populations has fostered an increasing awareness of race, class, culture, and social justice in the analytic process (Perez-Foster, Moskowits, & Javier, 1996; Leary, 1997; Pogue-White, 2002; Altman, 2009). The purpose of this article is to contextualize the historical origins of each of these concerns—Relational theory and practice, short-term psychodynamic therapy, diversity and social justice—in the modification of psychoanalysis in clinical work with the disenfranchised. Freud's 1918 keynote speech ignited the fires of social justice among the early analysts, and brought him closer to one of his most esteemed, yet undervalued, colleagues—Sándor Ferenczi.

Ferenczi has only recently been recognized for his contribution to psychoanalysis, today "created and found" as a forerunner of Relational psychoanalysis and short-term psychodynamic therapy (Neil Altman,

personal communication). The reach of his influence, whether direct or indirect, can be felt throughout the whole of psychotherapy; as Freud recognized, Ferenczi "made all analysts into his pupils" (Freud, 1933/1964). Echoes of Ferenczi's ideas can be found in streams as diverse as object relations theory, self psychology, Interpersonal and Relational psychoanalysis, humanistic psychotherapy, and short-term psychodynamic therapy (Marmor, 1980; Aron & Harris, 1993; Messer & Warren, 1995; Rachman, 2007).[1] Although the history of Freud and Ferenczi's relationship is tumultuous and tragic, their dialogues served as the anvil on which a "psychotherapy for the people" was crafted. It is out of this dialogue that I hope to extract some possibilities for thinking about psychoanalytic work with diverse, and all-to-often underprivileged, populations. I invite us to engage in what liberation psychology, a social justice-oriented movement in Latin American psychology, calls a "recovery of historical memory" (Martin-Baro, 1994). This entails rediscovering those elements of our tradition that open the horizon for a more dynamic and flexible psychoanalysis, a psychoanalysis that is responsive to the needs of the non-White, the poor, and the oppressed.

Tenacious Healer, Relentless Advocate: Ferenczi's Social Passion

In Ferenczi's writing, one finds ongoing self-scrutiny and reflection on the challenges posed by the power difference between analyst and analysand, and how this inequality must be negotiated in cases of severe trauma. Arnold Rachman (2007), a psychoanalyst who pioneered the resurgence of interest in Ferenczi's life and work, notes that Ferenczi's clinical experiments with empathy and mutuality were based on meticulous observations of the therapeutic relationship, especially the patient's moment-to-moment reactions to the therapist. These experiments, ranging from "active" intervention to the provision of reparative emotional experiences, pioneered the psychoanalytic treatment of complex trauma, and "laid the foundation for a relational perspective in psychoanalysis" (p. 76). It should come as no surprise, then, that before joining the psychoanalytic movement Ferenczi's professional life involved clinical work

[1] Although this is beyond the scope of this article, an argument can be made that Ferenczi's work foreshadowed some of the technical innovations of cognitive-behavioral therapy. See below.

with poor and oppressed populations who were victims of chronic trauma from the broader society (Rachman, 1993). Although Ferenczi, like Freud, was embedded in cultural streams of patriarchy and misogyny, and no less likely to repeat its ideologies wholesale (Meszaros, 1993), one can nevertheless discern that he struggled with these discourses. It is through this struggle that Ferenczi in turn challenged and critiqued them.

Ferenczi, who was Jewish and raised in a household of progressive values, began his clinical work in hospitals devoted to work with the poor and marginalized members of Hungarian society at the time. The populations Ferenczi served often included men and women who were persecuted due to their sexual orientation, or were pushed into such destitution that prostitution became the only means for survival (Rachman, 1993). Perhaps the best known patient from Ferenczi's preanalytic days is "Rosa K," a lesbian woman who was condemned as a "cross dresser." The publication of his therapeutic relationship with Rosa K was the first article written in Hungarian calling on the medical community to recognize the humanity of male and female homosexuals, and to reject theories that pathologized and dehumanized them (Rachman, 1993).

Ferenczi saw Rosa K during his clinical tenure at St. Elizabeth's Hospital for the poor in Budapest. Rachman's (1993) moving depiction of their encounter is suggestive of Ferenczi's later clinical developments:

> Ferenczi described the sad fate of Rosa K in an empathic way; it is clear from his description of her that he was attempting to understand her, not to judge, moralize about, or categorize her. Hunted, incarcerated, and oppressed by everyone, Rosa K, like most homosexuals at the turn of the century, was socially isolated and emotionally unstable when she met the young Ferenczi. The attitude of her family, the medical community, and society at large toward Rosa K was universally negative, rejecting, and condemning. But Ferenczi viewed this "cursed" woman as a person. (p. 82)

In order to better understand her experience of interpersonal and systemic trauma, Ferenczi encouraged her to write an autobiography, which he used therapeutically. Ostracized by her parents, mocked by her peers, unemployed and harassed by the police, forced into homelessness, poverty, and discriminated against, her relationship with Ferenczi may have been her first experience of recognition from an-other. Rachman (1993) states that "[t]his early perspective of 'the other in the treatment process'

was to become a significant theme in Ferenczi's clinical work" (p. 84), work that would redefine psychoanalysis into a transformative relational encounter grounded in empathy.

Ferenczi's clinical and social concerns for those who were oppressed increased after he joined the psychoanalytic movement, when he reflected on the sociopolitical implications of psychoanalysis soon after his first meeting with Freud (Moreau-Ricaud, 1996). In 1908, Ferenczi openly advocated for the rights of homosexuals, urging his analytic colleagues to "take sides against the unfair penal sanctions which homosexuals are subjected to in many countries, especially in Germany, but also in our country" (cited in Rachman, 1993, p. 84). Likewise, in a 1911 publication, Ferenczi diagnosed alcoholism as a symptom of "social neurosis," which could be cured only by addressing its social etiology in psychoanalysis and in society. Even earlier, in 1903, he presented a paper defending the rights of exploited medical workers, advocating for better wages and improved working conditions (Sziklai, 2012).

Politics and society were also vibrant topics of conversation in Ferenczi's correspondence with Sigmund Freud. In a 1910 letter, Ferenczi attempted to dissuade Freud from his belief in the inherent destructiveness of human beings by arguing for the role of social factors in human suffering. Reflecting on a related insight by Carl Jung, Ferenczi drew attention to the parallels between anti-Semitic and anti-Black racism, writing to Freud that "[t]he persecutions of [B]lacks in America [is because] [B]lacks represent the unconscious of [White] Americans. Thus, the hate . . . against one's own vices . . . could also be the basis for anti-Semitism. It is only since my analysis that I have understood the widespread Hungarian saying: 'I hate him like my sins'" (cited in Meyer, 2005, p.19). These social reflections were, in turn, tied to clinical observations, as Ferenczi intuited that in psychoanalysis "we investigate the real conditions in the various levels of society, cleansed of all hypocrisy and conventionalism, just as they are mirrored in the individual" (Ferenczi, 1993).

The challenge of the here-and-now relationship between therapist and patient, and the role of empathy, were clinical questions that took their earliest form in Ferenczi's experiences with oppressed individuals. The "ethics of truth and justice" (Borossa, 2007) present in Ferenczi's clinical and social thought were further nurtured by Freud's own social awakening, and the direction in which he would take psychoanalysis at the 1918 Budapest Congress.

The Origin, Meaning, and Effect of the 1918 Budapest Speech

Freud and Ferenczi's dialogues from 1910 through 1918 led to a deeper commitment on Freud's part to expand the scope of psychoanalysis to consider the plight of the masses rendered destitute in the wake of World War I. The ideas that would later become part of his 1918 keynote speech were first put to paper in the summer prior to the Budapest Congress, during Freud's stay in the home of Anton von Freund. Von Freund, a friend and training analysand of both Freud and Ferenczi (Danto, 2005), spoke with Freud about donating part of his fortune to help create a psychoanalytic clinic for the poor in Budapest. Although the first psychoanalytic free clinic would actually be built in Berlin, Freud would later write that von Freund's vision would "sharpen in all directions the sense of social justice" within psychoanalysis (Freud, 1920/1955b, p. 267). Freud's Budapest speech was influenced not only by von Freund's plans for a community-based clinic, but also by Ferenczi's experiments with time-limited therapy and "active" intervention during World War I. Based on these experiments with "active treatment," Freud envisioned new directions and challenges in psychoanalysis, and reflected on their implications for work with the underprivileged.

In "Lines of Advance in Psychoanalytic Therapy," Freud (1918/1955a) referred to Ferenczi's "active technique" as a step forward in psychoanalysis's evolution as a treatment. "Active technique" involved two types of interventions. The first was what Ferenczi termed "admonitions," in which patients were encouraged to gradually expose themselves to their phobia-inducing or anxiety-provoking objects within and outside the session, thus exposing them to the avoided affect associated with those objects. The second set of interventions involved "prohibitions," in which patients were instructed to cease self-soothing or compulsive behaviors in order to experience the defended-against anxiety without incurring the feared catastrophe. These techniques—presaging exposure, response prevention, and desensitization-based behavior therapies by almost a century—were to serve as supplements to an interpretive method, as they allowed repressed thoughts, affects, wishes, and memories to emerge into consciousness in order to be worked through psychoanalytically. Their application was highly dependent on the patient-therapist bond, which created a safe space within which the feared situation could be enacted, without the expected traumatic result (see also Ferenczi, 1926/1980). Although cautious about the analyst's in-

creased role in "active therapy," Freud welcomed the application of these interventions as outlined by Ferenczi (1918, p. 165).

Turning from the clinical to the social, Freud (1918/1955a) addressed "the vast amount of neurotic misery which there is in the world, and perhaps need not be" (p. 165). Lamenting psychoanalysis's inability to serve the majority of displaced and poor people after World War I, he foresaw a future in which "the conscience of society will awake," and compel it to take responsibility for their psychological as well as material well-being. Probably as a result of Ferenczi and von Freund's influence, Freud proposed the creation of outpatient clinics staffed by psychoanalytic clinicians, where "treatments will be free" (p. 165). At such clinics, analysts would "be faced by the task of adapting [psychoanalytic] technique to the new conditions" (p. 167). Freud suggested that clients who lacked formal education should be provided appropriate psychoeducation, demystifying psychoanalysis and making them active participants in treatment. He further intuited that for such treatments to be successful, it would be necessary to address the client's economic as well as psychological needs, "[combining] mental assistance with some material support, in the manner of the Emperor Joseph" (p. 167), a revered advocate of Jewish minorities and the poor.

Concluding his speech, Freud (1918/1955a) made a critical prediction about the future of psychoanalytic treatment with the many impoverished people of the postwar world, one that was to cast its shadow over the whole of psychoanalytic discourse on relationship and technique:

> It is very probable, too, that the large-scale application of our therapy will compel us to alloy the pure gold of analysis *freely* with the copper of direct suggestion; and hypnotic influence, too, might find a place in it again, as it has in the treatment of war neurosis. But, whatever form this *psychotherapy for the people* may take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psycho-analysis. (pp. 167–168; emphases added)

Sociologist and historian Elizabeth Danto (2005), to whom we are indebted for bringing the history of social justice in psychoanalysis to light, has chronicled the remarkable effect of Freud's speech on the psychoanalytic movement. In the vibrant period between 1918 and 1938, the first generation of analysts responded to Freud's words "half as prophecy and half as challenge" (Eitington, 1923), opening clinics in Berlin, Vi-

enna, London, Paris, and elsewhere, offering *pro bono* or sliding-scale psychosocial relief for the poor, developing new treatment methods, and participating in various feminist, gay rights, and socialist-Marxist movements seeking social change in post-World War I Europe (Danto, 2005). In order to meet the needs of a broader range of people, psychoanalytic practitioners such as Franz Alexander, Max Eitington, Ernst Simmel, and Sándor Ferenczi experimented with time-limited treatment and "active" interventions that increased the use of overt behavioral change strategies and the role of the therapeutic relationship (Danto, 2005). Freud appeared to encourage such explorations, although his ambivalence toward findings discrepant from his own was nevertheless notable (Haynal, 1993, p. 60; cf. Giampieri-Deutsch, 1996).

Freud's keynote is striking both for its progressive energies and its conservative pull. Freud welcomed the therapeutic interventions developed by Ferenczi, even to the point of seeing in them the future of psychoanalytic technique, yet rendered them subservient to his "classical" approach. Hence, Freud simultaneously called for the integration of his "analysis" and Ferenczi's "direct suggestion," while delegitimizing, denigrating, and devaluing the latter as "copper" and defining the former as "pure gold." Going a step further, Freud remarked that although these "copper" innovations may be welcome, perhaps even necessary, in providing services to impoverished populations traumatized by the ravages of war, the *real* ingredients of change would be analytic interpretations (i.e., "pure gold"). Reflecting Freud's hesitant downgrading of the intrapsychic (i.e., transferential and interpretive) type of psychoanalysis to the advice-giving and even directive kinds of psychotherapy, this passage has been criticized—not unjustly—as laying the groundwork for later stereotypic statements about the poor not being "analyzable" or capable of *real* psychoanalytic work due to lack of ego-strength and psychological mindedness, and, therefore, in need of a baser, more "supportive" and directive therapy (Altman, 1995/2009; Wachtel, 2002). I will return to this problem of "analyzability" when I examine the implications of this controversy for contemporary work with underprivileged populations.

In coining the terms "pure gold" and "copper," Freud set the "terms of engagement" (Paul Wachtel, personal communication) between what would be seen as "strict and untendentious" psychoanalysis and those degradations that would become its various "others," such as "psychodynamic" and short-term therapy, "supportive" therapy, and emerging relational trends in analytic theory. On the other hand, these terms also

functioned inclusively, and they allowed Ferenczi and other first-generation analysts to play with the boundaries of technique and create something new. As long as analysts understood these terms, did not stray too far from Freud's position, or argue that these new approaches were of equal value to analytic interpretation, they could experiment freely with technique. This back and forth between either/or and both/and betrays a deep ambivalence we have inherited from Freud. A no less ambivalent example of Freud's enthusiasm and reserve for the development of technique, followed by eventual excommunication, is Ferenczi and Rank's monograph, *The Development of Psychoanalysis* (1925).

The Development of a "Psychotherapy for the People"

Aided by Freud's encouragement, Ferenczi and Otto Rank initiated further clinical experiments on therapeutic activity and the role of the analyst in the healing process (Haynal, 1993; Rachman, 2007). In *The Development of Psychoanalysis* (1925), Rank and Ferenczi expressed their concern that clinical technique remained frozen in time while psychoanalytic theory soared to new insights (p. 2). Seeking to correct the atrophy of technique, they revisited Freud's earlier technical paper, "Remembering, Repeating, and Working Through" (1914), and created a series of reversals in their understanding of analysis. Although Freud emphasized the role of cognitive remembering, Ferenczi and Rank (1925) attributed the primary mechanism of change to "repetition" (p. 4), the enactment of the patient's core conflicts within the analytic session.

"The creation of the analytic situation," Ferenczi and Rank write, "really *exposes* the patient a second time to his infantile trauma . . . [reliving] the Oedipus situation in the relation of the patient to the analyst, in order to bring it, with the help of the patient's insight, to a new and more fortunate conclusion" (pp. 20, 54; emphasis added). The patient's forbidden wishes, feelings, and thoughts were to be enacted in relation to the analyst, consciously reexperienced, and allowed a "partial gratification" (p. 19) through the analyst's empathic responsiveness. Bringing the core conflict to a "new and more fortunate conclusion" (p. 54) makes new emotional and historical material available to consciousness, allowing the transition from repetition to remembering. Prioritizing repetition in relation to the therapist also placed "affective factors of experience" (p. 62) at the center of the change process, effectively reversing the relationship between pure gold and copper, as insight is framed as an important *re-*

sult of new emotional experiences, and intellectualization as a resistance that must be overcome by experiencing avoided affect within a responsive relationship.

Ferenczi and Rank (1925) conclude their text by anchoring their technical recommendations in Freud's Budapest speech (p. 58). Revisiting Freud's suggestion that psychoanalytic knowledge be conveyed to impoverished patients in simple and straightforward terms, Ferenczi and Rank likewise suggest that "[t]he reduction of the method to more simple actual facts . . . would [make it] much easier for doctors . . . to acquire psycho-analytic knowledge" (p. 63). It is not only the uneducated poor who would need the intricate nature of psychoanalytic theory to be "boiled down" to the pragmatic terms of the therapeutic process, but educated doctors and physicians as well! But, simplifying the esoteric nature of psychoanalytic theory and concretizing its precepts into pragmatic interventions would have another purpose for Ferenczi and Rank: it would "shorten and simplify the treatment" (p. 63). With the repetition of the core trauma in the transference, its subsequent transformation into remembrance through relational-affective reexperiencing, and provision of a corrective experience to the patient's catastrophic expectations, a path is carved for the setting of treatment goals and a focus on those particular areas in a person's psychic life in which they experience difficulty.

Finally, citing Freud's opinion that the "the pure gold of analysis might be freely alloyed with the copper of direct suggestion" in the modification of psychoanalysis with the poor, Ferenczi and Rank (1925) argue that psychoanalysis no longer needs to exist in "splendid isolation" from other therapeutic methods. They wonder "if the point were finally reached when other psycho-therapeutic methods which had proven themselves useful according to analytic understanding . . . were legitimately combined with psycho-analysis" (p. 64). In this regard, Ferenczi and Rank may qualify as the first assimilative integrationists (Messer, 1992), as they consider employing nonanalytic methods by "assimilating" them within a broader psychoanalytic perspective.[2] Rather than being subservient adjuncts to psychoanalysis, as it was understood at that time, "other psycho-therapeutic methods" were to be integrated on an equal level.

[2] Paul Wachtel's (1997) work is a contemporary example of psychotherapy integration, as he assimilates cognitive-behavioral interventions within psychoanalytic therapy.

Ferenczi and Rank's *The Development of Psychoanalysis* (1925) could in many ways be read as "The Development of a Psychotherapy for the People." It is a direct descendant of Freud's "Lines of Advance in Psychoanalytic Therapy" (1918/1955a), in which he highlights the increasing importance of the analyst's activity in treatment. This acknowledgment of the analyst's role is the result of applying the underlying principles of "active" intervention to the therapeutic relationship itself. What began as a series of techniques employed to expose patients to the avoided affect, anxiety, and pain elicited by objects in the world (a technique we associate today with behavioral exposure therapy), was now influencing the way Ferenczi and Rank thought about the patient-therapist relationship. The therapeutic relationship itself would be the context in which patients are exposed to disowned affect and desire through the person of the analyst, who provides a corrective experience through their empathic, nonretaliatory responsiveness. Ferenczi and Rank here cite the application of psychoanalysis to the poor as a source of their technical recommendations, applying those insights in a way that affectively deepened the transference relation. Hence, their monograph is a product of the progressive energies unleashed by Freud's own reflections on the future of analytic technique, and their application to the vast numbers of impoverished people in post-World War I Europe.

Ferenczi and Rank's (1925) monograph destabilized the relationship between classical psychoanalysis and other treatment modalities by contextualizing insight in affect, memory in enactment, and repetition in relationship, thus, redefining and "refin[ing] the gold of psychoanalysis itself" (Szecsody, 2007). Their work proved to be an important precursor to the development of Relational psychoanalysis and short-term dynamic therapy. Both traditions trace their lineage to Ferenczi and Rank's text and, although they might disagree on the place of short-term therapy in psychoanalysis, they would both agree on the crucial role of the here-and-now relationship, and the mutative power of the analyst's attunement to the patient's affective experience (Tosone, 1997; cf. Aron, 1993; 2001). It is a key element of these two traditions, an element that can be traced back to the disjunctions and conjunctions of Freud and Ferenczi's dialogues on psychoanalytic technique and their application to underserved populations. Ferenczi's contributions, based in part on these dialogues, emerged from a process of clinical experimentation that attempted to meet the needs of a variety of traumatized, oppressed, and socially marginalized populations (Rachman, 1993).

Gold, Copper, and the "Other": A Ferenczian Take on Analyzability

Ferenczi's continued elucidation of a relational perspective after 1925 echoed an "ethics of truth and justice" (Borossa, 2007), demonstrating his ongoing focus on the power difference between the therapist (who represents the social order) and the patient (whose symptomotology is the result of flawed relationships with that social order). In his seminal article, "Confusion of Tongues" (1949/1988), Ferenczi took a radical step forward in theory and practice:

> Gradually, then, I came to the conclusion that the patients have an exceedingly refined sensitivity for the wishes, tendencies, whims, sympathies and antipathies of their analyst, even if the analyst is completely unaware of this sensitivity. . . . The analytical situation—i.e. the restrained coolness, the professional hypocrisy and—hidden behind it but never revealed—a dislike of the patient which, nevertheless, he felt in all his being—such a situation was not essentially different from that which in his childhood had led to the illness. . . . The setting free of [the patient's] critical feelings, the willingness on our part to admit our mistakes and the honest endeavor to avoid them in [the] future, all these go to create in the patient a confidence in the analyst. (pp. 198–200)

Ferenczi noted that patients who were repeatedly abused and invalidated often develop an exquisite perceptiveness of others' internal states. If the analyst experiences and then disowns his or her negative countertransference to such patients, there is a risk of communicating these reactions unconsciously through one's behavior. Denying these reactions in turn invalidates the patient's reality and ruptures trust in the analyst, repeating the original traumatic event with significant caretakers. But, by owning their countertransference reactions, disclosing them to the patient, and validating their reality, the analyst provides a corrective experience that increases the patient's trust in this relationship. It is precisely this process of rupture, reconnection, and repair that, Ferenczi argued, leads to the curative power of the therapeutic relationship, influencing much relational thinking on enactments (Aron, 2001; Benjamin, 2004). This relational, two-person perspective has powerful implications for work with the underprivileged or culturally different, especially with regard to the criteria of analyzability (Altman, 1995/2009; Wachtel, 2002).

The criterion of analyzability refers to a cluster of attributes that define the "kind" of people that can be effectively treated in psychoanalysis.

These include psychological mindedness, ego-strength, verbal intelligence, frustration tolerance, and impulse control. Those who have these traits are considered treatable by the "pure gold" of psychoanalysis, whereas those who do not are referred to the "copper" of supportive or less intensive psychotherapy. Altman (1995/2009) and Wachtel (2002) argue that such criteria have been used to exclude ethnic minorities and the poor from psychoanalytic treatment, leading to sociocultural enactments in which practitioners decree that non-White, lower income populations are less amenable to analytic treatment and more responsive to, for example, more "directive" cognitive-behavioral approaches.[3] What is interesting about the so-called analyzability criteria is that it places the onus of engaging in the psychoanalytic process squarely on the patient, especially if the patient is a racial or socioeconomically different "other." The analyst's role in defining analyzability is entirely obscured.

Speaking from a relational perspective, Altman (1997/2009) argues that "[d]iscussions of analyzability, in which lower-class patients often end up on the unanalyzable side, may reflect the analyst's psychic defensive operations" (p. 92). What might be framed as the patient's inability to engage in the analytic process may, in fact, reflect the analyst's inability to engage the patient. The analyst's wish to be a competent, empathically attuned listener may be frustrated by biases and reactions operating outside of his or her awareness. In turn, the analyst's difficulties and insecurities in making empathic contact are projected upon the patient, who is then deemed unanalyzable (Frosch, 2006). In a parallel spirit, Frosch (2006) writes that "the analyst's *idea about* psychoanalysis is an essential variable that contributes to our concept of analyzability. And the analyst's ideas are always shaped by desire. Wishes and defenses organize our perception of the world, including the world of who is or is not analyzable" (p. 51; emphasis added). How we think about what psychoanalysis is, or is not, defines who we will and will not treat, because those we can treat are more likely to be "like us," making us feel safe and competent, whereas those we cannot treat, the "not-me," make us feel unsafe, incompetent, and uncomfortable. "Analyzable" and "unanalyzable" inevitably become shorthand terms for who gets the pure gold or the copper, distinguishing the "me" from the "not-me." To take this intersubjective reality into account would mean redefining analyzability as something that "is dependent on . . . a reciprocal relationship that allows for the

[3] See Brown's (2009) insightful commentary on this dynamic.

development of mutual trust" (Frosch, 2006, p. 52). Thus, analyzability is not determined by the supposed ego-strengths or deficits inherent in the patient, but is a function of each therapist-patient dyad's capacity to establish a trusting relationship. Given the asymmetrical nature of this relationship (Orange, 2010), it becomes imperative that we examine the unconscious assumptions that may impede the analyst's empathy, attunement, and understanding of the culturally different patient. In keeping with Ferenczi's thinking, the onus of analyzability—or at least a great deal of the responsibility for setting the conditions for psychoanalysis—falls on the subjectivity of the therapist.

A useful framework for thinking about this topic is Derald Wing Sue's (2010) work on "microaggressions." Microaggressions are often unconscious, "brief and commonplace daily verbal, behavioral, and environmental indignities . . . that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group" (p. 5). Whereas members of privileged groups (e.g., White, male, heterosexual, middle-upper class, able) are usually unaware of these implicit transactions, members of nondominant groups over time develop a finely tuned hypervigilance of such exchanges. All too often, people of minority backgrounds may detect that a microaggression has taken place, whereas the more dominant person—in our case, the psychotherapist—invalidates the minority's experience either by being unaware of a misstep, ignoring its impact on the other, or explicitly denying that anything problematic has transpired. The ethnic minority, the poor person, the female, or the nonheterosexual suddenly finds his or her internal reality usurped by an "other," leading to "a great deal of self-confusion and pain," as described by Kathleen Pogue-White (2002, p. 405). Reflecting on her experience as a woman of color, Pogue-White writes that "[e]rring on the side of wariness and vigilance" (p. 405) is an adaptive defense utilized by people who have been victims of prejudice and injustice, a sentiment that runs parallel to the experiences of chronically traumatized people.

Having reviewed the empirical literature available in the 1970s, Siassi and Messer (1976) concluded that White, middle- and upper-class therapists often hold negative stereotypes of the poor, unconscious attitudes that affect the interpersonal interaction and impair therapeutic empathy. These stereotypes can lead impoverished patients to experience rejection and drop out of treatment. Contemporary research has shown that this tragic reality still exists, showing that therapists who act out their preju-

dices corrode the therapeutic relationship. If this is not addressed, the chances that a minority patient will leave treatment are greater, further adding to the dropout rate for ethnic minorities in general (Gaztambide, in press). Although the issue of therapist responsiveness and attunement is not limited to work with underprivileged populations, it is especially relevant to them. Questions of power, rupture, attunement, and trust are central to cultural competence (Gaztambide, in press), and one can find each of these topics reflected in Ferenczi's (1949/1988) later thinking. His awareness of the patient's sensitivity to the therapist's often subtle negative reactions provides a clinically useful way of addressing microaggressions and cultural enactments in the here-and-now (Altman, 1995/2009; cf. Sue, 2010). Ferenczi calls attention to the inevitability of the therapist taking on the role of perpetrator vis-à-vis the patient, and reminds us of the need for critical self-reflection and honest self-disclosure in order to reconnect with the patient, repairing the injury provoked by therapeutic missteps. His later development of the concept of mutuality suggests that paying attention to cultural prejudices, accepting them when they arise, and owning them with our patients will help restore trust in the therapeutic relationship and make the work of analysis possible. Attention to cultural misattunements may reveal that the "unanalyzable patient" is a product of the therapist's unconscious assumptions about the patient based on cultural or socioeconomic biases that derail the work of analysis. And, if the work of psychoanalysis is to make the "unconscious, conscious," then the task of a "psychotherapy for the people" is to make the unanalyzable, analyzable.

Elements and Alloys: An Outline and Case Illustration

Another set of insights to be drawn from the efforts of the early analysts lead us to a critique of Relational theory itself, specifically its dyad-centricity. An implicit belief in Relational theory, and psychoanalysis more broadly, is that the analysand's difficulties can be resolved within the boundaries of the treatment dyad without addressing their ecological surround, including not only their relationships with "real others" in the world but also the broader systems in which the dyad is embedded (Paul Wachtel, personal communication; cf. Cushman, 1994; Altman, 1995/2009). Many early analysts recognized the need to "combine mental assistance with some material support," thus reducing their fees for poor clients and engaging systemic issues socially, politically, and academi-

cally (Danto, 2005). This suggests a perspective that grounds the therapeutic relationship within a broader sociocultural context, as seen in contemporary reflections on the social "third" (Cushman, 1994; Altman, 1995//2009). Such a perspective would not only invite dialogue on social dynamics as they are reflected in transference-countertransference enactments, but would also suggest that—under certain circumstances—the analyst may need to engage the broader social matrix directly, through systemic intervention, advocacy, and client empowerment, as seen in many family therapy approaches (e.g. Boyd-Franklin, 2003).

As noted above, several-times-a-week, long-term psychoanalysis may not be a treatment option for many underprivileged people. This is due to economic and logistical reasons rather than psychological ones. Many lower-income populations cannot afford therapy multiple times a week over an extended period of time. Aside from more immediate financial restraints, many individuals and families do not have the time to engage in this kind of therapy. In spite of what some stereotypes of the poor (e.g., "lazy" or "undeserving") lead us to believe, many impoverished people may be working hard to maintain a 40-hour a week job, or work several part-time jobs in order to make ends meet or, if unemployed, are working diligently to secure a new job. In addition, other issues—e.g., access to adequate transportation to and from therapy—may complicate the use of frequent sessions. Therapy in such circumstances becomes a luxury, one that demands time, money, and other resources. Once (at most twice) a week treatment on a short-term basis (e.g., 12–40 sessions) may be a more feasible alternative, financially and logistically.

As suggested by Freud (1918/1955a), psychoeducation may prove to be a useful tool for engaging clients from diverse backgrounds in treatment. Nancy McWilliams (2004) notes that psychoeducation has not received sufficient attention in the psychoanalytic literature, although most patients would benefit from preparation for the therapy process (p. 86). This might be even more important for patients from cultures that do not regularly engage in psychotherapy, or for whom therapy is stigmatized. A useful distinction might be drawn between the traditionally didactic kind of psychoeducation found in some treatment modalities, and a more process-oriented psychoeducation that draws on myth and metaphor. Didactic psychoeducation involves the therapist speaking as an authority and conveying direct information to the patient. Process-oriented psychoeducation makes psychoanalytic ideas, such as affect regulation, defenses, and transference-countertransference enactments, understand-

able to patients as they arise and are addressed in the moment. McWilliams sees metaphor as a rich medium through which to educate the patient in these moments, especially when metaphors are employed in a manner that is experience-near and culturally congruent (pp. 86–87). Exploration of the patient's cultural world may reveal a complex set of symbols that can be drawn upon in orienting them to psychoanalytic therapy.

By placing the relationship at the core of the analytic endeavor and inviting the integration of techniques seen as "non-psychoanalytic," Ferenczi refined the gold of psychoanalysis itself (Szecsody, 2007). This leads to an interesting question for analysis today. If Relational psychoanalysis and short-term psychodynamic therapy are the products of this refined gold, is there not the risk of creating a new "copper" to serve as "other" and foil to this "gold" (cf. Curtis, 1996)? Are cognitive-behavioral, family systems, and even experiential/humanistic therapies not rendered the contemporary "copper" of psychoanalysis? If so, are we to invoke the language of pure gold and copper anew to keep these different systems apart (and only tentatively related, if at all)? Or, are we to create new alloys, further refining psychoanalysis instead?

I will now present a case that illustrates some of the elements of a "psychotherapy for the people" as discussed in this article. The case itself is a pastiche of my pregraduate and graduate school clinical experiences providing mental health services in a variety of underserved settings (e.g., inner city outpatient clinics, in-home therapy, community externship placements). I have chosen to create a pastiche instead of drawing on a specific case in order to preserve anonymity and draw greater attention to the clinical process. To be clear, this is but one example of the possible alloys crafted from the elements of contemporary psychoanalysis.

Pablo (pseudonym) was a 28-year-old, male, low-income, bilingual, Latin American undocumented immigrant who sought psychotherapy at our clinic due to anxiety symptoms that affected his day-to-day life. At intake, he stated he was a Spanish-dominant speaker, and would feel more comfortable working with someone who was bilingual. Because I am an island-born Puerto Rican who is bilingual, I offered to pick up the case. After an initial assessment, it became clear that Pablo suffered from post-traumatic stress disorder related to his immigration experience. Although Pablo wanted psychological help, he confessed that he did not have a lot of money. As the clinic charged for services on a sliding scale, we were able to negotiate an affordable fee. Given Pablo's hectic work

schedule, arrangements were made for once a week treatment. Also, because I am a graduate student who takes vacation time at the end of each semester, we agreed to review progress and the need for further treatment at the end of the current semester.

During the first couple of sessions, I asked Pablo how he felt talking to me about his problems. Pablo disclosed that he felt comfortable with me, which was a relief to him because he worried we would not have "una buena onda" (a good vibe). Considering the importance of interpersonal warmth (*personalismo*) and trust (*confianza*) for many Latinos, I used this moment as an opportunity for psychoeducation. I told him that it was good for us to have a "good vibe," because we could use the chemistry between us as a way of exploring his needs and concerns. This became Pablo's introduction to transference and the relational nature of psychotherapy. Throughout our work together, I used similar moments and metaphors to explain the analytic process, and make psychotherapy a less alien and stigmatizing experience.

Given Pablo's post-traumatic stress symptoms, I employed relaxation and distress reduction skills training from cognitive-behavioral therapy, with the understanding that improving emotional regulation would facilitate the exploration and expression of the underlying emotions associated with his traumatic experience. By increasing Pablo's repertoire of coping skills and gradually beginning to discuss his immigration experience, he became more tolerant of previously unbearable anxiety, giving him the emotional freedom to disclose more details of his trauma. After some sessions of this kind of work, we agreed we could begin exploring Pablo's trauma in full. As I listened to Pablo's story, there were moments in which his range of affect suddenly narrowed, and his narrative became more constrained and less detailed. He would then cease talking about his narrative altogether and demand to know if I was sharing his story with *la migra* (i.e., the immigration authorities, ICE). I assured him this was not the case and asked him to continue. He would then resume his narrative, only to once again become preoccupied with my intentions.

Pablo withdrew emotionally from me, and increasingly feared I would sell him out to the authorities. I, in turn, had difficulty staying attuned to him, becoming increasingly uncomfortable during our sessions. I increasingly saw him as unnecessarily suspicious and disengaged, and I worried that the stereotypes of ethnic minorities as "unanalyzable," unable to engage in psychoanalytic therapy, were true (perhaps an ironic neurosis

considering that *I* am a Puerto Rican clinician who is *also* in his own personal psychoanalytic therapy!). Through supervision and reflection on the enactment, I realized that I was operating from an assumption that belied my privilege as a Puerto Rican, because Puerto Ricans from the island and the United States mainland are born with citizenship. Because the mainland was always a plane ride away from Puerto Rico, I had no idea what it was like to lose friends and family, and almost lose one's life, in the course of immigration. Hearing Pablo's story highlighted the experiential gulf between us, bringing my own unarticulated privileges into awareness and increasing my discomfort. Pablo must have sensed this discomfort and responded to it as a threat to his safety, a sign that I could not provide a holding environment for his affect. When he rightly questioned whether I was compromising his safety ("are you reporting me to *la migra?*"), my attempts at reassurance—the denial of my discomfort with our cultural difference—labeled him as paranoid, invalidating his experience of me in the here-and-now.

At our next session I noted the growing distance between us, and wondered aloud whether my "reassurance" had in fact invalidated him and implicitly communicated that he was being paranoid. Pablo confirmed this, sharing that he felt I was calling him a "Latino loco" (a crazy Latino). He had felt confused and disoriented, but knew that at some level I was not fully present with him, which made him worry about my intentions in listening to his trauma. I validated his observations of my avoidance, and disclosed that I was reacting to the cultural differences in our relationship: with him as an undocumented Latino and myself as—at this point Pablo finished my sentence for me—"Latino con ciudadania" (a Latino with citizenship). Bringing attention to the cultural rupture opened up space for us to address how our different experiences—his as a Latin American immigrant, mine as a U.S.-born Puerto Rican—affected our interaction and my ability to stay connected. The enactment resonated with Pablo's experience outside of therapy, in which others could not understand the profundity of his immigration experience, or his fears of being caught and "sent back" to his country by immigration officials. Repairing the cultural rupture allowed for the restoration of mutual trust by validating Pablo's experience of me in the here-and-now. Validating Pablo's reality facilitated the emergence of underlying feelings of injury and loss into awareness, allowing him to mourn those he had lost after he immigrated to the United States. Expressing this untapped affect to me provided Pablo with an experience in which his reality as a trauma victim

was validated and born witness to. Mutual reflection on our transference and countertransference, in turn, made new emotional and historical material available to consciousness and furthered the work of analysis.

As a result of our exchange, I connected Pablo with an immigration lawyer who did *pro bono* work and could inform him of his rights and help him navigate the U.S. immigration system. Empowerment through access to legal and community resources, coupled with increased coping and meaningful connection within the therapeutic relationship, led to symptom improvement, the creation of new meaning from the trauma, and improvement in emotion regulation capacities. As set out at the beginning of our time together, we reviewed our progress and assessed the need for further treatment at the end of the school year. At this point, Pablo felt he had achieved his goals and requested that we end treatment so that he could attend to some family responsibilities that had come up. After a collaborative dialogue we decided to terminate therapy after a course of 25 sessions. The therapy process was marked by a dynamic interplay between empathic exploration of affect, use of cognitive-behavioral skills training, here-and-now relational processing, and systems level intervention. Technical flexibility allowed us to deploy different types of clinical tools within a psychoanalytic framework.

Conclusion: Ferenczi's Contribution to a "Psychotherapy for the People"

Governmental bureaucracy, combined with the ravaging effects of World War I, prevented von Freund's dream of starting the first psychoanalytic free clinic in Budapest from becoming reality. Although Ferenczi was an aggressive advocate for a free clinic, one was not to be established in Hungary until the early 1930s. He blamed inadequate social services and economic destitution not only for the delay of the clinic's establishment, but also for the lives lost to hopelessness and poverty. In 1929, he published a case report, "From the Childhood of a Young Proletarian Girl," a clinical plea for social reform and increased awareness of the psychological effects of poverty (cited in Danto, 2005).

The case report was the diary of a 19-year-old woman from an impoverished family, whose suicide Ferenczi was unable to prevent. The diary chronicled her first 10 years of life, describing the misery she experienced as a result of her social class. Rendered powerless as a clinician in the face of structural injustice, Ferenczi took the words of her diary to

heart and tried to give her in death what she could not have in life: her voice, reminiscent of his work with Rosa K,

> Rich children are lucky. . . . They can learn many things, and [learning] is a form of entertainment for them . . . and they are given chocolate if they know something. Their memory is not burdened with all the horrible things they cannot get rid of. The teacher treats them with artificial respect. It was like this in our school. . . . I believe that many poor children learn poorly or only moderately for similar reasons and not because they are less talented. (quoted in Danto, 2005, p. 220)

Ferenczi's patient spoke truth from the margins of psychoanalysis then, and speaks truth from the margins of psychoanalysis today. Freud, Ferenczi, and others struggled creatively to alloy pure gold and copper and refine psychoanalysis into a metal that was more responsive to the needs of those who do not have the time or the money for long-term, open-ended, multiple-times-a-week analysis. These patients' limitations are not due to a lack of ego-strength, inability to tolerate frustration, or any such ideologically motivated notions. Ferenczi's "proletarian girl" exhibited none of these. She displayed a keen understanding of the forces that underlay her trauma, and composed a striking indictment of unjust conditions.

This article explores the historical importance of melding Freud's gold of psychoanalysis and the copper of less intensive psychotherapy to produce two important movements in contemporary psychoanalysis: Relational theory and short-term psychodynamic therapy. It does not argue, however, that poor and oppressed communities somehow respond better to these modalities, or that these should be the only options. In the same way that I don't see "traditional" psychoanalysis as the only way to "do" psychoanalysis, I don't wish for short-term therapy to become the "new norm." What makes the development of Relational psychoanalysis and short-term dynamic therapy "psychotherapies for the people" is the *responsiveness* that the early analysts—Freud, Rank, and Ferenczi among them—employed to adapt their therapy and themselves to various conditions and populations. What is important is not that the 1918 Budapest speech fostered the growth of these approaches, but that it stirred the flexibility necessary to alternate between long-term and short-term therapies, or between "supportive" and "expressive" interventions. What we need to realize is that this conversation is not about "psychoanalysis" versus "something-not-psychoanalysis." This is about different forms, al-

loys, permutations, flavors, and states: They are all psychoanalysis (Lew Aron, personal communication; cf. Safran, 2009). The history of the early analysts reveals that far from being apathetic to the needs of the poor, they were responsive, reparative, and aware of the need for modification and adaptation. It is this ethical impulse that can bring psychoanalysis to the people. Following Ferenczi's—and Freud's—lead, we must commit ourselves to an ethic of flexibility, and be prepared to tilt our ears to the voices of others.

Acknowledgments—This article was originally presented at the Sándor Ferenczi Center of the New School for Social Research on April 29, 2011, New York City. The author would like to thank Neil Altman, Paul Wachtel, and Lew Aron for their discussion and feedback after the presentation. The author also thanks Stanley Messer and Karen Riggs-Skean for allowing him to use the final assignment for their course on short-term dynamic therapy as a medium through which to develop this article.

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