

Psychological Immunotherapy: Reconceptualizing Spotnitz's Modern Psychoanalytic Technique Through a Medical Analogy

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Abstract

Modern Psychoanalysis, developed by Hyman Spotnitz, employs techniques of joining, mirroring, and reflecting to create graduated emotional experiences within the therapeutic relationship. This paper proposes that Spotnitz's approach can be productively reconceptualized as a form of psychological immunotherapy, in which carefully titrated doses of emotionally toxic stimuli — historically overwhelming to the preoedipal patient — are administered within the containing relationship with the analyst, building progressive tolerance and ego resilience over time. This framework is contrasted with classical Freudian analysis, which is analogized to surgical intervention targeting underlying structural pathology, and Cognitive Behavioral Therapy, which is analogized to pharmacotherapy through its symptom-focused, protocol-driven approach. The immunotherapy model is further examined through the lens of contemporary neuroscience, including stress inoculation research, polyvagal theory, and neuroplasticity, suggesting that the mechanism of action proposed by Spotnitz may have identifiable neurobiological correlates. The Treatment Expectancy and Engagement Scale (TEE-40), a companion instrument developed from the same Spotnitz theoretical tradition, is introduced as a diagnostic tool for guiding treatment selection. Implications for cross-disciplinary dialogue between modern psychoanalysts, CBT practitioners, and neuropsychologists are discussed, along with directions for future empirical research.

Keywords: *ego resilience, graduated emotional experiences, Hyman Spotnitz, immunotherapy, joining technique, mirroring, Modern Psychoanalysis, neuroplasticity, medical model, preoedipal, stress inoculation, treatment selection, windows of tolerance*

I. Introduction

The history of psychotherapy is rich with attempts to understand the mechanisms by which human beings change. Across theoretical orientations, clinicians have sought frameworks that explain not merely what they do, but how and why it works. Medical analogies have long served this purpose, offering conceptual bridges between the consulting room and broader scientific discourse. It is in this tradition that the present paper proposes a novel reconceptualization of Hyman Spotnitz's Modern Psychoanalytic technique as a form of psychological immunotherapy.

Spotnitz, working primarily in the mid-twentieth century, extended classical psychoanalytic theory to address patients whose difficulties originated in the preoedipal period — the first two years of life. Where Freud's classical technique was designed for neurotic, oedipal patients capable of tolerating interpretation, Spotnitz recognized that a significant population of patients could not. For these individuals, the standard analytic approach was not merely ineffective but potentially harmful, functioning as an emotional overdose rather than a therapeutic intervention. In response, Spotnitz developed a set of techniques — joining, mirroring, and reflecting — designed to meet the patient where they were, gradually building the ego strength necessary to tolerate deeper analytic work.

This paper argues that these techniques are productively understood through the lens of immunotherapy. Just as physical immunotherapy introduces carefully graduated doses of an allergen to build the immune system's tolerance over time, Spotnitz's approach introduces carefully titrated emotional experiences — including the very stimuli historically overwhelming to the patient — within the safety of the analytic relationship. The result, ideally, is progressive desensitization and ego resilience rather than symptom suppression or structural excavation.

To situate this analogy, the paper also examines how classical Freudian analysis and Cognitive Behavioral Therapy (CBT) are compared with alternative medical models — surgery and pharmacotherapy, respectively — illuminating the distinctive contribution of the immunotherapeutic approach. The paper then turns to contemporary neuroscience, exploring how concepts such as stress inoculation, polyvagal theory, the window of tolerance, and neuroplasticity lend biological plausibility to the mechanism Spotnitz described in purely psychological terms. Finally, a proposed diagnostic instrument is introduced to help clinicians determine which treatment approach is most appropriate for a given patient.

The intended audience for this paper is deliberately broad. Modern Psychoanalysts will find a new theoretical lens through which to articulate their clinical work. CBT practitioners may discover unexpected common ground, particularly in exposure-based interventions. And neuropsychologists will find in Spotnitz's framework a set of hypotheses worthy of empirical investigation. It is hoped that the immunotherapy reconceptualization serves not only as a contribution to psychoanalytic theory but as an invitation to cross-disciplinary dialogue long overdue.

II. Modern Psychoanalysis: Origins, Development, and Clinical Tradition

Foundations and Historical Development

Modern Psychoanalysis is a systematic body of psychoanalytic theory and technique developed by Hyman Spotnitz (1908–2008), an American psychoanalyst and neurologist whose clinical career spanned more than six decades. Spotnitz's foundational contribution was to extend the reach of psychoanalytic treatment beyond the neurotic patient population for whom Freud's classical technique was designed, to include patients whose pathology originated in the preoedipal period — the earliest years of life, prior to the consolidation of a stable sense of self and the development of reliable affect regulation. His major works, including *Modern Psychoanalysis of the Schizophrenic Patient* (Spotnitz, 1969, 1985) and *Psychotherapy of Preoedipal Conditions* (Spotnitz, 1976), established the theoretical and technical foundations of the approach and remain its primary texts.

Spotnitz's departure from classical technique was not merely theoretical but grew directly from clinical necessity. Working with schizophrenic and severely narcissistic patients at a time when such populations were widely regarded as unanalyzable — unsuitable for psychoanalytic treatment due to their inability to form a classical transference neurosis or make use of interpretation — Spotnitz observed that standard analytic interventions not only failed but actively destabilized these patients. This clinical observation drove the development of a new technical approach designed specifically for patients whose ego development had been disrupted before the oedipal period, and whose capacity to tolerate analytic work required careful, graduated cultivation rather than assumption (Spotnitz, 1969; Spotnitz & Meadow, 1976).

The term 'Modern Psychoanalysis' was chosen deliberately to signal both continuity with and departure from the classical Freudian tradition. Spotnitz regarded his work as an extension of psychoanalytic principles rather than a rejection of them, arguing that Freud's own theoretical framework, properly developed, implied the need for a different technical approach with preoedipal patients. The 'modern' designation reflects the application of psychoanalytic thinking to a broader clinical population and to the more primitive levels of psychological organization that characterize that population (Spotnitz, 1985).

Institutional Development and Training

Modern Psychoanalysis developed as a clinical tradition through a network of training institutions, supervision structures, and published literature that emerged around Spotnitz's work from the 1950s onward. The Center for Modern Psychoanalytic Studies (CMPS), founded in New York City, became the primary institutional home of Modern Psychoanalytic training in the United States, offering postgraduate programs for mental health professionals and producing a generation of clinicians trained in Spotnitz's methods. The society of practitioners trained in this tradition has continued to develop the clinical and theoretical literature through publication, supervision, and clinical application (Meadow, 2003).

The Modern Psychoanalytic tradition has produced a substantial clinical literature beyond Spotnitz's own foundational texts. Phyllis Meadow, a close collaborator of Spotnitz and a leading figure in the development of Modern Psychoanalytic training, contributed significantly to both technique and theory, particularly in the areas of resistance analysis and the treatment of narcissistic pathology (Meadow, 2003; Spotnitz & Meadow, 1976). The journal *Modern Psychoanalysis*, established as a peer-reviewed publication of the field, has served as the primary vehicle for ongoing theoretical and clinical development within the tradition. This body of literature represents a coherent and evolving clinical tradition with specific theoretical commitments, technical protocols, and a defined patient population.

Core Theoretical Commitments

Modern Psychoanalysis rests on several theoretical commitments that distinguish it from other psychoanalytic approaches and that are directly relevant to the immunotherapeutic framework developed in this paper.

The first is the centrality of the preoedipal/oedipal distinction as the primary basis for treatment planning. Where classical Freudian technique addresses conflict arising in the oedipal period — roughly ages three to six — Modern Psychoanalysis addresses the more fundamental disruptions of self-organization and affect regulation that occur in the first two years of life. This distinction is not merely developmental but technical: it determines which interventions are appropriate, at what point in treatment, and with what degree of interpretive intensity (Spotnitz, 1969; Kernberg, 1984).

The second is the concept of narcissistic transference, which Spotnitz distinguished from the object transference that characterizes neurotic patients. In narcissistic transference, the analyst is not experienced as a distinct other onto whom earlier relational patterns are projected, but rather as an extension or mirror of the patient's own psychological organization. This distinction has profound technical implications: interpretations that facilitate insight in object transference are experienced as intrusive, destabilizing, or incomprehensible in narcissistic transference, and

require replacement with a fundamentally different class of intervention (Spotnitz, 1976; Spotnitz & Meadow, 1976).

The third is the role of aggression in preoedipal pathology. Spotnitz argued that the central problem of the preoedipal patient is not repressed sexual conflict, as in classical neurosis, but the inability to tolerate and express aggression outwardly. Early developmental environments that failed to receive and metabolize the infant's aggressive communications led to the turning of aggression against the self — a dynamic that Spotnitz regarded as foundational to narcissistic pathology and, in its most severe form, to psychosis. Treatment accordingly aims not at uncovering repressed content but at creating conditions in which aggression can be safely mobilized, expressed, and ultimately integrated (Spotnitz, 1969, 1985).

Relationship with Other Psychoanalytic Traditions

Modern Psychoanalysis shares certain concerns with other psychoanalytic approaches to severe pathology but differs from them in important technical respects. Kleinian technique, with its emphasis on early object relations and its use of interpretation of projective identification and primitive anxieties, addresses preoedipal material but assumes a patient capable of receiving symbolic communication and tolerating the anxiety that interpretation produces. For the most severely disturbed patients, this assumption may not hold, and Kleinian interpretation risks the same destabilizing effects that Spotnitz observed with classical technique (Klein, 1946; Segal, 1973).

Kohutian self psychology similarly addresses preoedipal injury through its emphasis on empathic attunement and the repair of selfobject failures, and its concept of mirroring transference overlaps meaningfully with Spotnitz's technical use of mirroring (Kohut, 1971, 1977). However, self psychology does not provide the specific technical apparatus for the mobilization and metabolization of aggression that Spotnitz regarded as central to treatment of the most severely disturbed patients, nor does it articulate the graduated, dose-sensitive approach to intervention that characterizes Modern Psychoanalytic technique.

Relational and intersubjective approaches, while foregrounding the therapeutic relationship as the primary vehicle of change in ways consonant with Modern Psychoanalysis, similarly lack the specific technical protocols for calibrating interpretive intensity that preoedipal pathology requires (Mitchell, 1988; Stolorow & Atwood, 1992). What distinguishes Modern Psychoanalysis from these neighboring traditions is not its recognition of the importance of the early relational environment — a recognition shared across contemporary psychoanalysis — but its systematic attention to the question of dose: how much analytic intensity the patient can receive at any given point in treatment, and how that threshold changes as ego capacity develops.

Empirical Context and Treatment Outcomes

The empirical literature on psychoanalytic treatment of schizophrenia has a complex history. Early enthusiasm for psychoanalytic approaches to psychosis, represented by figures such as Fromm-Reichmann (1950) and Sullivan (1953), gave way to skepticism following long-term follow-up studies that raised questions about the efficacy of intensive psychodynamic treatment relative to pharmacotherapy for schizophrenia (Stone, 1986). More recent meta-analytic work has rehabilitated the evidence base for psychodynamic and psychoanalytic approaches, particularly for severe personality pathology and treatment-resistant presentations, though the

evidence base specific to Modern Psychoanalytic technique remains limited (Leichsenring & Leibing, 2003; Shedler, 2010).

Shedler's (2010) landmark meta-analysis of psychodynamic psychotherapy outcome research found effect sizes comparable to those reported for other empirically supported treatments, with a distinctive pattern of continued improvement following treatment termination that is not observed in cognitive-behavioral approaches. This post-treatment growth pattern is precisely what Modern Psychoanalytic theory would predict: structural change in ego capacity, once achieved, continues to develop after treatment ends, in contrast to the compensatory skill acquisition of behavioral approaches, which tends to decay without continued practice. The TEE-40 instrument introduced in Section VII of this paper is designed in part to capture exactly this distinction between structural change and symptomatic improvement.

The relative absence of randomized controlled trial data specific to Modern Psychoanalytic technique reflects the field's historical prioritization of clinical development over empirical validation, as well as the genuine methodological challenges of studying long-term, relationally intensive treatment with severely disturbed populations. Addressing this gap is among the primary motivations for the research program proposed in this paper and developed in its companion instrument, the TEE-40 (Payson, in preparation).

III. Spotnitz's Core Techniques

Having established the theoretical foundations and institutional context of Modern Psychoanalysis, this section turns to the specific clinical techniques Spotnitz developed — joining, mirroring, and reflecting — and to the dual role of the analyst as container and delivery mechanism. These techniques give operational form to the theoretical commitments described above, and their logic is directly illuminated by the immunotherapeutic analogy developed in Section IV.

Spotnitz's dual training as physician and psychoanalyst is not incidental to his technical contributions — it is their foundation. Where other analysts of his era approached severe pathology primarily through revised metapsychological frameworks, Spotnitz approached it through clinical observation of what the patient's nervous system could and could not tolerate. The clinical stakes of this attunement are concrete: classical technique applied to a preoedipal patient is not merely ineffective but can precipitate decompensation — the interpretive intervention that would produce insight in a neurotic patient functions as an emotional overdose in the preoedipal patient, triggering defensive intensification and potential psychotic regression rather than the productive engagement it was meant to foster. This is not a risk of poor technique but of good technique applied to the wrong patient.

Joining

Joining is perhaps the most distinctive and counterintuitive of Spotnitz's technical contributions. Rather than challenging the patient's resistance — as classical technique would — the analyst joins with it, communicating in a way that aligns with and validates the patient's defensive position. The rationale is immunotherapeutic in its logic: direct confrontation of resistance triggers a defensive intensification, much as a full-dose allergen exposure triggers anaphylaxis. By joining the resistance, the analyst reduces the patient's need to defend, creating a paradoxical opening.

Joining operates on the principle that the patient's resistance is not an obstacle to treatment but a communication about what the patient can currently tolerate. The analyst who joins is not being dishonest or manipulative, but is rather reading the patient's emotional state with precision and responding at the level the patient can receive. Over time, as the patient experiences the analyst as consistently non-threatening and non-intrusive, the ego strengthens sufficiently to tolerate more direct engagement.

In practice, joining may take many forms — agreeing with the patient's stated resistance, expressing curiosity about it, or reflecting it back without challenge. The common thread is that the analyst does not push against the patient's current position but instead meets the patient there, however regressed or defended that position may be.

Mirroring

Mirroring refers to the analyst's provision of a reflecting presence — responding to the patient in ways that echo the patient's own emotional and ideational content rather than introducing the analyst's own perspective. For the preoedipal patient, who experienced early caregivers as failing, to accurately reflect their inner states, the mirroring analyst provides a corrective emotional experience at a foundational level.

Mirroring serves the consolidation of self-experience. When the analyst accurately reflects the patient's communications — emotional tone, cognitive content, and underlying need — the patient's sense of self is gradually strengthened and clarified. This is not a passive technique; it requires considerable attunement and clinical judgment to mirror accurately without becoming either a blank screen or an echo chamber. The goal is for the patient to feel genuinely seen and recognized, an experience that may have been profoundly absent in early development.

The relationship between mirroring and tolerance building is direct. As the patient experiences accurate reflection without intrusion or retaliation, the emotional environment of the therapeutic relationship becomes increasingly safe. This safety is the precondition for the gradual introduction of more challenging emotional material — the incremental dosing at the heart of the immunotherapeutic model.

Reflecting

Psychological reflecting, as Spotnitz used the term, refers to a specific technique in which the analyst returns the patient's questions or communications back to the patient rather than answering them directly. When a patient asks, 'Do you think I am angry?', the reflecting analyst might respond, 'What do you think?' This technique serves multiple functions. It preserves the patient's autonomy and agency, avoids the imposition of the analyst's perspective onto the patient's emerging self-experience, and encourages the patient to develop their own capacity for self-observation.

Reflecting is particularly important in the early phases of treatment with preoedipal patients, when the patient's ego is most fragile and most susceptible to the destabilizing influence of the analyst's interpretations. By consistently returning experience to the patient rather than defining it for them, the analyst supports the gradual development of an observing ego — a capacity for self-reflection that is itself a marker of growing ego strength and tolerance.

The Analyst as Container and Delivery Mechanism

Across all three techniques, the analyst functions simultaneously as container and delivery mechanism. As container, the analyst absorbs and metabolizes the patient's emotional communications — including aggression, despair, and primitive anxiety — without being destabilized or retaliating. As delivery mechanism, the analyst carefully introduces emotional experiences — including manageable doses of frustration and stress — that challenge the patient's ego just enough to promote growth without overwhelming it.

The analyst is not merely a passive mirror but an active clinical instrument, making continuous judgments about what the patient can currently tolerate and calibrating interventions accordingly. It is this sustained attentiveness to dose — to what the patient can receive at this moment, in this phase, with this degree of ego resources available — that makes Modern Psychoanalysis uniquely suited to the immunotherapeutic reconceptualization that follows, and that distinguishes its mechanism from both the structural intervention of classical analysis and the symptom management of behavioral approaches.

IV. The Immunotherapy Analogy

Overview of Immunotherapy as a Medical Model

Immunotherapy, in its medical form, is a treatment approach that harnesses and modulates the body's own immune system rather than attacking a pathogen or symptom directly. Its fundamental mechanism is graduated exposure: introducing a substance that the immune system has been over-responding to — an allergen, a cancer antigen, a foreign tissue — in carefully controlled doses, over time, to build tolerance or active resistance. The immune system is not suppressed but educated.

The closest medical parallel to Spotnitz's technique is oral immunotherapy (OIT) for food allergies. In OIT, a patient who experiences anaphylactic reactions to, for example, peanuts is introduced to infinitesimally small amounts of peanut protein. The dose is increased incrementally over weeks and months, always calibrated to remain below the threshold that would trigger a full allergic response (Whitsel, Bjelac, Subramanian, Hoyt, & Hong, 2021). Over time, the immune system's reactivity is recalibrated, a desensitization process mediated by characteristic shifts in allergen-specific antibody production (Vickery et al., 2011). The allergen does not disappear, but the patient's response to it is transformed from crisis to tolerance.

This structure — graduated exposure, threshold management, tolerance building, maintenance — maps with remarkable precision onto what Spotnitz described as the task of Modern Psychoanalytic treatment.

Mapping the Analogy onto Spotnitz's Technique

The Antigen: Identifying the Emotionally Toxic Stimulus

In physical immunotherapy, the antigen is the specific substance to which the patient is hypersensitive. In Spotnitz's framework, the antigen is the emotionally toxic stimulus — the feeling state, relational experience, or intrapsychic content that the patient's ego cannot yet metabolize. For preoedipal patients, this is most commonly aggression, though it may also include intimacy, separation, need, or dependency. The antigen is not merely unpleasant but genuinely overwhelming — its undiluted presence would destabilize the patient's sense of self.

The Allergic Response: Resistance as Immune Reaction

In allergy medicine, the allergic response is not a pathological failure but an over-learned protective mechanism — the immune system responding to a perceived threat with disproportionate force (a characterization offered here is the present paper's interpretive framing rather than an established immunological term; cf. Whitsel et al., 2021). Spotnitz's understanding of resistance maps closely onto this model. Resistance is not obstinacy or willful non-compliance but the ego's protective response to what it experiences as dangerous. The patient who falls silent, changes the subject, or attacks the analyst is not failing at therapy — they are deploying the only defense available to them. To challenge this defense directly is to trigger a more intense defensive reaction, precisely as direct allergen exposure triggers anaphylaxis.

The Dose: Titration of Emotional Stress

The concept of dosing is central to both immunotherapy and Modern Psychoanalytic technique. In both, the critical clinical judgment is not what to introduce but how much, and when. The analyst who joins a patient's resistance is, in effect, administering a sub-threshold dose — present enough to maintain contact with the relevant emotional material, dilute enough not to trigger an overwhelming response. As tolerance builds, the dose can be increased: more direct exploration of the toxic material, more challenge to the resistance, more interpretation of underlying dynamics.

The Maintenance Phase: Consolidation and Termination

In immunotherapy, once tolerance has been established, a maintenance phase follows in which regular low-dose exposure preserves the immune system's recalibrated response. In Modern Psychoanalytic treatment, the analogous phase involves the patient's growing capacity to tolerate and integrate previously toxic material as a stable feature of their emotional functioning rather than a therapeutic achievement that requires constant support. Termination, in this model, is the point at which the patient has internalized sufficient tolerance to manage the antigen independently.

Anaphylaxis: Therapeutic Rupture as Overdose

Perhaps the most vivid element of the analogy is the concept of anaphylaxis — the acute, potentially dangerous allergic reaction triggered by too large a dose too soon. In the therapeutic context, this maps onto the kind of decompensation, psychotic break, or acute crisis that can occur when a preoedipal patient is exposed to more analytic intensity than their ego can manage. The classical analyst who interprets too deeply, too early, with a preoedipal patient risks exactly this outcome. Spotnitz's techniques are, in part, a set of protocols for preventing therapeutic anaphylaxis.

Could Successful Immunotherapy Render Classical Analysis Superfluous?

A provocative question arises from this framework: if Modern Psychoanalytic immunotherapy is sufficiently successful, does it render classical analysis unnecessary? The argument has genuine force. If the task of building ego strength and emotional tolerance is accomplished through the immunotherapeutic process, the patient may naturally arrive at insight, conflict resolution, and structural change without formal interpretation. The destination of classical analysis would be reached by a different road.

However, a more nuanced position is that the two approaches address different levels of pathology rather than competing for the same patient. Genuinely oedipal patients — those with

sufficient early ego development — may not need immunotherapy at all and could move directly to the structural work classical analysis offers. Classical analysis retains its place for this population. For preoedipal patients, Spotnitz himself suggested that Modern Psychoanalytic technique prepares the patient for deeper analytic work, implying a sequential rather than substitutive relationship.

Perhaps the most accurate formulation is that classical analysis, in the context of a successful Modern Psychoanalytic treatment, is not superfluous but absorbed — its goals achieved through a more fundamental mechanism. Where classical analysis delivers insight from the outside through interpretation, successful immunotherapy may cultivate the internal conditions from which insight emerges organically. This is a theoretically significant distinction and one with implications for how we understand the relationship between technique and change.

Strengths and Limitations of the Analogy

The immunotherapy analogy is productive in several respects. It provides a mechanistic account of how Spotnitz's techniques work, not merely a description of what they are. It situates Modern Psychoanalytic treatment within a broader scientific discourse, making it legible to clinicians and researchers outside the psychoanalytic tradition. It generates testable hypotheses about the neurobiological correlates of treatment. And it offers a vivid clinical heuristic — the concept of dosing — that can guide moment-to-moment technical decisions.

Its limitations must also be acknowledged. Immunotherapy operates on a well-understood biological mechanism; the mechanism of psychological immunotherapy is inferential and as yet unverified empirically. The 'dose' in Spotnitz's technique is not precisely measurable in the way that allergen concentrations are. And the analogy, like all analogies, breaks down at its edges — the therapeutic relationship introduces complexities of meaning, subjectivity, and intersubjectivity that have no direct parallel in medicine. These limitations do not invalidate the analogy but suggest that it should be held as a generative framework rather than a literal equivalence.

V. Comparative Medical Analogies for Other Therapeutic Approaches

Classical Freudian Analysis as Surgical Intervention

If Modern Psychoanalytic technique is immunotherapy, classical Freudian analysis is most aptly understood as surgery. The surgeon goes in — directly, purposefully, with technical precision — to excise, repair, or restructure what cannot heal on its own. The classical analyst similarly intervenes at the site of pathology, using interpretation to bring unconscious conflict into consciousness and facilitate structural change. The operation requires a patient robust enough to survive the procedure: sufficient ego strength to tolerate the anxiety of uncovering, sufficient motivation to endure the discomfort of insight, and sufficient object relatedness to make use of the transference interpretation.

This analogy illuminates both the power and the limitation of classical technique. Surgery is potent and precise when the diagnosis is accurate, and the patient can tolerate the intervention. But surgery on a patient in a weakened state — or surgery for a condition better treated by other means — can cause more harm than good. The classical analyst who applies interpretive technique to a preoedipal patient is, in effect, performing surgery on a patient whose immune system needs building before structural intervention is appropriate.

The surgical analogy also captures the classical analyst's relative activity and the directionality of the technique. The surgeon acts on the patient; the analyst interprets to the patient. In both cases, the curative agent is introduced from outside — expertise applied to pathology. This contrasts with the immunotherapeutic model, in which the goal is to activate and strengthen the patient's own internal resources.

CBT as Pharmacotherapy

Cognitive Behavioral Therapy maps most naturally onto pharmacotherapy — the use of targeted, evidence-based, symptom-focused intervention to reduce distress and improve functioning. Like a medication, CBT is protocol-driven, replicable, and measurable. Its efficacy is established through randomized controlled trials. It targets specific symptom clusters. And like many medications, it manages the problem effectively for many patients without necessarily resolving the underlying vulnerability — when treatment ends, relapse rates can be significant for conditions such as depression and anxiety.

This is not a criticism of CBT but a characterization of its mechanism and goals. Pharmacotherapy is genuinely valuable — sometimes lifesaving — and the comparison is not intended to diminish it. Rather, it situates CBT within the broader framework this paper is developing: considering it to be an approach that relieves symptoms efficiently and safely, appropriate for a wide range of presentations, but not designed to build the deep constitutional resilience that immunotherapy aims at.

There is, however, an important exception within the CBT tradition that complicates this analogy. Exposure and Response Prevention (ERP), the gold-standard treatment for obsessive-compulsive disorder (OCD) (Foa, 2010), operates on a logic much closer to immunotherapy than to pharmacotherapy. In ERP, the patient is exposed to feared stimuli in graduated doses, with response prevention replacing the compulsive behavior that functions as a defensive reaction. The mechanism — building tolerance through graduated exposure — is proposed here as a structural analogy rather than an established empirical equivalence, to both OIT and Spotnitz's joining. This suggests that the most effective elements within the CBT tradition are already, implicitly, immunotherapeutic, and that this framework may have integrative potential across orientations.

Summary Comparison

The three models can be summarized as follows. Classical analysis is surgery: structural, directed, requiring a robust patient, curative when conditions are met. CBT is pharmacotherapy: symptom-focused, protocol-driven, broadly applicable, effective without necessarily building deep resilience. Modern Psychoanalytic technique is immunotherapy: graduated, relational, building the patient's own tolerative capacity from within, preparing the ground for or rendering unnecessary the more invasive interventions. Each has its place; the question of which is indicated requires differential diagnosis — a point to which the paper returns in Section VII.

VI. Neuropsychological Correlates

Introduction

The immunotherapy reconceptualization of Spotnitz's technique is not merely a rhetorical analogy — it generates hypotheses about the neurobiological mechanisms by which Modern Psychoanalytic treatment produces change. Contemporary neuroscience has developed a rich set

of concepts and findings that lend biological plausibility to what Spotnitz described in purely psychological terms. This section surveys the most relevant of these, with the aim of establishing a foundation for the empirical research program proposed in Section IX.

Stress Inoculation Theory

Donald Meichenbaum's stress inoculation training (SIT), developed in the 1970s and elaborated subsequently, provides perhaps the most direct bridge between Spotnitz's clinical observations and the broader scientific literature. SIT is a cognitive-behavioral intervention that deliberately exposes individuals to manageable levels of stress to build coping capacity and resilience. The mechanism is explicitly inoculatory: controlled stress exposure builds tolerance to future stressors, much as a vaccine builds resistance to future infection.

The parallel to Spotnitz is striking. Both approaches use graduated exposure to a stressor — in Spotnitz's case, the emotionally toxic relational stimulus — as the primary mechanism of change. Both are grounded in the observation that avoidance of the stressor perpetuates vulnerability, while titrated exposure builds capacity. Meichenbaum's framework provides Spotnitz's clinical observations with a recognized empirical pedigree and situates them within a broader tradition of stress and resilience research.

The Window of Tolerance

Daniel Siegel's concept of the window of tolerance describes the optimal zone of arousal within which an individual can process experience effectively — engaged enough to access emotional material, regulated enough not to be overwhelmed by it. Arousal above the window produces hyperactivation — the fight-or-flight response, flooding, dissociation. Arousal below the window produces hypoactivation — numbness, withdrawal, shutdown. Effective therapy, in Siegel's framework, keeps the patient within the window.

This concept translates directly into the immunotherapy dosing model. The analyst's task is to keep the emotional 'dose' within the patient's window of tolerance — challenging enough to promote growth, contained enough to prevent decompensation. Joining and mirroring, in this framing, are techniques for expanding the window gradually, allowing the patient to process increasingly intense material without exceeding their regulatory capacity. The window of tolerance concept also provides a neurologically grounded account of why direct interpretation fails with preoedipal patients: it pushes them outside their window, triggering the defensive reactions that constitute narcissistic resistance.

Polyvagal Theory

Stephen Porges's polyvagal theory provides a physiological framework for understanding the autonomic underpinnings of the therapeutic relationship. Porges describes a hierarchical autonomic nervous system in which the ventral vagal system — associated with social engagement, safety, and connection — must be activated before higher-order processing of emotion and meaning is possible. When the ventral vagal system is offline, the individual defaults to sympathetic mobilization (fight-or-flight) or dorsal vagal shutdown — states incompatible with the kind of reflective engagement classical analysis requires.

The implications for treatment selection are significant. The preoedipal patient, whose early relational environment failed to reliably activate the social engagement system, may be chronically operating in sympathetic or dorsal vagal states. Classical analytic technique, with its

relative silence, neutrality, and interpretive challenge, may fail to activate the ventral vagal system and may in fact deepen defensive withdrawal. Spotnitz's joining and mirroring techniques, by contrast, signal safety and attunement at the autonomic level, facilitating the social engagement necessary for therapeutic work to proceed. Polyvagal theory thus provides a physiological account of why the immunotherapeutic approach is indicated before structural intervention.

Neuroplasticity

The concept of neuroplasticity — the brain's capacity to reorganize itself in response to experience — provides perhaps the most fundamental neurobiological support for the immunotherapy model. Repeated, graduated emotional experiences within the therapeutic relationship are not merely psychological events; they are neural events, shaping synaptic connections, modulating gene expression, and altering the functional architecture of the brain over time (see Milad & Quirk, 2012, for review of related mechanisms in fear-circuit plasticity).

Research on fear extinction — the process by which conditioned fear responses are reduced through repeated non-reinforced exposure — is directly relevant. The preoedipal patient's defensive reactions to emotional stimuli can be understood as conditioned responses, laid down in early development when the stimulus was genuinely dangerous. The therapeutic process, on this model, is one of fear extinction through new learning: repeated experience of the toxic stimulus in a safe relational context gradually attenuates the conditioned response through new inhibitory learning mediated by amygdala-prefrontal circuitry (Milad & Quirk, 2012). Spotnitz's technique, understood neurobiologically, is a protocol for optimizing fear extinction through careful dose management.

Potential Neurobiological Outcome Measures

The immunotherapy framework suggests several candidate neurobiological measures for empirical research. Amygdala reactivity to emotionally charged stimuli — measurable through fMRI — would be expected to decrease over the course of successful treatment, reflecting reduced hypersensitivity to the previously toxic antigen. Prefrontal-amygdala connectivity, a measure of top-down emotional regulation, would be expected to increase (Milad & Quirk, 2012). HPA axis reactivity — measurable through cortisol response to standardized stressors — provides an endocrine index of stress tolerance. And measures of heart rate variability, an index of vagal tone and autonomic flexibility, provide a polyvagal outcome measure (Porges, 1995) directly linked to the social engagement system Spotnitz's techniques are designed to activate.

VII. A Diagnostic Instrument: The Treatment Expectancy and Engagement Scale (TEE-40)

Rationale: Differential Diagnosis Before Treatment

In medicine, treatment selection follows differential diagnosis. The allergist does not recommend immunotherapy without first establishing the presence and specificity of hypersensitivity. The surgeon does not operate without accessing the imaging of the pathology in question. The prescribing physician does not initiate pharmacotherapy without a diagnostic formulation that justifies the choice of agent. Psychotherapy has largely lacked an equivalent systematic basis for treatment selection, with clinicians tending to apply the approach in which they are trained rather than the approach indicated by the patient's actual developmental organization. The immunotherapy framework makes clear that this is not merely a matter of clinical preference but a consequential diagnostic decision: applying surgical technique to a patient who needs

immunotherapy risks decompensation; applying immunotherapy to a patient who needs surgery wastes time and may collude with avoidance.

The Treatment Expectancy and Engagement Scale (TEE-40), developed by Payson, provides exactly this kind of diagnostic instrument (Payson, in preparation). While originally developed in the context of schizophrenia treatment research, the TEE-40's theoretical foundations map directly onto the broader preoedipal/oedipal distinction at the heart of the immunotherapy framework, and its clinical utility extends accordingly. It operationalizes Spotnitz's concept of ego capacity and narcissistic defense intensity in empirically assessable form, enabling the kind of treatment matching that the immunotherapy analogy requires but that the field has historically lacked. Like the allergist's skin prick test — introducing a small dose and measuring the reaction — the TEE-40 assesses what the patient can currently tolerate before a treatment modality is selected.

Structure and Scoring

The TEE-40 comprises 40 items across five ego function domains, each item rated 0–5, yielding domain scores of 0–40 and a total score of 0–200. Higher scores indicate greater ego capacity and defensive flexibility; lower scores indicate more rigid defensive structure and limited ego resources. The five domains are as follows.

Reality Testing (Items 1–8) assesses the patient's capacity to distinguish internal experience from external reality and to observe their own psychological processes with some degree of distance. High scores indicate the ability to consider alternative explanations, recognize symptoms as symptoms, and integrate feedback from the therapeutic relationship. Low scores indicate concrete thinking, fusion of thought and reality, and rigid defensiveness against alternative perspectives. In the immunotherapy framework, Reality Testing capacity directly predicts tolerance for interpretive intervention: patients with low Reality Testing scores are likely to experience interpretation as assault rather than insight, triggering defensive intensification rather than productive engagement.

Emotional Contact (Items 9–16) measures capacity for affective connection and differentiation of emotional states. High scores indicate the ability to experience and express nuanced emotions, maintain emotional presence in relationships, and use affect as information rather than threat. Low scores indicate emotional numbing, difficulty identifying feelings, and defensive withdrawal from affective experience. This domain maps directly onto the mirroring function of the analyst: a patient with low Emotional Contact requires extended mirroring before emotional material can be productively engaged.

Verbal Accessibility (Items 17–24) evaluates capacity for symbolic communication and psychological-mindedness. High scores indicate ability to verbalize internal experience, use metaphor, and engage in collaborative psychological exploration. Low scores indicate concrete communication, difficulty putting experience into words, and communication primarily through action or withdrawal. Verbal Accessibility determines how much of the analytic relationship can be conducted through language and how much must rely on the non-verbal elements of joining and presence.

Relationship Capability (Items 25–32) assesses capacity for object relations and interpersonal functioning. High scores indicate ability to maintain stable relationships, differentiate self from the other, and tolerate ambivalence — the hallmarks of object transference. Low scores indicate

narcissistic object relations, boundary confusion, and relational instability — the hallmarks of narcissistic transference. This domain is the most direct measure of the preoedipal/oedipal distinction central to the immunotherapy framework: a patient with low Relationship Capability is, by definition, operating in narcissistic transference and requires immunotherapeutic technique before surgical intervention becomes appropriate.

Stress Tolerance (Items 33–40) measures ego strength under pressure and the capacity to maintain functioning despite therapeutic challenge. High scores indicate ability to manage frustration, tolerate regression, and recover from setbacks without decompensating. Low scores indicate fragile functioning, rapid crisis response, and vulnerability to therapeutic overdose — the psychological equivalent of anaphylaxis. Stress Tolerance is the domain most directly relevant to dosing decisions: it determines how much emotional challenge the patient can receive in each session, and how quickly the dose can be increased over the course of treatment.

The Four-Category Diagnostic Framework

A critical contribution of the TEE-40 is that it measures *ego capacity* independently of symptom severity. Two patients presenting with identical symptom profiles may have profoundly different ego capacities and thus require opposite treatment approaches. The TEE-40 makes this distinction visible in a way that symptom-based assessment alone cannot. The resulting four-category framework, crossing symptom severity with ego capacity, maps directly onto the immunotherapy decision.

High symptoms, high capacity: The patient presents with significant distress but retains ego strength. Prognosis is excellent. Symptoms are likely stress-responsive and will resolve with appropriate joining and defense-focused work. The patient is ready for treatment despite acute presentation; surgical/interpretive technique may become appropriate sooner than presentation would suggest.

High symptoms, low capacity: The patient presents with both symptomatic distress and profound ego impairment. Prognosis is guarded. Immunotherapy is indicated as the primary modality; defensive work must precede any interpretive intervention. Introducing surgical technique prematurely risks decompensation.

Low symptoms, high capacity: The patient presents with minimal distress and strong ego functions. Surgical/interpretive technique is appropriate. Both symptom measures and the TEE-40 suggest good prognosis, though for different reasons.

Low symptoms, low capacity: The most dangerous diagnostic category, and the one most likely to be missed by symptom-based assessment alone. The patient appears stable but has rigid defensive structure and limited ego resources. Interpretive technique will precipitate decompensation. Extended immunotherapy is required before any structural intervention becomes possible. Treatment failures in this category are commonly attributed to ‘poor prognosis’ or ‘treatment resistance’ when the more accurate explanation is technique-capacity mismatch.

The TEE-40 as Progress Monitor

Beyond initial treatment selection, the TEE-40 serves as a longitudinal progress monitor — tracking the dose-building process over time in a way that symptom measures cannot. Rising TEE-40 scores over the course of treatment provides direct evidence that tolerance expansion is

occurring, even in phases where symptomatic presentation remains stable or temporarily worsens as previously suppressed material becomes accessible.

A psychometric validation study of the TEE-40 is currently being designed (Payson, in preparation), aimed at establishing internal consistency, inter-rater reliability, and convergent and discriminant validity. Its inclusion here reflects the close alignment between its conceptual architecture and the immunotherapy framework developed in this paper — an alignment that is not coincidental, as both emerge from the same body of Spotnitz's clinical theory applied to the problem of treatment selection and outcome prediction.

VIII. Clinical Illustration

The following vignette is illustrative rather than an actual case, designed to demonstrate how the immunotherapy framework can inform clinical reasoning.

A patient in his late twenties presents with a diagnosis of schizophrenia, paranoid type, following two prior hospitalizations. He lives with his mother, has not worked in three years, and was referred for outpatient treatment after his most recent discharge. He attends sessions reliably but speaks in brief, guarded statements, frequently scanning the room before answering a question. He describes hearing voices that comment critically on his actions, and states flatly that he does not trust most people, including, at times, his mother.

A TEE-40 assessment reveals significantly impaired Reality Testing, minimal Emotional Contact, fragile Stress Tolerance, and an autonomic profile consistent with chronic sympathetic activation punctuated by episodes of dorsal vagal withdrawal. An early attempt at an ego-oriented question is met with a long silence, increased guardedness, and a missed session the following week. The TEE-40 profile indicates severely limited ego capacity: immunotherapy at the lowest dose is the appropriate primary modality.

The therapist shifts to a joining stance. When the patient says he doesn't see the point of coming, the therapist responds with simple acknowledgment rather than persuasion: "That makes sense, given everything you've been through." When the patient falls silent mid-session, the therapist does not press for content, allowing the silence to continue while maintaining a steady, unhurried vocal presence at the session's natural points of contact. The antigen — in this case, the patient's own vulnerability and the threat he perceives in being known by another person — is present in the room but held at sub-threshold doses through the therapist's non-demanding stance.

Over the course of two years, the patient's window of tolerance expands gradually and unevenly. He begins arriving a few minutes early. He volunteers, unprompted, that the voices have been quieter on weeks when he sees his sister. He tolerates a single ego-oriented question per session without withdrawing. The severe guardedness that once dominated every interaction becomes intermittent rather than constant. At this point, the therapist begins introducing slightly more direct questions about his inner experience, increasing the dose incrementally and monitoring his response closely for signs that the threshold has been exceeded.

This vignette illustrates the immunotherapy framework in action: the identification of the antigen, the calibration of the dose through joining and sustained non-demanding presence, the gradual and uneven expansion of tolerance, and the eventual possibility of more direct engagement. It also illustrates what the TEE-40 assessment contributes: without the diagnostic clarity it provided at intake, the therapist might have continued introducing ego-oriented

questions at a pace this patient's ego capacity could not yet sustain, risking the kind of premature pressure that triggers withdrawal or decompensation rather than growth.

IX. Implications for Research

The immunotherapy framework generates a specific and tractable research program. Several directions warrant priority attention.

First, full psychometric validation of the TEE-40 is a pressing empirical need. The companion paper (Payson, in preparation) outlines a pilot validation study designed to establish internal consistency, inter-rater reliability, and predictive validity. Prospective studies should then examine whether TEE-40 scores predict differential treatment response across modalities, and whether treatment matching by capacity level improves outcomes relative to standard symptom-based assignment.

Second, neuroimaging studies comparing pre- and post-treatment neural profiles in patients receiving Modern Psychoanalytic treatment, classical analysis, and CBT would test the hypothesis that each modality produces distinctive patterns of neural change consistent with its proposed mechanism. The immunotherapy model specifically predicts that Modern Psychoanalytic treatment would produce changes in amygdala reactivity, prefrontal-amygdala connectivity, and autonomic flexibility that reflect genuine recalibration of the stress response system rather than symptom suppression.

Third, the relationship between Spotnitz's technique and established stress inoculation and fear extinction research should be examined through systematic review. A meta-analytic synthesis of existing outcome data for Modern Psychoanalytic treatment, examined through the lens of stress inoculation theory, would establish empirical foundations for the framework proposed here.

Fourth, process research examining moment-to-moment dosing decisions in Modern Psychoanalytic treatment — how clinicians calibrate the emotional intensity of their interventions, and how patients' autonomic and behavioral responses signal tolerance levels — would provide the kind of fine-grained mechanistic data necessary to test the immunotherapy model at the level of the individual session.

The interdisciplinary nature of this research agenda is its greatest challenge and its greatest opportunity. Collaboration between modern psychoanalysts, who hold the clinical knowledge and theoretical framework, CBT researchers, who bring methodological rigor and outcome measurement expertise, and neuropsychologists, who can provide the biological measurement infrastructure, would be necessary to pursue it fully.

X. Discussion

This paper has proposed that Hyman Spotnitz's Modern Psychoanalytic technique — specifically its core methods of joining, mirroring, and reflecting — is productively reconceptualized as a form of psychological immunotherapy. The analogy is not merely rhetorical. It identifies a genuine structural parallel between the mechanism of OIT and the mechanism of Spotnitz's technique, generates testable hypotheses about neurobiological correlates, provides a basis for treatment selection, and offers a common language for cross-disciplinary communication.

What does this framework add to existing psychoanalytic theory? First, it provides a mechanistic account of how Spotnitz's techniques work — not merely a description of what they are. The concept of dosing, of threshold management, of tolerance building, gives clinical precision to

what might otherwise appear as a collection of unrelated technical maneuvers. Second, it situates Modern Psychoanalysis within a broader scientific tradition that extends well beyond the consulting room, lending it credibility and legibility in contexts where psychoanalytic language has historically found limited traction. Third, it generates the diagnostic question — immunotherapy or surgery? — that has been largely absent from the clinical literature, with consequences for treatment outcomes that warrant urgent attention.

The framework also suggests that Spotnitz was, in important respects, ahead of his time. Working decades before polyvagal theory, neuroplasticity research, and the window of tolerance concept were developed, he arrived through clinical observation at a set of technical principles that contemporary neuroscience is now providing a biological foundation for. This is not an accident — it reflects the rigor of his clinical attention and the depth of his biological training as a physician.

The limitations of the current paper must be acknowledged. It is theoretical rather than empirical. The neurobiological correlates are hypothesized rather than demonstrated. And the clinical vignette, while illustrative, is not a case study with the evidential weight of systematic clinical documentation. Notably, the TEE-40 addresses one limitation directly: it provides a fully articulated diagnostic instrument grounded in the same theoretical framework developed here, with a psychometric validation study currently in design, lending the diagnostic framework a concrete empirical foundation that is in preparation rather than merely theoretical.

XI. Conclusion

The immunotherapy reconceptualization of Spotnitz's Modern Psychoanalytic technique offers a framework that is simultaneously clinically useful, theoretically rigorous, and empirically generative. By mapping the graduated, relational, tolerance-building logic of joining, mirroring, and reflecting onto the well-understood mechanism of physical immunotherapy, this paper has proposed a new way of understanding what Modern Psychoanalytic treatment does and why it works.

The comparative framework — immunotherapy for preoedipal pathology, surgery for oedipal pathology, pharmacotherapy for symptom-focused intervention — provides a basis for differential treatment selection that the field has lacked. The TEE-40 translates this framework into a concrete clinical and research tool. And the neuropsychological correlates examined here establish a foundation for the empirical research program that would test, refine, and extend the framework.

Perhaps most importantly, this paper represents an invitation. An invitation to modern psychoanalysts to articulate their clinical work in terms accessible to colleagues across theoretical orientations. An invitation to CBT researchers to examine the immunotherapeutic elements implicit in their most effective interventions. And an invitation to neuropsychologists to turn their methods toward the rich clinical phenomena that Spotnitz described — phenomena that may, on closer empirical examination, illuminate the neurobiological foundations of psychological change itself.

Spotnitz built a clinical framework of remarkable sophistication from the evidence available to him. It is time for the field to build the empirical scaffold that his work deserves.

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