Table of Contents
Volume 64, Number 1 – Spring 2019

Message from the Interim Editor .......................................................................................................................... 5
Gerald P. Perman, MD

From the President ...................................................................................................................................................5
Gerald P. Perman, MD

San Francisco 2019 Annual Meeting ................................................................................................................... 7
Silvio Olarte, MD and Alicia McGill, MD

Report from the Committee of the Advancement of Psychoanalysis ................................................................. 9
Drs. Mark Unterberg, Norman Clemens, David Edelstein, Phil Lebovitz

Teichner Update .................................................................................................................................................... 11
Dr. Cesar Alfonso, et al

Elise Snyder, MD

OPIFER 2019 ........................................................................................................................................................ 15
Dr. Joan Tolchin

World Psychiatric Association .................................................................................................................................. 15
Professor Helen Herrman

Remembering Marianne Horney Eckardt, MD and Milton Zaphiropoulos, MD .................................................. 16

ARTICLES
Climate Change – Stephen Peterson, M.D. and Patricia Huerta ........................................................................ 20

Narratives from Physician Health Task Force – Douglas Ingram, MD ............................................................... 23
   a. A Life-Threatening Illness
   b. A Story of Burnout
   c. When Duties Collide
   d. A Resident with Anorexia
   e. Medical Scribes
   f. Diagnosis and Treatment of Prostate Cancer

Chronification ......................................................................................................................................................... 31
Reimer Hinrichs, MD

Collaborative Treatment of a Bipolar Adolescent ................................................................................................. 33
John S. Tamerin, MD and Ethan Weibman

Shame and Guilt in Bipolar Disorder .................................................................................................................... 36
Eugenio Rothe, MD

BOOK REVIEWS
The Pigeon Tunnel: Stories From my Life by John le Carre .................................................................................. 38
Reviewed by Astrid Rusquellas, MD

The Red Book of C.G. Jung: A Journey into Unknown Depths by Walter Boechat .............................................. 40
Reviewed by Alvaro A. Giraldo, MD

NEW MEMBERS ................................................................................................................................................ 42

Cover Photo

About a year ago, the AAPDPP Executive Committee wanted to find a way to commemorate the merger of the Academy with the American College of Psychoanalysts. David V. Forrest, M.D., A Fellow of both the College and the Academy, prepared several designs for a lapel pin and the final choice is displayed on the cover of this issue of the Academy Forum. This pin has been sent to all Academy Fellows and will be given to all members of the Academy who attain the status of Fellow in the future.

Gerald P. Perman, M.D., DLFAPA
President, AAPDPP
Editorial Policy for THE ACADEMY FORUM

Articles may be submitted to the editor of this magazine by anyone who wishes to write about topics related to psychoanalytic psychiatry.

Authors who submit an article to THE ACADEMY FORUM magazine for publication agree to all of the following:

1. the editor may proofread and edit all articles for content, spelling and grammar.
2. the printing of the article in THE ACADEMY FORUM and the printing date and placement are at the discretion of the editor.
3. the author of the article may submit his/her article published in THE ACADEMY FORUM to additional magazines for publication after obtaining permission from THE ACADEMY FORUM.
4. THE ACADEMY FORUM does not normally accept previously published articles but may do so at the discretion of the editor.

Criteria for Submission:

1. All articles must be sent electronically as an attachment in a Word file (or text file) to articlesforforumeditor@gmail.com. Any pictures embedded in the file must be high quality JPG files of each picture used.
2. Articles should be 1,000 to 2,500 words in length although the editor may make exceptions. Book reviews should usually approximately 1500 words. Please note that lists and examples take up room and decrease the number of words allowed.
3. Submissions should be of interest to the membership that lists and examples take up room and decrease the number of words allowed.
4. THE ACADEMY FORUM does not normally accept previously published articles but may do so at the discretion of the editor.

Deadlines for Article and Ad Submission

- THE ACADEMY FORUM is published electronically in October (the Fall issue) and in April (the Spring issue).
- Confirmation for submissions are due seven weeks prior to the month of publication.
- Copy (articles) is due four weeks before publication

ADVERTISING

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The Academy Forum welcomes contributions from readers. All manuscripts must be submitted in computer-readable format. All manuscripts are subject to editing for style, clarity, and length. All communications, including manuscripts, queries, letters to the Editor and changes of address should be addressed to: Angela M. Hegarty, Editor of the Academy Forum at info@aapdp.org.

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Note from the Interim Editor
By Gerald P. Perman, M.D.

Dear Readers,

The Forum cover photo is of the beautiful new Academy pin designed by long-time Academy member David V. Forrest, M.D. This ¾ diameter pin is being sent to all Academy Fellows and, as such, serves as an incentive to become more involved in Academy activities so that you too may become the proud owner of this stunning pin!

The first section of the spring 2019 Forum is overflowing with important and relevant articles and announcements that include contributions from: (1) the President of the Academy; (2) the Co-Chairs of the May 16-18, 2019 Annual Meeting in San Francisco - register and make your travel arrangements now; (3) the Committee for the Advancement of Psychoanalysis (CAP); (4) the Chinese American Psychoanalytic Association (CAPA); 5. An OPIFER update; (6) a Teichner Award update and (7) the President of the World Psychiatric Association. In addition, we remember founding Academy members Mari-anne Horney Eckardt and Milton Zaphiropoulos.

Regular articles include contributions on: (1) how Climate Change is affecting our planet and our patients; (2) narratives from Doug Ingram, M.D.’s Physician Wellbeing Task Force; (3) what happens when acute psychiatric illness turns chronic; (4) the collaborative treatment of an adolescent with Bipolar Disorder; and (5) shame and guilt in Bipolar Disorder.

We have one book review and a list of the newest Academy members. I am appreciative to Sarah Nobel, M.D. for her long-standing work as Forum Book and Film Editor, and to Ms. Marie Westlake for her steady hand and brilliant mind in helping the Editor put each issue of the Forum together and to get it mailed to our members in a timely fashion.

I encourage each of you to submit articles on clinical topics, stories about your life as a psychodynamic and psychoanalytic psychiatrist, and book and film reviews. The pleasure you will receive in connecting with your fellow members by writing for the Forum will vastly outweigh the labor of love that you will have invested.

Best wishes to all,

Gerald P. Perman, M.D.
Interim Editor of the Academy Forum

Message from the President

Dear Academy Friends,

I welcome this opportunity to share my reflections with you about the American Academy of Psychodynamic Psychiatry and Psychoanalysis. We are in our 63rd year and continue to evolve and keep up with the times. Ours is a unique organization of psychiatrists with a primary interest in psychodynamic psychiatry based on the fundamental discoveries of Sigmund Freud that began over 125 years ago. Whereas many new therapies and treatments for mental illness have since been developed and are more “popular” today than is psychodynamic and psychoanalytic psychiatry, our members remain convinced of the profound importance of recognizing unconscious conflict in our patients, of appreciating the defense mechanisms that our patients use to cope with these conflicts, and of valuing the efficacy of the treatments we provide in many varied settings. In this regard, I want to extend a deeply felt welcome to the former members of the College of American Psychoanalysts who are new members to the Academy.

We live in anxiety-provoking times. How could the cataclysmic threats posed by climate change, the devastating opioid crisis in America, and the lethal domestic violence and mass shootings that are now a routine part of the American scene, not cause anxiety in ourselves, in our society’s children, and in our patients? I hear about these issues frequently in my practice, as I imagine that you do as well. Even though we work at the “micro” level treating one patient at a time, the effect of our treatment is analogous to throwing a stone into the proverbial pond that creates ripples that affect the lives of the many people under our patients’ spheres of influence.

The antidote to anxiety is to turn passive paralysis into assertive action. In our work, we help our patients productively release their energies that are bound up in neurotic conflict to improve their lives and to help those around them as well. This then is our potent professional contribution to some of the important problems that exist in our world. To quote Freud: “The voice of reason is small, but very persistent.”

Most of you are familiar with the Teichner Scholarship Program overseen by Sherry Katz-Bearnot, M.D., and the eponymous Scott Schwartz Award, both of which are described in detail on the Academy website (www.aapdpp.org). I hope to let you know soon about two additional awards that are currently under consideration in the Academy. In addition to these initiatives, I have created a Social Media Task Force to look at potential advantages for the Academy to develop a social media presence on our
The Academy maintains a strong physician identity and as such is an Affiliate Organization of the American Psychiatric Association. We had been effectively represented in the APA Assembly for a number of years by Eric Plakun, M.D. Eric was recently promoted to become a Trustee of the APA and his role as Assembly Representative has been filled by Barry Fisher, M.D. Barry, a long-time colleague of mine in Washington, D.C., had previously asked how he could become more active in the Academy. When I asked Barry if he would consider taking on the role of Assembly Rep, he enthusiastically accepted and he has already attended his first APA Assembly meeting.

I love my work as a full-time psychodynamic psychiatrist in Washington, D.C. I have been in practice for almost 40 years and retirement looms sometime in the future. I find it hard to let go of my practice with grateful patients who don’t want to lose me. At the same time, I hold on to the deluded belief that I will live forever, that I will never retire, and that I will just continue to decrease my hours gradually without an endpoint. Like an old general, I will “never die, but just fade away.” We all need to be aware, however, of how long we can safely practice medicine as our powers will most assuredly wane with advancing age. In this regard, Douglas Ingram, M.D.’s critical work with the new Physician Wellbeing Task Force will have much to offer members of the Academy as well as the larger psychiatric community.

I wish to thank our Executive Director, Ms. Jackie Coleman, and Executive Assistant, Ms. Marie Westlake, for working closely with me and providing sage advice through our frequent email correspondence and weekly telephone meetings that keep the Academy running smoothly and effectively. I also extend a heartfelt “thank you” to members of our Board and everyone else who volunteers their time and energy to help maintain our wonderful organization.

I look forward with great anticipation to the May 2019 Academy Annual Meeting in San Francisco co-chaired by Drs. Silvia Olarte and Alicia McGill. I recently reviewed a draft of the program and it looks excellent!

Please don’t hesitate to contact me with questions about the Academy, and about initiatives that you would like to undertake on its behalf. Submit your scholarly contributions to our prestigious journal, Psychodynamic Psychiatry, your opinion pieces and briefer scientific articles to the Academy Forum, and your newsworthy items to our Newsletter. Both Psychodynamic Psychiatry and the Academy Forum welcome your book reviews – please contribute!

I look forward to seeing each of you in San Francisco in May 2019.

Best cordial regards to all,

Gerald P. Perman, M.D.
President, American Academy of Psychodynamic Psychiatry and Psychoanalysis

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**REMEMBER TO REGISTER!**

The American Academy of Psychodynamic Psychiatry and Psychoanalysis
63rd Annual Meeting
May 16 - May 18, 2019
Westin St. Francis San Francisco on Union Square
San Francisco, California

Download the Preliminary Program and Register online: www.AAPDPP.org

For questions or assistance with registration, contact the AAPDPP Executive Office by email (info@AAPDPP.org) or phone (888-691-8281).

We look forward to seeing you in San Francisco!
The founding members of the Academy were committed to developing an association that would provide a forum for the free expression of ideas and the advancement of concepts and research in Psychoanalysis. By 1996 the Academy recognized the expanded scope of its membership and added “Psychodynamic Psychiatry” to its name. By 2013, Academy journal editors were ready to define Psychodynamic Psychiatry as “a new discipline that has emerged from a fusion of psychoanalytic and extra-psychoanalytic psychology, neuroscience, and academic psychiatry” (Psychodynamic Psychiatry 41(4) 511-512 2013). This was followed by a change in the organization’s name to The American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP). This change reflects the shift in training and practice of contemporary psychiatrists and the Academy’s efforts to provide a welcoming forum for new and innovative ideas in these augmented fields. Since the expansion of our name and purpose, our annual meetings have been designed to explore how Psychoanalysis and Psychodynamic Psychiatry foster the evolution and integration of these disciplines into the ever-changing specialty of Psychiatry. The basis for our inquiries lies in the psychoanalytic theories that established concepts, processes, and the descriptive language that we use. From this foundation, case studies and selections of clinical experiences can be used to illustrate and enrich the understanding of theoretical concepts. Indeed, psychoanalytic interpretations have long since migrated from the consulting room to influence various areas of academic pursuit, including psychoanalysis applied to the arts, literature and biographical inquiries. Explicitly and implicitly, dynamic theories have spawned and influenced allied fields including various approaches to psychotherapy based on social science and neuroscience research.

This year’s meeting seeks to provide members with a status report on existing efforts to elaborate upon psychoanalytic and psychodynamic thinking. These efforts are resulting in the development of re-imagined theoretical concepts and the application of new, derivative clinical techniques. The content of this year’s meeting will also provide methods for interrogating our foundational psychoanalytic concepts with the tools supplied by neurobiological science and multicultural insights. The direction for our future collective work will also be open for discussion and given helpful frameworks by those who are training the next generation of clinicians and researchers and by those who are daily seeking to address the particular demands of modern clinical settings.

Program

The disciplines of Psychoanalysis and Psychodynamic Psychiatry are both rooted in the essence of clinical processes such as the exploration of past experience and their connection to the present, the fundamental role of the unconscious in understanding motivation, the use of transference and counter-transference phenomena, and the role of the therapeutic relationship among others. A number of presenters will share their experiences with utilizing psychoanalytic and psychodynamic tenets to better treat challenging patients in a variety of settings. Presenters will report on their work including the use of art therapy in underserved neighborhood clinics, outreach services that seek to train providers and parents in infant mental health and the efforts of those who seek to thoughtfully modify treatment frames to accommodate incapacitating physical illness. Presenters will also consider the ways in which cultural differences between patient and therapist introduce challenges to the therapeutic relationship or allow for transcendence of divides based on similarities and emphasized shared humanity.

We will hear from colleagues who are thinking about contemporary cultural issues such as depression in children of the affluent, non-binary gender identity and adaptations to CL psychiatry in the realm of “patient-centered care” such that unconscious factors can be rightfully considered.
Not surprisingly, psychodynamic psychiatry continues to influence the work of clinicians well beyond the United States. Colleagues from Southeast Asia will inform us about their work in various psychiatric settings and European colleagues will consider the impact of changing epidemiology on the efficacy of long-term psychotherapy treatments.

The Academy’s longstanding commitment to inclusivity in the realm of psychoanalytic theory invites the contributions of presenters who seek to share their preferred theoretical perspective as well as their attempts to advance theoretical concepts. To this end we will be treated to presentations on dream interpretation from various psychodynamic schools of thought by a panel organized by the newly-minted Committee for the Advancement of Psychoanalysis.

A presenter with first-person experience of the Second Chechen War will lead us to consider psychoanalytic explanations for the motivation behind modern day acts of terrorism. Some theorists among us will return to Freud’s original work and wonder about whether Freudian theories can be seen as supported by science or if advances in our understanding of early development require a complete re-conceptualization of Freudian theory. Still others will encourage us to revisit primary psychoanalytic tenets to create treatment frames that best support efforts towards effective treatment of severe character pathology.

Neuroscience findings command an ever-growing influence on psychiatry with advancing identifications of neural networks that seemingly underlie and correspond with manifestations of human emotion, motivation and behavior. Various presenters will invite us to consider ways in which patients treated in psychodynamic psychiatry can be additionally helped when provided with experience-near explanations of the brain-based mechanisms undergirding their struggles with self-defeating compulsions such as addiction and neurotic repetitions of maladaptive behavior.

Presenters will provide case studies to reflect their forays into the use of brain-based interpretation. Additionally, a psychobiography of Tennessee Williams will seek to further these endeavors given what we know of the reported limitations of psychoanalytic treatment to address the playwright’s various compulsions and his experience with unremitting depression. Contributions from neuroscience will also be used to consider various “talk therapies,” including psychodynamic psychiatry, and the likely neurological basis for therapeutic action across psychotherapies.

Some presenters will seek to convince us that discovery in neuroscience, and the data collection and related algorithms, will ultimately serve to validate psychodynamic approaches to treatment. Still others will encourage us to wonder about what may be lost or obscured in the current efforts to “fuse” or bridge the gaps between the findings of neuroscience and the subtleties and elusive aspects of what transpires during psychodynamic and psychoanalytic treatments. Finally, we will be invited to consider particular elements of the human experience that play crucial roles in the reparative, therapeutic experience but have yet to be fully elucidated by neuroscience including resilience and creativity.

Neurobiology has contributed a great deal to our understanding of the role for medications in the alleviation of psychic suffering. But, as psychoanalytic and psychodynamic informed therapists, we also grapple with the best practice methods for prescribing medications within an ongoing psychotherapeutic treatment. A peer psychopharmacology session during the meetings will create an opportunity to consider relevant, challenging medication-related issues. Additionally, presenters will offer updates on the use of psychedelic drugs and NMDA antagonists and consider ways in which the subjective experiences generated by the use of these medicines may serve to support the aims of insight-oriented therapies.

Importantly, we will be called upon to consider the future direction for the training and supervision of psychiatry residents in programs across the country. Residency programs are under pressure to prepare psychiatric residents to function well in a variety of settings that increasingly privilege medication management and collaborative care. We will be invited to listen to first-hand experiences of recent psychiatric residents and to contemplate the arguments for the renewed importance of psychodynamic psychiatry in the training of tomorrow’s leaders in the field of general psychiatry.

The Academy is not only concerned with the patients we treat but also the mental health of those providing treatment. To that end, the Academy has enlisted a group of its most creative and committed members to explore ways in which the Academy could offer support to its members. Our Opening Session, entitled How Can Psychiatric Associations Offer Support to Their Members, will be given by Dr. Douglas Ingram.

It is the good fortune of the Academy to count among its members a group of outstanding professionals who have committed their professional careers to work in a long-term care facility dedicated to psychodynamic psychiatry and psychoanalysis. Our disciplines and the work of those at Austen Riggs have evolved over time. Drs. David Mintz and Eric Plakun, accompanied by other members of the Austen Riggs group, will provide the Keynote Address entitled, How to Evolve and Be True to the Principles. They will share with us their thoughtful approach to the challenging experience of serving a unique patient population in a long-term residential setting which has become the exception rather than the norm for psychiatric care.

Drs. Eugenio Rothe and Fructoso Irigoyen will offer
the first Plenary Session that will revisit the story of Don Quixote through the lens of psychodynamic thinking. Academy President, Dr. Gerald Perman, will give the second Plenary Session providing an introduction to the theoretical and clinical work of Jacques Lacan. Dr. Ingram will be the discussant for Dr. Perman’s presentation. Finally, Dr. Richard Friedman will deliver the meeting’s Presidential Address titled Modern Psychodynamic Psychiatry. As the Editor of the AAPDPP journal, “Psychodynamic Psychiatry,” Dr. Friedman has made substantial contributions to our understanding of what constitutes psychodynamic psychiatry.

As Co-Chairs, we are thrilled to offer such a diverse, eclectic group of presentations. San Francisco with its spectacular natural beauty, culinary delights and distinctive neighborhoods will undoubtedly provide an enriching dimension to this Academy meeting. We look forward to spending time with all of you!

Part 1: The College: A Unique Learning Style

By David R. Edelstein, M.D.

The membership of the American College of Psychoanalysts consisted of psychiatric psychoanalysts who were researchers or organizational leaders or active educators in psychiatry or in psychoanalysis. College members came from across the United States and also from France, Germany, and Japan. The College held one meeting per year and the purpose of the meeting was to select two or three areas of intense current psychiatric psychoanalytic interest and to provide a setting in which members could learn together and share ideas in a collegial setting. The collegiality was enhanced by opening all aspects of the meeting to attendance by spouses/significant others, many of whom were also in fields related to mental health.

The format of each meeting was to invite two or three expert presenters, who would each speak in the morning, to all attendees, for an hour followed by 30 minutes of discussion from the floor. There would then be colloquia, smaller meetings, in the afternoon headed by the two or three expert presenters and attended by College members who had a particular interest in the topic presented by a particular expert presenter. Meeting attendance would be 60 or 70 and each colloquium would have 20 or 25 attendees. A luncheon would be held after the morning presentations and a cocktail party followed by a formal dinner would be held in the evening. Throughout all of these events, the topics of the meeting would be continually and very actively discussed. Members carried an enlivened glow with them as they traveled home; they had learned about a new topic as well as how others had processed the new information. A sense of deep involvement in sharing knowledge created a lasting sense of the collegial value in being a College member.

Providing a few examples can help bring this process to life. At one meeting, a psychoanalyst from Germany presented her analysis of one of the children of a leading Nazi who had a very strong role in running death camps.
Another example was the meeting held in Paris jointly with a French psychoanalytic society. Dr. Gil Kliman, who presented many years ago to a joint Academy-College meeting, gave an extensive presentation of his treatment of autistic children, including videos of several on the floor sessions with an autistic boy and a description of his illness and his recovery over several years. Following this presentation, there was a very lively discussion from the floor during which many of the French and German analysts spoke about clinical practice within their countries and how autism was differently conceived and managed. Other presentations by Vamik Volkan, Harold Blum, and Henri Parens touched on many aspects of child development, trauma, and the effects of war on children. Panels of French psychoanalysts led by Sophie de Mijolla-Mellor then conducted searching discussions in English and French, with translations provided. The College’s customary banquet at a legendary restaurant, Le Procope, capped off the two-day meeting with much bonhomie.

In planning College programs, it was felt that this level of intense engagement was necessary to embrace and understand the complex topics which were presented and that it was a special and unique opportunity for everyone to participate in such open discussions. Members were able to set aside their own competitive feelings so that everyone could embrace each topic as a student eager to learn with other students. The expert presenters also fell into the same mindset and generally felt that they too had been enriched by the discussions through the day. I remember very well having a lengthy discussion with Dr. Perry Ottenberg, who had spent many years studying psychological issues in prominent political figures, an area about which I knew little, and we were able to see how we could bring our own psychoanalytic perspectives out openly and raise questions, and grope for answers, in a lively and respectful manner.

When the merger of the Academy and the College was being planned, College members hoped that this strong underlying philosophy of respectful collegial discussion, in depth, could be shared with the Academy. In retrospect, the collegial lunches and cocktail parties and dinners were quite helpful in promoting this sharing and joint learning. Aspects of the College model might be productively applied in Academy meetings. Drew Clemens will, in the second part of this article, spell out how this might be accomplished.

Part 2: Looking to the Future: Advancing Psychoanalysis

By Norman Andrew Clemens, M.D.

Fellows of the American College of Psychoanalysts who accepted the invitation to stay on board are now Fellows of the American Academy of Psychodynamic Psychiatry and Psychoanalysis. We also automatically became members of a new Committee for the Advancement of Psychoanalysis (CAP), created as part of the merger to honor the memory and ideals of the College.

As time goes on, other graduate psychoanalysts in the Academy will join the committee, we hope, and take part in the work. Our ideals and strengths and those of the Academy will form a common purpose. Our aim will be to further the understanding of the rich, ongoing field of contemporary psychoanalysis. The intensive work of psychoanalysis must go on because some people need nothing less; because we learn so much about the mind from it and we need to propagate that learning; because we need the experienced analysts to treat and train new psychoanalysts; and because it will enrich our equally important contributions to psychodynamic psychiatry.

Mark Unterberg, the last president of the College, has become chair of the committee, assisted by Drew Clemens. David Edelstein and Phil Lebovitz have helped as a steering committee. Our first task was to develop a presentation for the 2019 scientific meeting, titled “One Dream, Three Perspectives: The Place of the Dream and Dreaming in Clinical Practice and Training.” College past president Harriet Wolfe helped arrange a panel presentation, starting with a detailed process account of actual work with a dream in a psychoanalytic session. Each of three discussants will then discuss the material from a theoretical perspective: Freudian/contemporary ego psychology, LaPlanche/French school, and Klein/British school/object relations. Audience discussion might provide a taste of the traditional College colloquium as we try to fit together the pieces of the elephant. In future planning, we believe that it would be a great asset to the Annual Scientific Program to schedule a colloquium of an hour or two into the future scientific programs of the Academy, perhaps as an alternate track for part of a day. We strongly urge that this recommendation be considered.

Another tradition of the College was to sponsor several psychoanalytic or psychiatric advanced trainees to attend scientific meetings without a registration fee. We hope to have such a program in place by the meeting in May 2020, if not this year. They will be called Laughlin Fellows in honor of Henry P. Laughlin, the founder of the American College of Psychoanalysts as well as the American College of Psychiatrists. The registration cost would be covered by the Laughlin Fund of the College, which was transferred to the Academy as part of the merger.

The Laughlin Fund is retained as a reserve fund which can be used to further the purposes and activities of the Committee for the Advancement of Psychoanalysis, subject to the approval of the Executive Council. For example,
We who are writing this are profoundly grateful for the warmth, support, and good sense of the leaders of the Academy who worked with us to facilitate this merger. Our sadness at the passing of the College is more than assuaged by the welcome we have received and the promise of a meaningful future ahead for the advancement of psychoanalysis in the Academy.

Teichner Forum Report: Winter 2019
By Sherry Katz-Bearnot, M.D. with Cesar Alfonso, M.D.

Eugene Beresin, M.D.
and I are pleased and proud to announce the successful completion of the 12th cycle of the Victor J Teichner Award. Our winning program this year was the Child and Adolescent Program at the University of Florida at Gainesville, FL. The winners are the team of Training Director, Mariam Rahmani, M.D., and the Director of Psychotherapy Education, Michael Shapiro, M.D. Dr Shapiro is also this year’s recipient of the educational They have been working diligently to improve the didactics in their program. This marks the first time we have chosen a Child and Adolescent Program and this will be an interesting endeavor. We are encouraging the winners to include the members of the General Psychiatry division in some of the activities, but clearly the more advanced level of instruction to which the Child Fellows have been exposed may make this a challenge.

Last year’s visits are ongoing. Allan Tasman has completed his visit to Greenville, South Carolina in October. Cesar Alfonso, M.D. reports that the University of Iowa Teichner visit is scheduled for April 10-12, 2019. Dr. Alfonso has been in communication with the training director recipient, Erin Crocker, in order to structure and optimize the visit. Dr. Alfonso will conduct Grand Rounds and clinical case conferences to demonstrate the applicability of psychodynamic ideas in general psychiatry. Faculty and residents at the University of Iowa selected the following areas of study to focus the visit: The application of psychodynamic theory in contemporary psychiatric practice (including non-outpatient settings such as inpatient psychiatric units and C/L service), Psychodynamic Aspects of Suicide, and Common Factors in Psychotherapy.

The Chinese American Psychoanalytic Alliance (CAPA)
By Elise Synder, M.D.

CAPA’S MISSION:
“The China American Psychoanalytic Alliance is a volunteer organization dedicated to training the leaders of the next generation of Chinese psychodynamic psychotherapists.”

CAPA’S GOAL:
To train as many psychodynamic psychotherapists as possible. To encourage our graduates to obtain analytic training. To continue until our graduates are ready to take over psychotherapy and psychoanalytic training in China.

CAPA came into existence more or less as an accident - it was not planned. I visited China in 2001 and searched for anyone interested in psychoanalysis. Strangely, and for reasons not clear, those in the IPA who might have known of people or groups interested in psychoanalysis, did not respond. Finally, with the help of Robert Tyson, M.D., I found a group interested in psychoanalysis in Chengdu, the capital of Sichuan province. Sichuan University had a course in psychoanalysis taught by a Lacanian analyst. I lectured at the university and also gave some public lectures. More than 300 people came: businessmen, shopkeepers, Buddhist monks, etc. I was invited back for several years and also to other cities. Mental health professionals asked for supervisors and finally, one man asked me to find an analyst for him. I said, “But, there are no analysts in China.” He said, “What about Skype?” I said. “What is Skype?” and thus, CAPA was born.

At that time, I knew very little about China and psychoanalysis. Here are some of the things I did not know about China and psychoanalysis. I did not know that Freud’s “Autobiographical Study” was translated into Mandarin by the Chinese Minister of Education in 1921 and that Freud urged him to introduce psychoanalysis to China. I did not know that the first required medical school course in psychoanalysis anywhere in the world was in a Chinese medical school in the 1930s. I also did not know that in the 1930s, bottles of cough medicine with Freud’s picture on them were sold in Shanghai.
This past fall, CAPA (China American Psychoanalytic Alliance) celebrated its 10th graduation - actually, there were graduation ceremonies in seven cities: Beijing, Shanghai, Chengdu, Wuhan, Shenzhen, Nanjing, and Hangzhou. At the 2018 graduations, 42 Basic Training graduates, 29 Advanced Training graduates, 6 Infant Observation graduates, and 14 Supervision Training graduates received certificates from CAPA and from the Chinese Psychological Society (CPS). CAPA is, I believe, the only Western training group whose graduates receive CPS certificates for all the work they do as CAPA students. In the 10 years CAPA has been teaching in China, there have been almost 500 graduates. The graduation ceremonies are part of conferences, often with as many as 200-300 people attending, and are followed by parties and banquets.

CAPA TRAINING
Each year between 120 and 160 Chinese mental health professionals apply for CAPA training (psychiatrists, psychologists and counselors - there are few social workers in China). Our applicants come from 39 cities. The application form requires several essays. Applicants are first interviewed for English competence and the 60-70 applicants who remain are then interviewed by CAPA teachers and supervisors. Forty are chosen and divided into four classes. We believe that learning to do psychodynamic psychotherapy is not possible in larger, non-seminar classes. All CAPA students receive PEPWeb access as part of their tuition. The Basic Training Program consists of a theory class, a technique class and continuous case conference; four hours of class/week, 30 weeks/year, 100-150 pages of reading in English and written homework. Students email comments, queries, and responses to instructors’ questions prior to each class.

Each teacher evaluates the students every trimester and the students evaluate the teachers every trimester. The students find this a difficult task, one they have not done before. All Year, 1-4 students have an individual supervisor with whom to work on an appropriate long-term psychodynamic psychotherapy patient. This supervision is also covered by their tuition. The highest ranked Basic Training graduates are invited to the Advanced Training Program (organized similarly to the Basic Program). During the last five years, CAPA has offered a number of elective courses: some open to all students, some open to all graduates, some open only to Advanced Program graduates.

These courses are, for the most part, oversubscribed and several require three sections. These courses are given each year: How to Supervise, Infant Observation and Student Teacher Training. In 2018, a Couples Therapy Seminar, a Group Relations Seminar, an Ethics Seminar and a Research Workshop were also offered and will be given again. All CAPA Training is in English. All CAPA training is on ZOOM, (HIPPA compliant). All CAPA teachers and supervisors volunteer their time and expertise pro bono.

Most CAPA Advanced graduates go into private practice. Most are so busy it is difficult to find someone to take a new patient. Many continue to work at university Student Mental Health Services. The government pours money into these programs. At one university, 10% of the entering class is trained as student counselors. All Freshmen are required to attend a 1 hour lecture each week on “How to Live a Happy Life.”

VOLUNTEER TO TEACH, TREAT OR SUPERVISE GIVE SEMINARS, LECTURES OR BRIEF COURSES Contact elise.snyder@yale.edu

ANALYTIC TRAINING
About half the Advanced graduates begin full analytic training at APsaA institutes. Most APsaA Institutes
6th year- 1
5th year- 1
4th year- 6
3rd year- 7
2nd year- 6
1st year- 5
TOTAL 26
Distance- 23
Local-3 APsaA Institutes with CAPA Grads
Chicago-------11
Philadelphia--10
WAW---------3
CFS----------1
Balt/Wash-----1 Non-APsaA Institutes with CAPA Grads
4th year-1
3rd year-1
1st year-4
TOTAL 6
Distance-6 Non-APsaA Institutes with CAPA Grads
Jungian-Zurich-------1
Winnicott-England--1
IPA/China/Eng--------1
SF Lacan----------------1
IPA Sidney----------1

CAPA analytic candidates opt for distance training, despite the fact that the IPA still does not recognize people with distance training. The APsaA institutes that have accepted distance candidates for full training only give them Academic Associate status when they graduate. There is some hope that this will change in the near future. Distance analysis has been discussed at many CAPA meetings. The consensus: negative reactions to it are from people
who have never either done or been a patient in distance analyses; some of the negative responses seem to be from older people who are not comfortable with their computers. Some of the objections to seem to come from the IPA which may have concerns about American institutes working in China. They may want to reserve working China for themselves and for other IPA groups.

In the past year, two people who had been accepted for local training at American institutes were not granted visas by the American government. This seems to be a result of the current trade and administrative struggles between the Chinese and the Americans. This situation increases the urgency for changing the so-called rules about distance training. CAPA is recruiting the APsaA training and supervising analysts who are CAPA members in the hope that institutes with many elderly TA's and SA's will use these analysts for Chinese candidates.

TREATMENT PROGRAM

All CAPA students are encouraged to begin low fee psychoanalysis (3-5 sessions/week) or psychodynamic psychotherapy (1-2 sessions/week). Most do and those who begin in psychotherapy often switch to analysis. Since CAPA began in 2008, there have been 175 Chinese mental health professionals in psychoanalysis and 251 in psychodynamic psychotherapy. Many of the analyses have proceeded for more than 7 years.

SOME OF THE FUTURE IS HAPPENING NOW

Jiang Qi Zhuang, an Advanced Training graduate in Chengdu and a distance psychoanalytic candidate has begun a Psychotherapy Training Program in Mandarin in Chengdu. It is based on CAPA readings and has both local and distance students.

RESEARCH PROGRAM

CAPA has research funds. We seek to train our students to do research as well as being clinicians. CAPA accepts applications for research about China and about distance analysis and treatment. In 2018, the following grants were awarded:

Dr. Maranda Sze - “Professional Development of CAPA Graduates and Students”
Dr. Simone Setterberg-Schwank - “Child Policy Shift and its impact for Chinese Families Health: An International Collaboration in Perinatal Health”
Dr. Ren Zhebglia - “Opportunities and Challenges of video psychodynamic training in China-Experiences from trainers and trainees”
Dr. Wenhua Yan - “Research on cross-cultural psychoanalytical therapy via internet in China: how culture, internet and language influence therapy?”
Dr. Jessica Borelli “A Longitudinal Examination of Attachment-based Predictors of Psychological Well-being in Chinese International Students”
Dr. Wiola Rebecka “History of shame- meanings of rape in Chinese culture.”
Dr. R. Dennis Shelby “Negotiating Culture in Intercultural Psychoanalytic Education.”

WE URGE YOU TO APPLY FOR RESEARCH FUNDS

CHINA TOUR

Every year since 2008 (11 years), CAPA members, other mental health professionals and members of their families have joined me on my annual trip to China. These “CAPA Tourists” visit Beijing, Xi’an, Chengdu, Tibet, Shanghai and sometimes other cities. Besides the usual tourist attractions (the Great Wall, Tiananmen Square, Summer Palace, Art Galleries, Terracotta Warriors, Giant Panda Base, Potala Palace, Zhujiajiao Water Town, and many other places), they attend the graduation conferences in three cities with graduations. Often, the “Tourists” give papers, do supervisions and consultations for CAPA and non-CAPA mental health professionals. Thus, these tours are probably tax deductible.

The tours are extremely interesting. They provide an opportunity to meet and speak with Chinese colleagues; to visit a local public grade school where the psychology teacher talks about “bad touching” and “how to handle anger” with kindergarten children; to visit a culinary museum where they learn to cook some Chinese dishes; and, of course, visits to all the usual attractions. Other sites are available for those who don’t wish to go to Tibet or who want to stay in China for a longer time. We stay at four-star hotels and the only complaint (and it is a frequent one) is that there was too much good food.

While most Americans who have NOT been to China do not think that the women there still have bound feet, the tour presents an opportunity to see what China is really like today; what Chinese colleagues feel free to talk about, and what psychotherapy practice is like in China.

DIM SUM

Every year CAPA rents a restaurant from 9:00 AM-2:30 PM on a Saturday during the APsaA meetings. After coffee and donuts there are two discussion groups. People participate from China and elsewhere in the world on Zoom and of course those at the restaurant participate. As well as the intellectual interest, the annual Dim Sum meeting gives CAPA members an opportunity to meet each other. We urge those attending on-line to get take out Chinese food. Please attend Dim Sum on February 9 in person or on-line.

SIGN UP FOR DIM SUM

TRANSLATION PROJECT

For the past seven years, CAPA, in cooperation with the Eastern China Normal University Press, has had a translation project. Chinese translations of the analytic literature have, in general, been very poor. In an effort to correct this problem, the press has been translating books chosen by the CAPA curriculum committee. After being translated
into Mandarin, the books are translated back into English by bi-lingual speakers to make sure the translations are accurate. These books have the right to use the CAPA logo. Because of CAPA’s fame and prestige in China, this helps sales - a win-win situation.

CAPAINCHINA (CIC)

As the number of students and graduates in each city in China increases, they form a local group which is part of the overarching organization, CAPAINCHINA (CIC). These local groups give lectures, offer supervision, have movie nights, teach courses, recruit people for CAPA training, act as centers for psychodynamic psychotherapy. In 2020, CIC is planning hold large conference which will include members from all groups. Although they speak with each other frequently WeChat, most Chinese students and graduates have never met in person. They are looking forward to this opportunity and hope that many Westerners will also attend this meeting and present papers.

WESTERN CAPA MEMBERS

Besides the familiar CAPA logo, the Big Tent has become iconic of the way CAPA functions in the West. There are members from many countries, from many training programs, psychoanalysts, psychotherapists, psychiatrists, psychologists, social workers, JD’s, EdD’s, etc. The curriculum covers many flavors of psychodynamic psychotherapy. Teachers and supervisors are expected to teach without privileging one theory over another or bad-mouthing a theory not their own. The generosity of CAPA members of their time and experience is extraordinary and, considering the history of internecine warfare in psychoanalysis, the lack of such warfare is equally unusual.

FROM #DEGREE # TRAINING/ 
Country #Other Psychoanalytic 
Membership Institutes

Australia . . . . . . . . . . . . . 5 MD/DO_139 APsaA 
200_AIP-1
Argentina 2 M.D./Ph.D._3 AAPDP 
14 Chicago Center Psa.-2
Brazil . . . . . . . . . . . . . 2 J.D._3 NPAP_22 ICP-2
Canada . . . . . . . . . . . . . 15 Ed.D._4 CFS_16IEA-6
Colombia . . . . . . 1 Ph.D._189 NYU Post Doc_16Italy-1
Germany . . . . . . . . . . . . . 1 Psy.D._19 WAW_12IPTAR-3
HK . . . . . . . . . . . . . 2 LCSW_54 Postgrad. Ctr._6 Lacan PSA Inst.-1
Israel . . . . . . . . . . . . . 3 MSW_18 IARPP_7MIP-1
Italy . . . . . . . . . . . . . 6 MBA_1 Other PSA*_32New Center-2
Japan . . . . . . . . . . . . . 1 MA_29 IPA_19 Newport Center-3
Mexico . . . . . . 6 BA_2 Psychotherapist_119 Tel Aviv-2
Sweden . . . . . . . . . . . . . 1 Other_19 Friends_17 Wash. Square-1
Taiwan . . . . . . . . . . . . . 1
UK . . . . . . . . . . . . . 3
USA . . . . . . . . . . . . . 431

PSYCHIATRIC TRAINING IN CHINA and a request of special interest to AAPDP Members. In China, people enter medical school immediately after high school. They make a decision about what they want to do early in their lives. Because they do not have a college degree before they attend medical school, the degree granted by Chinese medical schools is an MB not an MD. This is the reason that so few Chinese psychiatrists are found at American hospitals or practicing in America. Many Chinese medical graduates go on to doctorates. Some get a doctorate in medicine and then they are awarded an MD. Others get Ph.D.’s in psychology or some other branch of medicine or psychiatry (for example, in psychotherapy).

The Chinese psychiatry residency is 4 or 5 years long. In recent years, it has improved remarkably - especially at university hospitals. Chinese residencies are similar to American residency programs in many ways. Although both American and Chinese programs require psychotherapy training, in China it is most often limited to CBT. There is very little psychodynamic psychotherapy training.

During my last visit to China (October 2018) the Chairs of psychiatry and hospital director at several university hospitals asked me if CAPA could offer a one-year training program for their psychiatric residents. There have always been psychiatric residents and psychiatrists in the CAPA program, but, as hard as American residents in psychiatry work, Chinese residents and psychiatrists work even harder. They are on call by the government for disasters. For example, in 2008 during the Sichuan earthquake, psychiatric residents from all over China were called to Szechuan province to help with treating the 60 million people traumatized by the earthquake. They remained in Szechuan for several months.

Thus, it is difficult for psychiatric residents and psychiatrists to take the regular demanding CAPA Program. Relatively few Chinese psychiatrists are in private practice - most remain working at hospitals in inpatient and post-inpatient facilities. The request for a training program specifically for psychiatrists (a kind of “CAPA-lite” program) arises from the recognition of the increasing interest in dynamic psychotherapy. Two psychiatrist CAPA graduates have asked me start such a program.

Of course, the hope is that after this CAPA-lite program, they will join the regular CAPA training. The program will probably be conducted in Mandarin using either translators or CAPA graduates as teachers and supervisors. It will use translated versions of the CAPA curriculum. CAPA is seeking an American psychiatrist to work with Chinese groups to set up this program. It will be conducted for one hour/week for 48 weeks/year. There will be seminars both on technique and theory and once a week group supervision. Teachers and supervisors will be needed.

Please help.
Thank you!
Message from the President of the World Psychiatric Association

Colleagues,

Let me begin by wishing you all a Happy New Year and thanking you for your contributions in 2018. It was a fruitful year.

We successfully convened with Member Societies and other partners the first of our now annual program of World Congresses in Mexico City, as well as a Thematic Congress in Melbourne and the third WPA Regional Congress in Africa – this time in Addis Ababa. Participants in all of these Congresses appreciated the quality and diversity of speakers, the range of topics, and new opportunities for exchange among speakers and with audiences. We made progress in work with the University of Melbourne towards an online graduate diploma in psychiatry, worked with colleagues to establish the Lancet-WPA Commission “Reducing the global burden of depression,” refreshed the WPA branding, approved the formation of a consulting committee with service users and family careers, and formalized a partnership agreement with CitiesRISE.

Behind the scenes, the WPA Standing Committees have been active and providing invaluable advice to the Executive Committee and me as we pursue our action plan and institution-building agenda. Also instrumental has been the advice and help from the other WPA components including the Board, Council and Scientific Sections. The new Section on Early Career Psychiatrists has been among the most active of our 70 Sections, and supporting a number of initiatives, including the WPA fellowship program that brought some 50 early career psychiatrists from all over the world to Mexico City.

2019 is also shaping up to be a productive year. We will step up the pace on our work with CitiesRISE. 2018 was a year of planning and preparation. 2019 will see us putting some of those plans into action in several countries, working towards the broader aim of strengthening the community orientation of our profession.

17th Joint Meeting
American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP)
Organizzazione di Psicoanalisti Italiani Federazione e Registro (OPIFER) - 2019

The 17th Joint Meeting of the AAPDP with OPIFER will be held in Florence, Italy October 19-20, 2019.

The theme of the conference is:

*Psychiatric Practice and Psychoanalysis Today: Evidence, Guidelines, Diagnosis and Treatment; In the Footsteps of Silvano Arieti.*

The Academy membership will be updated as soon as we have more information.

Joan G. Tolchin, M.D.
Past President
We also look forward to partnering with our member society, the Portuguese Psychiatric Association, to host our next WPA World Congress in Lisbon, Portugal. The Scientific Committee, led by Professor Norman Sartorius has been working hard to build another outstanding program, and we are delighted to have already received many high-quality abstracts and proposals. Please visit our website to learn more: 19th WPA World Congress of Psychiatry. Of course, if the program alone is not enough to tempt you to attend the meeting during the traditional holiday period, perhaps the outstanding weather and picturesque city of Lisbon will encourage you to combine this opportunity for learning with a summer vacation this coming August.

Before this we hope you will join us in the historic city of Ohrid where the Psychiatric Association of Macedonia (FYROM) is hosting the WPA Thematic Congress on Dementia, 15-18 May 2019.

The first issue of World Psychiatry for 2019 has just been published. Thanks again to Professor Mario Maj for editing this important journal. There is little doubt that his stewardship is key to the publication being ranked Number 1 in the Social Science Citation Index. In this issue, you can also read more about the CitiesRISE work I mention above.

In my last message to you, I hinted that a new WPA website was on its way. I am delighted to let you know that in just a few weeks’ time, we will launch “stage one” of the new site. What does “stage one” mean, I hear you ask? Well, as with all good websites, our new website has been built to evolve and grow to meet the needs of all our components and visitors. This first stage will bring you WPA news and information in a clearer, more modern, and easy-to-navigate site. Stage two will offer secure login areas where our members and components can share information, pay their memberships fees online and access confidential documents.

Finally, please read on below to see news from our Sections, Zonal Representatives and Member Societies.

http://www.wpanet.org/subIndex.php?section_id=7&category_id=25

2019 is going to be an exciting year for WPA and I look forward to working with you all to advance psychiatry and mental health worldwide.

Best wishes,

Helen

Professor Helen Herrman AO
President, World Psychiatric Association

Remembering Milt

Of regal stature
With shimmering eyes
An open friendly face
An enveloping smile
A quiet imposing presence
Inspired the old and the young
He taught by example
He clarified our doubts
He expanded our minds
A welcomed balsam of great depth
We learned from his knowledge
We longed for his smile
We admired his humbleness
We evolved with his clinical touch
We grew in his presence
We cherish his memory in our lives

Silvia W. Olarte
Edited on 2/19/2019 from a poem read to Milt on October 15, 2011
Honoring the Founding Members of the American Academy of Psychodynamic Psychiatry and Psychoanalysis

By Alicia McGill, M.D. and Silvia W. Olarte, M.D.

Co-Chairs 63rd Annual meeting AAPDPP

Founding members of the American Academy of Dynamic Psychiatry and Psychoanalysis, at the time named the American Academy of Psychoanalysis, created a professional association guided by the following principles:

- To provide a forum for discussion of psychodynamic work in the consulting room as well as ideas and research in psychodynamic psychiatry and psychoanalysis;
- To encourage research and scholarship in psychodynamic psychiatry and psychoanalysis;
- To support education in psychodynamic principles and skills for trainees in psychiatry and psychoanalysis as well as for graduate psychiatrists and for other mental health clinicians;
- To support inquiry into the phenomena of individual motivation and social behavior, basic building blocks of psychodynamic thinking;
- To foster communication among psychiatrists, psychoanalysts, and colleagues in the sciences and the humanities.

The AADPP Executive Council and the two co-chairs of the 63rd Annual Meeting of AADPP wish to dedicate this meeting to the wisdom, foresight, courage and dedication of the founding members whose legacy we are still benefiting from.

With the death of Miltiades Zaphiropoulos in 2015 and of Marianne Eckhardt in 2018 the Academy lost its two last founding members. We decided that we were going to highlight them as the last representatives of an extraordinary group of professionals to whom we are grateful for their legacy every day.

We asked Michael Blumenfield, M.D., Past President of the Academy, whose career at the Academy and the American Psychiatric Association crossed paths with Milt, besides having interviewed Milt as part of his project to interview all Past Presidents, to write about Milt.

Silvia Olarte had asked Marianne around the time she was turning 100 years old if she could write some thoughts about her professional experience. Dr. Blumenfield’s interview of Milt will be followed by Marianne’s reflections of her long and productive career.

Miltiades Zaphiropoulos
1914 – 2015

I had the privilege and pleasure to interview Dr. Milt Zaphiropoulos on June 8, 2014 shortly after his 100th birthday. A video of this interview is on the website of the American Academy of Psychoanalysis and Dynamic Psychiatry

Dr. Zaphiropoulos was born in Alexandria, Egypt of Greek parents shortly before World War I. His family lived in Port Said and he was originally home-schooled and then attended a Greek public school. His father worked on the Suez Canal and was the captain pilot of a ship. At age of fifteen-and-a-half he was sent to school in Paris where he eventually attended medical school. He said that his parents expected him to be “The next Louis Pasteur.” He attributed his subsequent interest in history and literature as a key factor in his wanting to become a psychiatrist. He believed that he first read Sigmund Freud’s writings in Greek and then in a French translation.

Dr. Zaphiropoulos came to the United States for his psychiatric residency (1936 – 1939) at the Psychiatric Institute (Columbia) under Dr. Nolan Lewis. He was a co-resident with Dr. Jacob Arlow. Some of his supervisors were Doctors Bill Horowitz, Phil Politan and Eugene Milch. He also recalls convulsive therapy being introduced by Dr. Kallinowsky and having some of his patients undergo this treatment.

Dr. Zaphiropoulos then became involved with the William White Institute and his analyst was Clara Thompson. He recalls a schism between the New York Psychoanalytic Institute which was known for its interest in classical analysis and the less orthodox institutes such Columbia and the White Institute.

Dr. Zaphiropoulos remembers the formation of the American Academy of Psychoanalysis which he also describes as less orthodox and less exclusive. It was founded in 1956 with the first president being Dr. Janet Rioch. Dr. Zaphiropoulos eventually became the 26th president of this organization (1981 – 1982). He said that during his presidency there was a resolution of conflicts between different factions. He also is one of the founding members and an early president of the Westchester District Branch of the American Psychiatric Association. He went on to become the Speaker of the Assembly of the American Psychiatric Association. He recalled at that time the Assembly was no longer the stepchild of the APA.

Dr. Zaphiropoulos practiced psychiatry and psychoanalysis in both Westchester where he lived with his family and in Manhattan. Among other things he was interested in schizoid patients and transcultural issues particularly how they impact the transference. He reflects back on how his profession has evolved rather than changing by revolution.
On October 15, 2011 a reception was held in New York City honoring Dr. Zaphiropoulos. At this reception the current president, Dr. Alfonso of the American Academy of Psychoanalysis read a message from a senior member and a contemporary of Dr. Zaphiropoulos, Marianne Eckhart. Dr. Scott Schwartz presented him with a specially prepared certificate. Dr. Olarte commented how Dr. Zaphiropoulos always lead by example. Dr. Ingram, Dr. Turkel and myself also made comments. The reception was also attended by Dr. Zaphiropoulos’ family members. Dr. Zaphiropoulos concluded the evening with a few words. A video of this reception is also on the website of the American Academy of Psychoanalysis and Dynamic Psychiatry.

Milt Zaphiropoulos was a very wise man who made everlasting contributions to his profession and the patients whom he treated. He played key roles in both the American Academy of Psychoanalysis and the American Psychiatric Association. On a personal level he was warm, empathic and had a great sense of humor. He shall be missed and very fondly remembered by all whose lives he has touched.

By Michael Blumenfield M.D.

Marianne Horney Eckhardt
1913-2018

On the occasion of her upcoming 100th birthday, Silvia Olarte asked Marianne Eckhardt to share from her long life perspective highlights from her professional development. She was not given a time table as the small ceremony was a surprise. The thought was to read her informal essay at a small official acknowledgement during one of our meetings of her upcoming birthday. The essay did not make it on time, so Silvia saved it. Now we can read about Marianne….in her own words.

Highlights of my professional development.

Looking back, I became increasingly aware of how fortunate events have shaped my life. My emigration in 1933 to the United States from Germany was handed to me on a silver platter. In 1932, my mother, Karen Horney, was asked by Franz Alexander to become co-director of the newly founded psychoanalytic institute in Chicago (the first in the U.S.) I followed one year later after completing the essential examination (physicum) given half way through one’s study of medicine.

My transfer to the Chicago University medical school was arranged. I had my medical internship there I had not been exposed to even one lecture in psychiatry, as the psychiatric department was just opened there during my internship. Aware of this educational hole, I obtained a psychiatric residency at the Payne Whitney (Cornell) in New York. My entry into psychiatry had more to do with the necessity to fill this gap than with deliberate choice. My residency was followed by participation in a Josiah Macy Foundation project on community cooperation of mental health resources in the Yorkville area of New York.

Further events proved fortunate for my professional development. My mother’s book is challenging Freud and suggesting new directions in psychoanalysis lead to conflict with –the New York Psychoanalytic Institute and to the formation of the American Institute of Psychoanalysis. I became one of the early candidates. Erich Fromm was my analyst. My indebtedness to him is hard to put into words. I feel I owe to him much of the quality of my life. Circumstances again played a role. He knew my mother and my family well. He knew a reality that I with my then existing anxieties, insecurities, and shyness could not have conveyed to him. Years later, that is long after my analysis, I learned to appreciate his philosophies and had the opportunity to appreciate him as a person.

The newly founded psychoanalytic institute, in spite of an idealistic commitment to conceptual tolerance and diversity, split twice into new groups and institutes. These schisms were as much due to personal frictions as to conceptual disagreements. For me this was a disillusioning lesson, but also taught me a perspective on ‘schools of thought’ in our field. They were innovative perspectives, not answers, and the complexity of human existence needed many such perspectives to guide us, as each individual patient presents a new challenge. After my graduation, these schisms influenced my decision not to become a member in any of the three institutes available to me. This was in 1944. I had married, my first daughter was born, and my husband had been drafted into the army. Work and single motherhood kept me busy.

After the war, my husband, a journalist, who had been stationed in Germany and had had contacts with the remnants of the German underground, cooperated with Allan Dulles to write the first book on the German underground. This led to his accepting a job as research analyst at the Nurnberg trials. We left for Germany for a five-year stay. Informally I conducted a private practice, part time. My patients were Americans working for the occupation forces. We returned to the States in 1952 settling in the suburbs of Washington, D.C. This was the height of the McCarthy era and my husband’s job at the Voice of America, the prime target of McCarthy’s communist witch hunt, placed us near the center of this unpleasant aberration. It taught us two lessons, one black and one white. Mass aberration can happen anywhere, and respect for our constitution of the balance of power, for in due time McCarthy was history.

I developed a private practice, welcomed by the congenial psychoanalytic community. I restricted my working time to the children’s hours at school, to be available to them and available for participation in the suburban community life which I enjoyed.

The psychoanalytic community in DC had solved their problems with the restricting orthodoxy of the American
Psychoanalytic Association by creating the Washington School of Psychiatry, a kind of forerunner of the Academy. It was a forum giving members of the psychiatric community opportunity to give seminars or teach courses of any persuasion. I participated in seminars and taught various courses.

The most important event was the creation of the American Academy of Psychoanalysis in 1956, a truly remarkable organization. Its constitution was well thought through to provide interdisciplinary contacts and prevent schisms. It became my professional home, my professional family. I began to give papers, participated for years in a fascinating on-going workshop on dreams, enjoyed years as trustee and a turn as president.

My marriage came to an end in 1973 and I moved to New York, where I joined the staff of the Psychoanalytic Institute of the New York Medical College. I deliberately paced my working hours to provide me with a free weekday to have time for personal interests. I took courses in art history and began my interest in photography. I lived in the East River at Waterside Plaza, a special place with a sense of community, rare to find in New York. Visiting my younger sister in 1980 when she moved to a city-size retirement community in California, I fell in love with the place, bought a condominium to have available whenever I decided to retire. “Whenever” turned out to be ten years later, but even then still retaining my office in New York. I decided to return for three weeks at regular intervals, three times a year, and continue contact with those fairly well functioning patients who felt benefit from the kind of consultation I had to offer. I expected this practice to wither of its own accord, but ten year later still finds me heading for my office. I gained experience offering telephone sessions, both on a regular as sporadic basis. Some patients use telephone sessions very well. The quality compares well with face to face sessions. For others it does not work, they need the visual contact.

I have enjoyed doing book reviews for our journal and continued my participation in the Academy. This fusion of retirement and work has been very enriching. We all love “Leisure World,” where we live. A city of almost twenty thousand people with a wealth of amenities, sports, arts and crafts, college courses, and special interest groups. We call it paradise and feel privileged to live here.

I have written many papers, contributed chapters in books, my focus of interest has varied. I have written on aspects of psychoanalytic history, on pioneers in our field, e.g. Horney, Rank and Alexander. I have stressed the value and the limitations of schools of thought, stressed creative flexibility in our treatment techniques, have been fascinated with the metaphorical underpinnings of our psyche and always awed by the creativity of dreams revealing patients’ undercover understanding of themselves. I have stressed the neglected role of active inquiry to enhance our understanding, using inquiry rather than interpretation. and so on.

Marianne Horney Eckardt M.D

Obituary of Marianne (Horney) Eckardt
Provided to Cesar Alfonso, M.D. by Dr. Eckardt’s daughter, Mariana

Marianne (Horney) Eckardt, psychoanalyst, founding member and former president, American Academy of Psychoanalysis, died on August 31, 2018 in Providence, R.I. at the age of 105. She was born in Imperial Berlin, Germany on February 12, 1913, the second daughter of the psychoanalyst Karen Horney, who was of the first generation of women physicians to undertake psychoanalytic training, and businessman Oskar Horney. She was the second of three daughters, her elder sister being the Weimar film star, Brigitte Horney.

Educated in Berlin-Wilmersdorf, she undertook analysis with Melanie Klein as a ten-year-old. She began her medical education at the Universities of Freiburg, Munich, and Berlin from 1930 to 1933 but entered the University of Chicago School of Medicine in October 1933. She there joined her mother, who had become the educational director of the new psychoanalytic institute then at the University of Chicago. She received her medical degree from Chicago in 1937 and subsequently trained as a psychiatrist at Payne Whitney Clinic in New York City until 1939, undertaking a psychoanalytic training with Eric Fromm, whose Eros and Civilization she translated in 1957. She completed her training in 1944.

Her major influences as a psychoanalyst came from the interpersonal theories of Adolph Meyer, Clara Thompson, and Harry Sullivan and from Eric Fromm’s emphasis on the relationship of the individual to their culture. In 1941 she married Wolf von Eckardt, the son of Gertrud von Eckardt-Lederer, the widow of the founding dean of the University in Exile in New York. They resided in Washington D.C. where she had a private psychoanalytic practice.

Dr. Eckardt was a founding member of the American Academy of Psychoanalysis (now the American Academy of Psychodynamic Psychiatry and Psychoanalysis) in 1956 and was president of the Academy in 1972-73. In 1975 she divorced and moved to New York City where she maintained a practice into her 90s. She relocated to Southern California, and then, at the age of 100, to Providence RI, where her elder daughter lived. She was the mother of two daughters, Barbara von Eckardt, of Providence, and Mariana Gilman, of Atlanta, four grandchildren and seven great grandchildren.
Marianne - a poem by Silvia Olarte, M.D. 
on the occasion of Marianne Eckardt’s 
100th birthday

Sparkling eyes  
Incisive mind  
Ethereal energy  
Spirit of soaring might  
A quiet presence  
Of intense impact  
Precise discourse  
Pristine insights  
Incisive words  
Simplifies complexity  
Of concepts and life  
Inspiring by being  
Teaching by sharing  
Mentoring by example  
She embellishes our lives  
We call her a treasure  
We relish her time  
We smile in her presence  
She radiates sheer light

Silu, April 4, 2013

ARTICLES

The Psychiatrist’s Challenge as Earth 
Warms and Ideas for Prevention

By Stephen Peterson, M.D. and Patricia Huerta

Extreme weather events - heavier rains, prolonged extreme drought, major hurricanes, widespread tornado outbreaks - have become a new normal, and “lethal heat waves have become fixtures on the evening news.” (Brannen, 2017, p249). They are warning signs of what might be considered the greatest health threat - global warming.

We know that average annual temperatures have risen 0.85 degrees C or 1.53 degrees From 1880 to 2012 (IPPC,2014). Consequently, the polar ice and glaciers are shrinking and oceans have risen by 6.7 inches (National Geographic).

Industrialization powered by fossil fuels has caused the rapid rise of temperature as CO2 levels have risen to greater than 400 PPM. Methane release and increased atmospheric water vapor are also trapping heat. Droughts and deforestation contribute to CO2 release, as do draining peatlands and damaging wetlands (Drawdown,2017 p 122,112). Once enough warming occurs, permafrost will release enormous amounts of CO2 (Brannen, p 260; Drawdown, p 122).

When oceans warm, more energy is available to fuel stronger hurricanes. Scientists predict that if the temperature climbs by 4 degrees Centigrade in the next century, heat waves will worsen, especially in the middle of continents such as the American heartland (Brannen, p258). Oceans will rise several feet or more. Unprecedented deluges of rains have already occurred, as seen with Hurricane Harvey. Surely with more heat energy, tomorrow’s hurricanes will become even more devastating. Coastal areas are already regularly flooding, as seen along the east coast in Miami and Norfolk. Rising heat in the ocean directly harms coral reefs, causing bleaching. Moreover, the rising CO2 acidifies the waters, preventing calcifying organisms like mollusks and corrals from building new skeletal structures (Brannen, p 163).

For years floating plastic detritus, discarded fishing nets and other debris have been accumulating cutting into the coral reefs, causing widespread disease, (Washington Post, January 30,2018, A3). Already more than half of the world’s reefs are at medium to high risk (Reefs at Risk, 1998, p8). Reefs’ ecosystems provide “food for one billion people in Asia alone.” (Reefs at Risk. p9).

These manmade stressors threaten not only reefs. Sadly, if the rise of CO2 is not halted, the temperature increase threatens most life as we know it. Life survives in a narrow range of temperature. Heat kills, as we have seen in heat waves across the globe. Indeed, the ongoing heat rise caused by many human factors could bring on a mass extinction event for life on earth, mankind included.

The public is rightfully becoming more and more alarmed about climate change. Symptoms of anxiety, depression, and general stress are increasing. This is especially true with women under 35 who have a pro-environmental orientation and/or who have personality traits such
as high levels of future anxiety. Vulnerable individuals will need our help with dealing with this distress. As temperatures rise, the stress can only grow (Searle, 2010). Psychotherapy will help to turn despair into hope, reframe worries and concerns, and encourage behavior toward positive actions for prevention.

In another sense, climate change becomes more troubling considering that hotter temperatures have been associated with violent conflicts and social upheaval. For example, drought and water shortages have been identified as causes for the war in Syria that continues to this day. A recent analysis of armed conflicts between 1980 and 2010 found that about one quarter of violence is associated with climate change induced catastrophes. Water shortages, droughts, floods, and famine will worsen conflicts unless social cooperation improves (Kaplan, 2018). How can psychiatrists play a role in facilitating social cooperation and communication?

And how may we as a profession help address a burgeoning refugee crisis for those who no longer have shelter, food, or a way of life? Mass migrations are already occurring from North Africa and surely will only increase worldwide as the coasts flood, droughts worsen, and heat waves increase. If psychiatrists can help prevent these weather-related catastrophes, we will minimize the need to deal with the aftermath; but surely dealing with the aftermath will be in our playbook.

Equally as disturbing, studies show that as temperature goes up, so does self-harm. Citroner showed that for every degree Celsius rise in temperature, there was a 2% increase of suicides in Mexico and a 1% rise in the American Southwest. By 2050, the authors estimate thousands of increased suicides (Citroner, 2018). Similarly, a study in Turkey among youth also showed an increased rate in the summer, particularly when the temperature was elevated in the preceding 10 days (Akkaya et.al, 2017). Weall know the importance of suicide prevention and how troubling dealing with the aftermath can be. The chief response to climate threat is pervasive denial. This defense is afoot when nature is defied and citizens build on flood plains, on rivers, on low lying beaches and on deltas, such as New Orleans, which is notably the only city built on a river delta in the world (Jones, 2018). We rationalize that national disasters won’t affect us. The top rationalization is “hope fueled by optimism; a disaster won’t affect me.” A second rationalization is that “technology will save me; levees will hold, the pumps will work.” But nature can overwhelm anything we devise (Lewis, 2011). The denial drumbeat never stops. Psychiatrists need to find effective ways to deal with the denial. A start will be continuous education and appropriate messaging about the oncoming heat.

As regards messaging, when persons first learn of impending disaster, they play it down and minimize the risk. After a hurricane hits an area, perceived risk is changed very little after the event. Only if repeat hurricanes hit the same area do we see perception of risk change. In most communities, “the extent of threat denial is shocking” (Drabek, 1999).

Katrina is an event that was conceptualized in detail well before the storm hit. But the plans of various governmental, city, and emergency agencies were never implemented (Jones, 156). Similarly, the storm in Puerto Rico was forecast, yet the supplies had been used for a proceeding hurricane so that plan was not able to be implemented. Surely efforts were made, yet they were woefully insufficient. There was much blame to go around. Was denial at play? Obviously we cannot plan for every contingency. Rather, we must do the best we can with great humility. In these and many other instances, adequate preparation is key.

To repeat, when a disaster warning comes we tend to minimize the risk. Younger persons take it more seriously than those who have “seen it all.” But when received, messages usually arrive to persons in groups and often the group may debate and minimize the risk (Drabek, 1999). Certainly, prior experience and social background plays a role. For example, distrust of authority may occur in some groups. Additionally, when various messages arrive from multiple sources, there may not be consistency (Drabek 1999).

Knowing of these messaging problems, social scientists have established seven characteristics of effective disaster warnings, and psychiatrists can help insure that the following seven characteristics are identified (Drabek 1999).

• The person who issues the warning
• The specific threat
• The exact geographical area to be impacted
• The time of the threat
• The probability of the event
• The specific risk locations
• The protective actions that must be taken

Further, if warnings are perceived regarding approaching storms that do not include possible escape routes, the individual is less likely to evacuate. The same is true if the message comes at the beginning of a trip or if the individual is staying with relatives. But if at the end of a trip, or if the person is staying at a hotel or motel, he or she is more likely to leave. Psychiatrists can help insure that when warnings from authorities go out, they are done effectively. Many lives have been lost due to poor or insufficient messaging (Drabek, 1999). How will we message a global storm that is coming over the next several decades?

Our greatest, most natural role as psychiatrists will be to treat those who have been through a disaster. As disaster psychiatrists teach us, we will need to provide acute aid to the injured (Norwood et.al, 2000), Then we should provide the appropriate recommendations to reduce overstimulation by limiting exposure of victims to further exposure at the disaster treatment site or through media (Norwood et.al, 2000).

We will need to identify those at risk and assess those who need more help. An excellent screening tool has
been developed by Dr. Merritt Schrieber called PsyStart (Schreiber, 2010). This screen will identify those at risk for posttraumatic disorders after disaster level trauma. All psychiatrists who work in this area should utilize this tool. Getting those at risk into treatment in the first month, the golden month, has been shown to be of great benefit. Ongoing efforts will be to help victims return to their normal lives. This includes those without resources, especially food, shelter, and security (Norwood et al., 2000). Those with persisting symptoms of a traumatic nature will need individual help and vulnerable groups will need specialized attention, especially children.

When it comes to children and other vulnerable groups, psychiatrists can help provide an opportunity to review what has happened in groups. They can review responses, which can be reframed as normal reactions to abnormal events and remind people that they will get better overtime (Norwood et al., 2000). Special attention will need to be paid to help the chronically mentally ill adjust and to get their necessary medication. Those with addiction issues will require similar help.

Longer term, others will need our expertise in the traditional office setting utilizing psychotherapy and psychotropics for treatment of PTSD, anxiety, and depression (Norwood et al., 2000). At the Medstar Washington Hospital Center Outpatient Behavioral Health Clinic in Washington DC, we have treated and continue to care for trauma victims of the 9/11 Pentagon attack. Many improved quickly but some needed longer term care.

Research has shown that providing hope may be the strongest predictor of positive outcomes in mental health. Practical approaches, such as grass roots efforts to deal with emergencies, arise in most communities and should be supported. Such actions help make despair tolerable and help build resilience and hope (Rapheal & Ma, 2011). After all, this is what we strive to do for all of our patients - give hope.

Knowing that prevention is key, what can be done to stop the burgeoning greenhouse effect? Two hundred knowledgeable scientists and researchers have made a comprehensive plan to deal with the CO2 buildup - a plan called “Drawdown”. This is a plan to reduce or draw down the greenhouse gases over the next 30 years and this is thought to be a conceivable, reachable goal. We have also begun to develop “clean” alternative sources of energy. “Drawdown” would expand this development. Further, “Drawdown” fosters methods to re-sequester CO2 back into the earth. Clean sources of energy include wind power, solar energy, geothermal energy, and tapping tidal shifts of the oceans.

In addition, we could reduce the amount of methane, (a greenhouse gas 24 times more potent as a heat-trapping gas than CO2) released into the atmosphere by decreasing food waste and moving from animal-based to plant-based diets. Food waste alone accounts for 8% of global greenhouse gas emissions. Ruminant livestock produce far more methane. Cattle alone produce the 3rd highest greenhouse gas emissions among all the nations, if cattle were a nation (Drawdown, p39). Other improvements would include genetically enhanced crops, use of electric cars, making cities walkable, and making buildings environmentally friendly. These are but a few of the 100 strategies suggested in the Drawdown plan. Other strategies involve growing meat artificially, more efficient crop production, and farming methods.

The urgency is real since climate change is here and will not be easy to reverse, considering our dependence on fossil fuels. Who among us wants to give up that big car, stop flying on airplanes or turn off the climate control? The time has come to think about change and to educate ourselves in this regard. The threat may seem a long way off; however, our children and their children will live through this era. We need to take responsibility to educate the public regarding health risks and respective prevention methods for this looming calamity.

Anyone can start with simple changes. These changes include using more efficient LED light bulbs, decreasing energy and food waste at home, unplugging appliances when not in use, recycling, composting, walking instead of driving when possible, using electric-powered vehicles, moving to a plant-based diet and promoting the many innovations of Drawdown. Let us do all within our power to make the future survivable.

Global warming is preventable. Drawdown shows that prevention is practicable and doable, though not easy. Health care providers can join scientists to band together and fight for our species’ survival. Surely, we have the way and it is achievable. As President John F Kennedy so aptly said:” I believe the problems of human destiny are not beyond the reach of human beings.” (September 20, 1963).

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The Academy’s Project for Psychiatrist Wellbeing and Support has begun to compile references and accounts related to stressful experiences that psychiatrists have encountered. The Academy website will be hosting the Project’s compilation. Below, are some of the anonymous narrative accounts that will be included. Academy members are encouraged to submit references, links, or personal accounts for inclusion in our Project. Write to me at dhingrammd.com for further information and perhaps assistance in preparing a narrative of your own encounter with stress.

Douglas H. Ingram, M.D.
Chair, Task Force on Psychiatrist Wellbeing and Support
The Effect of a Life-threatening Illness for the Psychodynamic Psychiatrist and Her Patients

Like a lot of my colleagues, I approached growing older as I faced my 70’s with a degree of ambivalence about retiring (Ingram, D.H. and Stine, J., 2016, How senior psychodynamic psychiatrists regard retirement, Psychoanalytic Psychiatry 44:211-237). I had already reduced my practice to seeing patients only three days a week, largely because I had taken on teaching at a local university. I had been thinking of starting the process of retiring gradually. I had number of patients whom I had seen for years, at this point periodically to renew stable medications. I had thought that in the summer I would suggest to these patients that they see another psychiatrist who would continue these medications, or I would suggest that their primary care physician would be willing to prescribe for them. I had five or six patients in intensive psychotherapy, and by the end of the year, I planned to see only those few patients who were actually involved in the intensive psychotherapy. Over the next four or five years I anticipated their terminations.

I believe I had choices in the process of relinquishing my identity as a psycho-dynamically oriented psychiatrist. However, one afternoon in April all those choices and my autonomy were shattered. While I was visiting a friend, I suddenly began to have focal seizures in the right side of my face. A CT scan revealed a tumor, most probably a glioblastoma. I knew enough to be terrified. Was I going to die? Was there any hope? What was going to happen to me? I know that a prominent politician was dealing with this diagnosis, but I was not sure that he was not dying. All at once I was becoming a patient to whom things happened, not a physician who made decisions. I had to wait for several hours to be transferred from the first hospital to another where they performed neurosurgery. The nurses and ambulance drivers could not answer questions. I tried to be polite and cheerful to the hospital staff, but inside I was screaming. There was no one could address my concerns.

When I arrived at the second hospital, I was kept busy with CT scans and MRI’s throughout the night. I met once with a neurosurgeon who told what he was going to do. I had no choice but to undergo brain surgery. It was all a blur as people came and went. After the surgery I was helpless. The hospital nurses came and went, came and went as their shifts changed like clockwork. A hospitalist physician checked in once a day.

Because of the location of the tumor, on the premotor cortex, my speech was drastically affected. Immediately after surgery I could barely speak one word at a time. The next few weeks my husband told me that I was “channeling Stephen Hawking.” I sounded robotic and was mostly unintelligible. There was no possibility of my speaking to my patients. I could barely get my needs across to anyone even when I was tangled in the sheets and could not reach the “help” button.

There was nothing I could do about my practice while I was in the hospital. I recalled a day in the course of my own analysis when I was confronted by a note on the door of my analyst’s office that he was ill and there was “No time to inform.” The note was all I knew for four or five days, and my fantasies then covered all sorts of possibilities. Unfortunately, for a week or so after my surgery, there was nothing I could do but put a similar note on the door of my office.

In the hospital I did not have access to any list of my patients and my speech was so garbled that I could not have spoken to any of them. Eventually, when I got home, I wrote a form letter informing everyone that “It is with deep regret . . .” that I had to suspend my practice. I think I chose the work “suspend” because I secretly harbored a hope that I would recover and be able to resume seeing patients. I wanted to be able eventually resume my work, but I thought I knew inwardly that “suspend” meant “end.” At that time, however, I referred everyone to two of my colleagues who agreed to help my patients with refilling prescriptions and finding referrals. Despite my extreme speech impediments, I tried to answer phone calls. Ellen Pinsky, who was confronted by the sudden death of her analyst, describes an “Olympian delusion” (Pinsky, E., 2011, The Olympian Delusion, Journal of the American Psychoanalytic Association 30:351-375) that analysts do not die.

To some extent, unwittingly, I had subscribed to that delusion. Although I had briefly discussed with one of my colleagues how she could access my records and how I could get to hers, I don’t think either of us took seriously the possibility that we would really need to get to each other’s records. Frankly, I had not given a thought about the effect on my patients if I died suddenly as Pinsky’s analyst did. About six months earlier my own analyst had died after a prolonged battle with leukemia. He spent about a week in hospice care, and his family encouraged me and a few of his friends to spend time with him as he died. I was one of the suggested referrals for the few of his patients who had not made other arrangements as his illness progressed. However, most of his patients had already made arrangements or worked through some sort of termination. His death when it occurred was anticipated.

I think my patients shared with me the Olympian delusion that I would always be there for them. I know that I had never discussed with any of them the possibility that I could disappear: the closest to the topic were written instructions regarding who to contact when I was on vacation. Ellen Pinsky’s analyst died suddenly. My analyst prepared all of us, family, friends, colleagues, and patients, for his death. I was in different situation. I was not dead, but I was not available to see patients. My disappearance was sudden and unexpected, but I was not dead. My patients – and myself – were unsure whether I would recover and when I might be able to work with them again.
ever, over the next couple of months it became clear to me that I would retire and I would not see patients again.

Different patients reacted differently. A few went ahead and found sources that could renew their prescription and only asked me to prepare a summary for the new prescriber. One woman, even after I had repeatedly told her that she should find a new prescriber, told me that she expected to see me in October, after her summer vacation. I allowed some long-term patients to come for one visit so that they could see that I was alive and realize the extent of my disabilities. One long-term psychotherapy patient broke into tears and asked to visit me. I told him that I would be amenable to a visit in a few weeks. He never called back. A couple of patients who visited - in the living room of my house - wanted to come again. I was concerned that they were essentially transforming the patient/therapist relationship into a friendship. I chose to simply not be available to repeated requests. Some long-term patients repeatedly emailed me, again apparently wanting to transform our relationships.

Throughout the first couple of months, as I started the debilitating radiation and chemotherapy treatments, I was supported by my husband and friends. I was inundated by flowers and cards. Friends and colleagues called. My synagogue community sent so much food that we could never have eaten it all. A friend who is retired pediatric oncologist came along to consultations to be sure my husband and I asked all the questions we needed to. None of this support was connected to my professional identity, and all of it eased the decision for me to explore what my life would be like if it did not revolve around my seeing patients. Who would I be? I expect that new identities will emerge. I will take up my loom again and be a weaver and a lacemaker. I will write the papers I have kept in mind. I go walking with a girlfriend once a week, discussing theological questions as we circle our track. This month I will resume teaching a class on psychodynamic psychotherapy to the PGY-III residents at the hospital. In the meantime, there are speech therapy and physical therapy appointments. There is a schedule of blood tests and doctor’s appointments. After all, I am a patient.

A Clinician’s Experience of Burnout

Dr. P. had always been interested in applying psychodynamic concepts to clinical practice. Over many years, his dedication to teaching psychodynamic psychiatry to residents had become legendary. On one occasion, a surprise party was thrown in his honor by scores of former residents. Newly encouraged, he decided to interview elsewhere in the hope that his skills as a teacher and his conscientious devotion to patient care would be recognized.

Dr. P. applied for a promising position, sailed through the interview, and was immediately accepted. The salary would be adequate. He looked forward to a full out-patient practice in the hospital clinic and the opportunity to teach residents, and he looked forward to working with like-minded psychiatrists in a clinic for indigent, disenfranchised people.

Over the next few years, Dr. P. found he was absorbing the care of patients as other clinicians resigned. Also, he found that his paychecks were considerably lower than had been promised. There had been a misunderstanding. Then, Dr. P. suggested to the Director or Psychiatry that, since he was the recipient of the annual Best Teacher awards, perhaps this achievement merited an announcement in the hospital newsletter. That did not happen. Increasingly, Dr. P. found this hospital system was repeating the mix of excessive demands for administrative and patient care responsibilities, inadequate pay, and insufficient recognition that he had found before.

He decided to avoid hospital politics. He would keep his head down, teach residents who valued his lectures and supervision, and continue to provide good patient care. Before long, the hospital-associated methadone clinic was sending him most of its patients. Often, these patients sought benzodiazepines. Acknowledging that he was susceptible to flattery for his clinical competence and diligence, Dr. P. accepted the increased responsibility. He realized only slowly that his work hours were lengthening, his sleep suffering, and his mood darkening. Still, his caseload grew. The cumulative demands from housing counselors, vocational programs, and SSI lawyers for updated evaluations steadily increased. Dr. P. commuted to the hospital to complete paperwork at 5 a.m. in order to be ready for the 8 a.m. onslaught of the methadone addicts with their ineradicable complaints about shelter accommodations or benefits checks.

Dr. P. recognized that his conscientiousness, perseverance, and compassionate attention to patient care were not solely a function of his professional identity. He noted that he did much of this not from goodness of heart, but because it was easier than facing confrontations with the murderers, drug-dealers, or other felons that constituted much of his patient group. To insist on setting limits on these patients’ demands was often futile. Patients would find ways to work around limits, including complaints to pliable administrators. Though Dr. P. was once again finding himself descending into burnout, the administration was delighted: he worked hard, completed required paperwork, and was well-liked by patients, staff and residents.
He was told, “Why, you earn us more money than all the rest of the staff put together.” Later, he learned that staff were sent to homeless shelters to “drum up business.”

Dr. P. acknowledges that he was told by the administration to “take it easy.” Yet in practice, if he took a day off, he would face double the number of angry regressed patients the next day. His daily challenge was to maintain a professional attitude even as he was cursed and threatened for attempting to set limits, or adored and flattered if controlled medications were renewed on request.

Several years into this employment, Dr. P. was told during a routine medical exam that he had suffered a silent myocardial infarction. He was told that a second MI could be fatal. His work routine needed to change. Though his Director heartily agreed that he needed to slow down, the administration continued to invite more and more patients to come for Dr. P.’s “excellent compassion.” The Director insisted that it was up to Dr. P. to place limits on the hours of patient care he could offer. But Dr. P. found that this was not possible and he criticized himself saying that it was his own psychological deficiency, that he just couldn’t say “No.” The administration continued to send more patients, with compliments like, “Oh, you love it and you’re so good! Nobody else could take it.” The administration could not stop the increasing flow of work. Neither could he.

Doctor P. became increasingly angry, curt, sarcastic, and unempathic. Outside of work, he ceased all creative pursuits including work at his easel, and he was unable to experience sexual or intellectual satisfaction. He had lost physical strength and energy. He had little appetite. As he lost weight, he became increasingly haggard. His sleep became interrupted. At home, his wife was concerned about his increased moodiness, apathy, his excessive hours of work, and his growing disinterest in his adult children’s lives. Whereas he had had been a loving and available grandfather, he had become morose and distracted.

He was burned out. After seeking support, he took the next step and resolved that he must slow down. Yet he was trapped in his hospital job. Over years, he had established a reputation among patients and administrators all of whom had a claim on Dr. P. sustaining the same level of effort. Although pulling back was necessary in the abstract, the specific needs each day of individual patients and administrative tasks proved impossible to decline.

Dr. P. learned of a new job opportunity. It promised a much higher salary and far better working conditions than he imagined possible. He applied and was hired. Though he knew leaving his current job was necessary, he had bonded ambivalently with patients and staff. With the encouragement of his family and friends - and his awareness of his health concerns - he served notice and arranged to start in his new position.

Within a week of moving forward, his appetite returned and he began to gain weight. He started walking more, returned to his easel, and regained libidinal interest. He became hopeful and showed renewed interest in friends and family. When he started at his next position, he found he interacted well with patients and staff. He feels hopeful that he can recognize the signs of burnout if they appear and, if they do, to prioritize the need to make midcourse corrections.

Commentary by Douglas H. Ingram, M.D.

We are grateful for Dr. P.’s narrative - for his courage in speaking forthrightly about his circumstance. He is a diligent professional, an outstanding teacher, and a clinician generous in his work with the indigent. He perseveres professionally despite insufficient recognition, excessive administrative demands, and inadequate remuneration. He is aware that he is exploited by the hospital administration and yet is inhibited in effectively addressing the many inequities.

Some of us might shout out, “Stand up for yourself! Insist on getting good pay and limit the clinical work they are demanding of you!!” Why is that accusation an impulse we might have? Why must it be that we are prone to “blame the victim,” in this case the victim of administrative oppression? We know the answer. He is right here, a clean target. We are spared needing to consider the blurred abstraction known as “the administration.” Our easy impulse is to blame him. We must look harder. We must remind ourselves, this is Kafka’s world.

Still, it is also true that standing up to the administration was not Dr. P.’s way. Aggressive confrontation is not a notable characteristic of most physicians. Physicians tend to assume that clinical competence, diligence, and caring will be appreciated. As a consequence, Dr. P. endured and endured. Over the course of years, his work life satisfaction eroded. His personal life was impacted. He became a victim of burnout. He was fully aware that he was characterologically resistant to speaking up to a mostly intransigent administration. He wished, instead, to keep his head down. Rather than speak up, he eventually chose to take his skills and talents elsewhere.

Dr. P. is like us all. Whether or not we care to admit it, we are all more-or-less damaged. Mostly, we are blind to just how much. But unlike many of us, Dr. P. owns his difficulties as they apply here. He is flattered by the administration and inhibited in setting limits. Both traits conspired with expectable administrative overreach to cause a downward spiral in his work life.

Our task is to recognize Dr. P.’s strengths, namely, generosity, excellence as a teacher, perseverance, general goodwill, and courage. At the same time, we need to underscore how administrative greed to exploit these same traits eroded Dr. P.’s wellbeing. We hasten to remind ourselves that this is also the story of countless other physicians.
When Duties Collide: Medical Privacy v Public Safety

The following material was presented by Dr. G. in modified form at a panel on ethics in a meeting of the American Psychiatric Association. The matter concerned the troublesome conflict we face as psychiatrists between protecting society and protecting the patient - a Tarasoff-related litigation.

About thirty years ago, a married 2nd year resident in psychiatry, fully licensed to practice medicine, and a candidate in the medical school’s psychoanalytic training program, sought Dr. G. as his training analyst. The medical school had a psychoanalytic training institute and candidates-in-training needed a personal analyst, a so-called training analyst. This candidate was also aiming for a child fellowship after his residency. He had been in treatment with another training analyst but, the patient said, they did not get along. Later, Dr. G. would find out that it was more complicated.

In one session six months into their 3-times-weekly analytic work together, Dr. G’s patient disclosed that he had strong erotic interests in young boys. Dr. G. was astounded. His patient said that he was at peace with this erotic desire. It was entirely ego-syntonic for him. It was also politically colored. He believed that he and others like himself were wrongly regarded. Pedophiles, he believed, should have a right to pursue their interests as they do in certain other cultures. He sought what the gay community had achieved years earlier: to overthrow the pathologizing of what he called his sexual orientation.

In that session, Dr. G. said something simple like, “We will talk about this, but you must not act on these desires.” The patient assured the doctor that he never did act on these desires and that he would not so long as it was widely regarded as immoral and illegal. Within hours of his patient’s disclosure, Dr. G. began seeking advice. He phoned an outstanding forensic psychiatrist of his acquaintance. In their brief call, the forensic psychiatrist ruefully joked that the doctor’s only option was to put a bullet through his patient’s head. The forensic psychiatrist lived in another state and did not know the law in Dr. G’s state. There was no further help he could offer other than: “Why not speak to the Chair of Ethics of the local district branch?” That person, on hearing Dr. G.’s first words, said he should get a lawyer and abruptly hung up.

Fortunately, the medical society lawyer Dr. G. then consulted considered the matter. The lawyer researched the state law code and found that reporting a threat to potential victims and to law enforcement required that the threat be imminent against an identifiable individual. Furthermore, the lawyer said, the doctor had a responsibility to inform his patient that he would report him if such a threat arose. This followed the legal theory on which the Miranda principle is based, he said.

Dr. G. recognized that his psychiatric colleagues did not want to enter what might be a pit of quicksand. He was surprised and dismayed at this limit to what collegial consultation can offer. But on reflection, he realized, they had legitimate reason to stay away. When he spoke the next day over lunch to a colleague, he placed the issue in the form, “I have a friend who . . .” This colleague, like the others, said nothing and advised him to speak with an esteemed psychiatrist, a colleague in the psychoanalytic institute associated with the medical school. This colleague was a senior clinician and an expert in the paraphilias.

The senior clinician graciously invited Dr. G. to dinner to discuss his “friend’s dilemma.” He listened carefully and said that the patient needs to withdraw from the analytic school. The direction of therapy must be supportive and prescriptive, not psychoanalytic. “Your colleague is going to have hard time with this next point,” he told the doctor. “Your colleague will need to stand by this patient indefinitely regardless of whether fees are paid, regardless of scheduling difficulties, all in order to contain this matter of his patient’s pedophilic fantasies. Only if the patient explicitly abandons the therapy should your colleague take further action, which we can discuss if that should happen. The patient should stay in the residency and not lose his sense of identity as a psychiatrist and as a child psychiatrist.” The consultant said that he would appear in court if it came to that.

With halting determination, Dr. G. followed this advice. He recalled feeling some pride in doing the ‘hard thing’ heightened in its drama by the privacy it required. From time to time, Dr. G. occasionally contacted his senior colleague. When the patient rotated through out-of-state hospitals, sessions which were now once weekly, were by phone. The general strategy was to maintain the dialogue, to seek to contain anxiety that could erupt in pedophilic enactment, to emphasize that the patient must not act on his desires, and to recommend that he choose work with adults to reduce the temptation that children stimulated.

About three months after the disclosure, Dr. G.’s patient molested two boys in an out-of-state hospital and was arrested. He lost his medical license and served years in prison.

Then, several years later, Dr. G. received the formal legal complaint: he had failed to do something to protect a child from this predator. He immediately contacted his malpractice insurance company. A discussion of settlement ensued. Dr. G. was confident in his position. He had done what he could, consulting the best in the field and following through conscientiously. If the insurance company wanted to take this to trial, he was secure that he had done what was ethically, legally, and clinically correct. After review, the insurance company agreed. A modest settlement was offered and the plaintiff refused.

Five years later, a jury trial was scheduled in federal court. Newspapers, television news shows, and psychiatric trade papers picked up the story. The immediate impact on Dr. G.’s personal and professional life was intense. Though his family, friends and colleagues commiserated and sup-
ported him, hate calls spewed venom into his answering machine. Ironically, he also received requests from people seeking to consult with such a discreet psychiatrist.

The jury trial lasted a month. The state law on which the doctor depended was effectively interpreted in the light of law in the state where the crime was committed. This meant that the threat to an identifiable individual could be regarded as a threat to an identifiable “class of persons.” That is, the threat expanded from an identifiable child to the entire class of children. This greatly increased liability. In court, also, Dr. G.’s advising his patient about his need to report him if he proved an imminent threat - the *Miranda* principle - was frankly ridiculed by the plaintiff’s attorney. What he was really doing, she said, is telling his patient not to speak about reportable activities. Meanwhile, the doctor was the sole witness who presented the facts of the case. The experts, three on each side, offered their views pro and con concerning his liability. Also, in the 13 years the senior colleague on whose counsel Dr. G. relied had died. And, finally, it was learned that the patient’s first training analyst had dropped the patient when he disclosed his pedophilic interests. That analyst had shut the door on him. She said nothing to anyone and just discontinued treatment. She, too, had died.

After three days of jury deliberation, Dr. G. was found liable. The jury seemed to believe he should have figured out a course that would have protected children. The medical school was not found liable. The matter was duly reported in the local newspaper and the out-of-state papers. The insurer and the plaintiff settled within the bounds of the insurance coverage. Subsequently, the insurer denied Dr. G. malpractice insurance. He got insurance elsewhere. The amount of the settlement triggered a state department of health investigation for professional misconduct. Three years later, the department closed the case without comment. There were no other ethical or administrative inquiries.

During these few years, Dr. G.’s academic position at the medical school was advanced. His clinical and scholarly work progressed without adverse impact. Years later, a representative of the original insurance carrier phoned and offered once again to cover his professional liability needs at the advantageous premiums accorded psychoanalysts. The statute of limitations for child abuse - 17 years after the age of majority - had run its course. The doctor accepted the insurance company offer.

At the time of the disclosure and in the ensuing years through the trial and after, Dr. G. maintained that his actions were consistent with clinical, ethical and legal behavior. He believed that his senior colleague’s recommendations were correct. Yet, now, he says, he is no longer sanguine about it. Perhaps the senior colleague was wrong. These days, decades after his patient disclosed his pedophilic desires, Dr. G. sometimes still plays out different scenarios and traces their possible consequences. The expert witnesses who opposed him in court said he was wrong but could not offer any alternatives. Standing by his patient and trying to help him contain the impulse to act on his desires was not sufficient for them.

What should Dr. G. have done? Perhaps that previous training analyst who had discharged the patient on hearing his proclivities and said nothing - perhaps she chose the best path. Drop the patient and never look back. Perhaps Dr. G. might have denied the patient ever raised the matter of pedophilic desire and simply perjure himself. There was no one other than his compromised patient who could gainsay that lie.

Perhaps the ego-syntonic nature of his patient’s desire and his wish to change society’s view of pedophilia were a sufficient trigger to report the matter immediately. But to whom? On a couple of occasions, when the patient failed to call for his appointment, should that have been a line bright enough for Dr. G. to blow the whistle? But how, and to whom, and what might be the unintended consequences of that? What is the basis for breaching confidentiality and destroying the doctor-patient alliance when no crime had been committed or was immediately threatened? How well can we predict dangerousness? What criteria need to be present to act? Act how? What if we are wrong?

Was Dr. G. a coward as at least one caller insisted? Was he courageous as some psychoanalytic colleagues said? And what about the children who might be molested? Did Dr. G. care enough about them? Did he suffer from a failure of imagination in failing to find a solution? Did the jury believe him? To what extent was he self-deceiving?

Dr. G. says these possibilities and questions remain open for him, at least somewhat. About this case, he finds that his earlier complacent self-assurance, a self-assurance that rose at times to self-congratulatory righteousness, has faded. The matter has not come to rest, not fully. In moments of idle thought, it all may come back as a shadowy revisited awareness.

At those times, he occasionally finds himself wondering about the case. To the extent he can, and out of a belief in the value of skeptical self-review, he prefers to keep the questions raised by his experience open rather than bury them beneath what might be a convenient denial.

Comment:

This case illustrates the value of establishing a service that would provide for psychoanalysts’ direct consultation with forensic psychiatrists. Though we have no data, it seems likely that questions like those set forth in this case arise with some frequency in the course of psychotherapy. About this specific case, my view is that that the senior analyst who was consulted was wrong. The author is hesitant to acknowledge it.

The author of the narrative faces two important matters. First, he needs to relinquish any shame still associated with challenging the senior analyst for failing to do so. Second, he needs to neutralize any guilt associated with activating a Tarasoff matter. Tarasoff matters do create a collision of duties.
**Treating Burnout Syndrome with a Medical Scribe**

I am an “out-of-network provider,” which means that patients pay me directly the day they see me or at the end of the month when I give them my bill. They then submit it to the insurance company and attempt to get some form of reimbursement.

It took me several months of internal reworking of my personal analysis to tolerate the narcissistic blow of just being an “out-of-network provider” in the eyes of the current healthcare system. Did the insurance carrier’s 20-something clerk who picked up the phone to “deny reimbursement for further sessions” care that I had over a decade of postgraduate studies or special skills of any sort? No! I am just an “out-of-network provider.” Sorry for the repetitive narrative, but it mirrors the mantra-type cognitive work I need to do on a daily basis.

I have a large solo practice in psychodynamic psychiatry in the suburb of a major metropolitan area. Roughly 30% of my patients are adults, 30% are teenagers, and 40% are children. Almost all of my patients are seen in weekly or twice-weekly psychotherapy and I prescribe medications to about 80% of them. For a long time, I managed to stay as a “non-HIPPA entity,” which - as long as I wrote a bizarre lawyerly legend at the end of my faxes - meant I could continue to practice as always.

But then, two years ago Uncle Sam forced me to use electronic prescriptions, which also meant I was now “a HIPPA entity” … and an “out-of-network provider.” Talking like this makes me feel like I’m ordering a coffee at Starbucks!

So, now I had to:

1) Keep electronic medical records
2) Receive consents to talk to other doctors with a HIPPA format
3) Keep abreast of the latest codes to place in the bills, and make sure they are “itemized”
4) Work through endless faxes from CVS and the likes telling me which medications I should be renewing – and for 90 days, if I may.

All this was on top of doing “precertifications” and “precertifications” with my 20-something buddy at the other side of the phone line who tells me how to run my practice. And beyond that, I need to write all those notes and letters to colleagues in the special HIPPA-compliant format.

“A tall, half-caff, vanilla soy at 120 degrees, half sweet -no foam- latte, please… ah, with caramel drizzle, too… please”.

I WAS BURNED OUT!

I decided I needed a permanent solution - I just needed to find it! After talking with many colleagues, one of my supervisees - a resident who was current with the latest “whatever” procedures - gave me the perfect solution. She said, “You need a medical scribe.” A medical scribe is a paraprofessional who is updated in the latest legal requirements and is not only capable of doing all this clerical work, but is also capable of scheduling, filing, writing emails, requesting labs results, and managing the office.

The first thing my new scribe did was to order a Keurig coffeemaker. “Phew,” we got rid of Starbucks!

Now, by the time I arrive at the office when my scribe is there, my coffee is waiting for me at my side table. I give her my schedule that she transcribes into an Excel spreadsheet and that, at the end of the month, will be used to generate patient bills. I give her notes about my patients from the previous day and any checks that have arrived in the mail that she also enters in an Excel spreadsheet.

I tell her about the patients who need to be called to schedule appointments and I forward her any messages from pharmacies. She uses my jotted one-liners to create notes that follow the latest insurance company guidelines, just in case the insurance company requests the notes. My scribe also pairs the notes with the billing codes so that my patients can easily request the reimbursement they are entitled to.

The end result is that:

1) My progress notes are now in an electronic health record format.
2) I am no longer concerned that my progress notes will fail to accurately reflect the “activity” that my bills show.
3) My patients are happier since they are receiving a higher reimbursement more frequently than before.
4) I no longer use up my time talking to pharmacies, insurance companies, or coordinating the messages the patients receive from them.
5) I have Excel mastersheets that show the name of each patient, the day I see them, how much they owe from before, how much they paid during the month, and how much they owe me.
6) I am no longer concerned about needing to prepare bills or address envelopes. I just check that they are all correct.
7) I am no longer concerned about scheduling appointments, rescheduling, or providing administrative information to patients.
8) I am no longer concerned with filling forms, writing letters to patients or to colleagues, filing, faxing, and reordering supplies.

All this for the cost of what I charge for one session every week (plus the cost of a cup of coffee!).

And I am no longer burned out! For further information on psychiatric medical scribes please go to the website of the American College of Medical Scribe Specialists: https://theacmsss.org.
A Psychiatric Resident’s Struggle with Anorexia

My mental health deteriorated significantly during my third year of medical school. The stress of rotations, the schedule, and the academic pressure built up and on the background of recent trauma - a near-fatal motor vehicle collision that resulted in prolonged hospital stays for two friends - it was the perfect storm. By the end of the year, I knew something was off and made an appointment at the medical school’s counseling center.

Working with a psychologist there for months resulted in diagnoses of PTSD, anxiety, and depression. Cognitive processing therapy and exposure-based therapy dramatically reduced my symptoms, though I believed the diagnoses to all be overreactions to my current situation. Before we could nicely wrap up the therapeutic relationship, I left for away rotations and residency interviews. Hidden beneath the depression, anxiety, and PTSD was an ill-conceived coping mechanism - dietary restriction coupled with over exercising. I hadn’t lost much weight but, when it came up, I explained it away as a result of a better diet and more time spent in the gym.

In the months that I spent away, everything worsened. While I once believed that I was just following a healthy diet, I was increasingly aware that my relationship with food and activity was abnormal, though I wouldn’t admit that to myself much less to anyone else. When I returned, I looked like a different person. I had lost over a third of my body weight. My diet had become increasingly restrictive over the course of the two previous years, both in terms of the type and quantity of food I ate. I regularly over-exercised and used exercise to compensate for eating “too much.” I made myself vomit. I chewed and spit out food. I didn’t deny the fact that I lost some weight that seemed to throw off concerned friends and classmates who noted physical changes, and I continued to offer the same excuses about my increased time in the gym and my focus on a healthier diet.

Fortunately, my primary care provider heard the concerns voiced by others, noticed the physical changes, and directly confronted me. Being open about the behaviors I was engaging in was incredibly difficult. I spent most of the appointment looking intently at the floor and, if I hadn’t already had a good relationship with her, I don’t know if I would have been able to share as much as I did. She worked with the psychologist I had previously seen and started building an outpatient treatment team.

I vehemently refused treatment at a higher level of care. After all, I knew which hospital systems were covered by my insurance and I was aware of the overlap with my top ranked residency. I was similarly hesitant to involve a psychiatrist in my care. If I matched to my first-choice program, then I would likely interact with whomever my psychiatrist was as a resident. More rational minds prevailed and a psychiatrist who was only peripherally affiliated with the residency program was added.

Eating and food-related behaviors and mood and anxiety were the dominant theme of my last year of medical school. I spent a tremendous amount of time in appointments. At times I was seeing my psychiatrist, psychologist, and primary care provider weekly. Group therapy was added because I needed more support and yet I was still refusing to consider a higher level of care. The flexibility afforded by the final year of medical school meant that I was able to make my appointments without taking formal medical leave or making my school aware of what was going on.

Just as I refused to consider a higher level of care, I refused to consider medical leave. Anything other than graduating on time with the rest of my class was unfathomable. I worried about the impact that my psychiatric diagnoses could have on my future career and I believed that having to explain medical leave would only highlight my medical history going forward. Instead, I changed my schedule and opted for rotations with reputations for minimal work hours.

When match results came out, I did match to my top choice program with which my psychiatrist was affiliated. It was a relief to not worry about finding new providers although there was still some transition in my treatment team. A therapist with a background in eating disorders, as well as a dietician specializing in eating disorders, were added and I stopped seeing the generalist psychologist. I was terrified of being identified as the “anorexic, depressed psychiatry intern” and, at the same time, the eating disorder identity had become so important to me that I was terrified of recovery and losing that piece of myself. Contrary to my opposition to the diagnoses of PTSD, depression, and anxiety, once I was willing to admit that I had a problem with food I embraced the diagnosis of anorexia.

It validated how sick I was, and I associated the label with extreme dedication and self-control. As a medical student, when patients expressed familiar sentiments regarding their past traumas or their mood, I desperately wanted to share that I had a deeper understanding of the sense of guilt, responsibility, and pain that they related. But I knew that this was not my place and that this was not appropriate.

This was only magnified when I became an intern. I routinely outscored my patients on depression screeners. My SSRI dose was higher than many of my patients. When a patient with an eating disorder was on the unit, I was aware of their behavior use, despite the fact that my team was not caring for them. During morning conferences, the judgments and discussions around diagnoses and behaviors that I shared with patients were hard to sit through. More than once, I desperately wanted to share my perspective, talk about the weeks when I found it impossible to get up and actually do anything, or the feelings of profound guilt and failure associated with my successfully following my meal plan. When I watched my patients discuss their own relapse prevention plans, I inwardly compared aspects of
their plans to the plan that my therapist and I had updated only weeks previously. After a senior resident commented on my lunch a few times, I wanted to burst and scream that I had an eating disorder and that I wasn’t just eating healthily but that there was a meal plan that I had to follow.

When discussing PTSD treatment modalities, I also wanted to share my experiences, but I was afraid of crossing boundaries. Interns do not have access to supervision in the same way that senior residents do, so I had no one to talk to about these concerns - self-disclosure, over-identifying - without revealing a significant amount of personal information. I was hesitant to spend time in my own appointment sessions discussing these issues when I was still actively struggling with disordered eating behaviors, low self-esteem, and depressed mood. I was aware that I was not well enough to carry a patient who was engaging in disordered eating behaviors and I wondered how I would handle it should I be assigned such a patient. I dealt with this daily, in addition to trying to follow my meal plan and practice my skills.

Despite my intern schedule I still needed to attend group therapy, individual therapy, and psychiatric appointments weekly, see my dietician twice a month, and see my primary care provider at least monthly, all on top of the PRITE (the annual in-training exam for psychiatry residents), licensing exams, residency academics, being on-call, and the months of medicine that are required of all interns.

It was an exhausting and isolating experience - being an intern and having mental illnesses that I struggled with daily. I felt there was so much stigma around mentally ill providers that I avoided reaching out for support from my residency because I continued to fear gaining a label that would follow me for the rest of my career. I longed for the kind of clarity on connecting and relating to my patients that could only come from having a discussion with someone who knew my whole story.

While I no longer looked anorexic and depressed when I started my intern year, my disease was by no means cured. I soon resented the fact that I did not wear that label at work. The fact that I no longer looked ill amplified the emotions and behaviors that I struggled with because I felt as if I had to prove to myself and others that I still needed the intensity of treatment I was receiving. No one understood how significant it was that I ate a potluck lunch at academic gatherings. When I said I had a bad weekend, no one could guess that it meant I spent it lying on my living room floor, wishing I might fall asleep and never wake up again. I couldn’t share my struggles and successes with my colleagues because I worried about what that information might do to my future as a psychiatrist.

I was lucky to have had supportive care providers throughout this time and currently. Despite the support, I still wrestle with over-identifying with patients and the urge to self-disclose, both with my patients and with my colleagues. I struggle with my diagnoses every day. I am not recovered, but I believe that full recovery is possible. I know that I have a unique perspective on mental illness. As a resident I’m regularly challenged to find a way to incorporate my knowledge and perspective into my practice, and I am sure this challenge will continue for the rest of my career. I know this can make me a better psychiatrist, but only if we change our approach to how we regard providers actively struggling with mental illness.

The author is a female psychiatry resident in the United States.

**COMMENTARY by Anna Dickerman, M.D.**

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In this piece, the author gives a poignant account of how isolating and painful it can be to experience mental health problems while in medical training. She became symptomatic in medical school and did not immediately receive treatment. We know that medical students experience higher rates of mental illness than age-matched controls - even though they start their training with lower rates of burnout and depression (Brazeau et al. 2014) - and are less likely to access appropriate help when this happens (Grant et al. 2015). Indeed, even when the author did engage in treatment, the level of care was not initially adequate for her needs. This was not necessarily due to lack of access to care, but rather due to reticence to receive such intensive treatment. Barriers to appropriate care in the author’s case included concerns about stigma, confidentiality, and time constraints. These are similar to findings in the literature that explore medical trainees’ reticence to seek help (Moutier et al. 2009). We observe here a quality of courage and fortitude as this medical student, now a resident, perseveres in her professional work.

Fortunately, there has been an increased focus in recent years - in both the general media as well as the academic literature - on exploring and addressing challenges to optimizing physician trainee mental health (Baker and Sen 2016). The Accreditation Council for Graduate Medical Education (ACGME) has recognized the need for improved wellness among physicians-in-training and have recently announced a commitment to ensure that this is an integral part of training and the culture of the learning environment (Daskivich et al. 2015). In 2017, major additions were made via addition of a robust section in the ACGME’s new proposed Common Program Requirements (CPR) which both specifically acknowledges the elevated risk among trainees as well as addressing the need to promote well-being. The ACGME has created a Physician Well-Being web page (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being), which includes content for key areas to facilitate physician wellness (including resources, education, and research, among others).
Academic clinicians within the field have also proposed and developed multi-tiered interventional approaches to address the mental health needs of medical trainees (Baker and Sen 2016, Grant et al. 2015, Sharp and Burkart 2017). More research is needed to refine these models, but the hope is that we have begun to engage in a productive scholarly conversation as a community, and that there are more comprehensive solutions in the works so that trainees such as the author of this submission will no longer need to suffer in silence.

Chronification: Nightmare for the Therapist, Weapon for the Patient
By Reimer Hinrichs, MD, German Academy for Psychoanalysis, Berlin, Germany

Frame and Introduction Classic fields: Pain, Addiction, and Rehabilitation
The term of chronification was first and still is mainly used in the treatment of chronic physical pain in organic medicine (pain lasting for more than 3 months). Beside that, it still is used in therapy of addictive diseases as well as in rehabilitation programs.

Psychotherapy uses the term of chronification in cases where a certain psychogenic complex of symptoms is enduring longer than two years, has a primordial onset, or is proven as having crossed the border to physical damage (e.g. from functional gastritis to stomac ulcer). In Germany, this last phenomenon is called “second regression” in memory of Alexander Mitscherlich (1967), who first used it. This marks the point where de-somatization by psychotherapy is no longer possible because of somatic tissue damage.

In this pattern, cooperation with organic medicine is mandatory. Psychotherapy here is used in a more supportive rather than in a disclosing or psychodynamic way. In rehabilitation, the approach is similar: no causal healing in words of “restitutio ad integrum” is aimed at. The goal of rehabilitation is harm reduction of disability, impairments, and handicaps.

Everything circles around coping mechanisms and tertiary prevention and phenomena such as: Improvement of compliance, establishing resilience, and building tolerance of frustration, not only for the patient, but for the therapist as well, and also for friends and family members, who all are involved in many ways by the patient’s chronification. Primary prevention involves improving the patient’s health, secondary prevention involves early diagnosis through screening, and tertiary prevention is harm reduction.

Chronification is not a sympathetic issue for dynamic psychotherapists. The term has a negative and sometimes boring connotation for readers and helpers. Its main role in organic medicine of chronification is pain therapy, but implicitly this also plays an important part in the therapy of all kinds of addictive patients, not only substance addiction. In Germany, 60% of all psychiatric patients are considered to be chronically ill since they have had psychogenic symptoms for more than two years before coming to a diagnosis by a psychiatrist or psychotherapist.

The psychodynamics of chronification are described often in connection with resistance and defense mechanisms, such as negative therapeutic reaction or projective identification, or, more simply, masochism and repetition compulsion, e.g. the bad luck champion (Menninger, 1938) or the chronic crime victim (Hinrichs, 1987).

The limitations of causal healing in chronification is evident in the fact, that the term healing is replaced by auxiliary support and partial concomitant procedures including tertiary prevention or harm reduction. In other words: Incomplete help in pieces: primary prevention: checking the healthy; secondary prevention: screening + early diagnosis; tertiary prevention: harm reduction. In psychiatry, we know the term of deficit healing, meaning that there is a rest of disease remaining, a lack of something good, a deficit in the sense of residual symptoms. The recovery is incomplete.

Some authors in psychotherapy use the expression of therapeutically resistant or resistant to therapy for the chronic patient (Schmauss, Messer, 2009). This term has a devaluating flavor, because it implies the blaming of a patient. It is a description without any dynamic understanding or postulates. In general, there is no understanding without dynamic interpretation.

In this connection, I am convinced that chronification in psychotherapy does reflect the therapist’s frustration. However, from the patient’s unconscious point, chronification can be a filigree, sophisticated, and senseful accomplishment, that, in many cases, is connected with morbid gain and the guarantee of being saved from the dangers of harm or aggression, which all is a matter of protection. And being protected is a basic human right.

Current Aspects: Change of the therapist and endless therapy
It is not seldom that patients come to us, who have undergone several outpatient psychotherapies in the past. This should be a warning sign of chronification for the new therapist. Sometimes he will learn about past therapies only by persistently inquiring about the patient’s past medical history because the patient might be too bashful to tell about past therapies spontaneously. The patient knows that the therapist who the patient is currently seeing will most likely not be the last one in his or her life.

Contacting a new therapist always presents a good chance for the patient to talk about his/her own life and feelings of self-pity one more time that is a form of primary morbid gain.

Metapsychology: The regressive nature of chronification
Chronification per definition is a regressive phenomenon. The goals of psychodynamic psychotherapy, on the other hand, are progressive. Whereas dynamic psychotherapy uses regressive phenomena as a temporary and episodic
therapeutic tool to later help expanding the patient’s active impulses, regression is crucial in the dynamics of chronification.

Alexander Mitscherlich (1964/65: 648) describes the dynamics in the development of symptoms in psychosomatic medicine as a regressive matter to master dealing with unbearable conflicts as second regression. If a conflict comes up in the patient’s life and world, tension rises on many levels, often giving way to pathological functioning expressed in somatic systems. This pattern allows the patient to delegate helpful support and responsibility to somatic medical experts, family members, and to friends, i.e. the patient externalizes these needs. In doing so, the patient has gained a new time window: He/she can postpone the difficulty of solving the underlying conflict, as long as somatic therapy is necessary. He/she also can delegate responsibility in this connection. As long as this pattern is not brought to the patient’s awareness through de-somatization by analytic or dynamic psychotherapy, the patient has a powerful tool for handling similar situations in his future. A handy way to cope, so to speak.

**Dynamic Aspects:**

(1) **Connections to morbid gain**

Morbid gain plays an important part in many cases and dynamics of chronification in psychotherapy (Hinrichs, 2015). (1) Primary morbid gain is the protection and empathy received from the family and peer group, (2) secondary morbid gain results from using the disease as a tool to receive public bonuses, like early retirement, and (3) tertiary morbid gain is defined by all the benefits, that caring helpers plus the industry and clinical facilities receive when they deal with the patient.

If morbid gain is connected with an obsessive-compulsive personality structure, it may lead to early retirement, and the patient is freed from the chains of work. In Germany, this became a social sports game in circles of patients with a poor professional education. Even if they were not qualified for retirement, the welfare money they received was often higher in than what they would have been paid if they worked in a low-budget business.

This is often connected with addictive symptoms and - ironically - with a high social intelligence. This was a pattern I saw when I worked for five years in a methadone substititional institution (2006-2011) in Berlin, Europe’s capital of drug dealing. Some addictive patients called early retirement, or being on welfare, their permanent holidays.

They usually traded methadone for heroin or cocaine on the black market, and many of them never thought of kicking the habit. We as doctors knew the rules and implicitly were co-players because doctors prescribing methadone receive good money from insurance companies and medical authorities.

(2) **Regressive defence of overwhelming stimuli**

It is easy to understand that an overwhelming amount of stimuli can cause traumata of any kind, especially in the current age of *digital dementia*. This trauma or this confusion also can be used easily as a source of chronification by even very young patients. It quite often is a common thing, because the parents of these young patients are sitting in the same boat. A line of a Johnny Cash song (*Committed to Park View*) calls this the *Withdrawal from the rat race.*

(3) **Regressive defence of spoiling in therapy**

The psychotherapeutic situation, through its spoiling nature, can lead to chronification. The Super Ego of the therapist may follow all rules of so called empathy so strictly, that the result is nothing but spoiling. A German saying is: The surgeon does everything, but knows nothing; the internist knows everything, but does nothing; the psychotherapist doesn’t know anything and can’t do anything, but understands everything. (Editor’s Note” and the pathologist knows everything but it is too late.)

Confrontation in therapy is neglected in these cases, and the neglect in many casuistic examples has it’s roots in the depressive structure of the therapist’s personality, which fears the loss of the patient by the risk of confrontation. The outcome, again, is chronification.

(4) **Demarcation to a negative therapeutic reaction**

A negative therapeutic reaction is defined by an unexpected worsening of the patient’s subjective situation, shortly after a seemingly successful process of working through has taken place. The dynamic background is typically fear of loss on the patient’s side. The patient is afraid of losing the therapeutic alliance by getting healthy. *If I make progress and lose my symptoms, I also might lose the therapeutic relationship.* Wilhelm Stekel (1914) and Freud (1918), in this connection, wrote about the necessity of clear and early announcements of the therapy’s termination. The effective way to solve this problem is, in Germany, to confront the patient with the fact that the insurance will only pay for 20 more hours. The back door to continue would be if the patient would find a way to self-pay beyond the 20 remaining hours on their own, i.e. with private money. Patients rarely choose to do this and this will be a test of the patient’s motivation to continue in ongoing therapy.

(5) **Demarcation to projective identification**

This matter is a bit more complicated. If a patient pushes the therapist into the role of an early pathogenic object by projective identification, it is the therapist’s task to focus very early on interpretations at the level of transference: *What are you doing right now with me; look at what you do on an imaginary screen, and try to remember when you did this the first time, or who did that for the first time to you.*

(6) **Chronification and repetition compulsion**

Repetition compulsion is a is psychogenic and ego-dystonic pattern of symptoms which are of an unconscious nature and can be cured by analytic psychotherapy and its different techniques.

On the other hand, chronification is a result of many
intervened patterns of therapeutic effort and different comorbid levels of symptoms, e.g. intrapsychic, vegetative, functional, and somatic. The nature of chronication is estimated by the looking back on the patient’s life and therapeutic history. It is connected with less suffering and less acute dramatic aspects, compared to repetition compulsion.

In summary, it is an interesting dilemma that, without therapy, chronication is inevitable but, on the other hand, many and long therapies can be the trigger points for chronication. It is reasonable to consider that the patient’s (and not the therapist’s) subjective view of the disease is of bigger importance to the course of the disease than we had assumed in the past.

Character and Chronification

In his famous work about Character and Neurosis, German psychoanalyst Sven Olaf Hoffmann (1979) pointed out that both character neurosis as well as a neurotic character contain patterns of chronication. The difference is that the neurotic character is more ego-syntonic and usually not a promising place for therapeutic attempts; the dynamics are closer to the pattern of a psychopath (Dutton, 2013). Not the patient is suffering by his weird ways, avoidmants, and manners, but rather all around him are suffering by the patient’s manners. On the other hand: The patient with a character neurosis is dealing with his symptoms in a more ego-dystonic way: The more he suffers by his chronic symptoms, and the more insight he has into the endless losses of love and possessions, the more likely he can be a patient with a better prognosis for dissolving his symptomatic picture.

Iatrogenic chronication: The self paying private patient

I will allow myself to conclude this rather dark topic of chronication with a smile. Beyond insured payment, once in a while, we are confronted with a sympathetic self-paying patient who is not interested in getting written bills, but rather likes to pay cash after each session. Typically, this patient is wealthy, has a mild narcissistic personality structure or even disorder, and seeks what he may call character analysis, because he is interested in insight and in getting to know his inner Self.

Is this patient welcome in my office? Yes. Do I appreciate his informal suggestion of payment? Yes. Do I understand his need of help? Oh, yes. Will I put any strong effort in abbreviating this therapeutic procedure and reduce it to a short term therapy? No. Does my conscience accept the fact that this patient might need therapeutical support for a longer time than I thought at first? Yes.

Do I unconsciously induce a chronication in this case? No way. Why not? Because here are no losers.

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The Collaborative Treatment of a Bipolar Adolescent
John S. Tamerin, M.D. and Ethan Weibman

Introduction

Prior to the 1920s psychiatrists assumed that intensive psychotherapy with psychotic patients could not be done because they believed their communications were unintelligible and lacked meaning. Through the insights of psychoanalysis, there was a belief among some psychiatrists that information produced by patients during psychotic episodes could be meaningful and potentially understandable. This belief was ultimately rejected by many in the profession.

As psychoanalytic hope for the effective treatment of Manic-Depressives waned, lithium and Depakote became the standard of care in the 1970s and 80s and has continued to this day with the addition of the atypical antipsychotics. These treatments have made a huge difference in effectively dealing with the manifestations of acute psychosis and in reducing the likelihood of relapse and re-hospitalization.

If this treatment were sufficient and patients who were stabilized on lithium or Depakote and an antipsychotic could then go on to live full and productive lives, further psychotherapy would be unnecessary. This is not the case. There is ample evidence that pharmacological treatment alone is insufficient for many people who have experienced a bipolar psychotic episode because pharmacologic therapy alone neglects significant developmental, characterologic and psychodynamic factors that must be addressed if full and complete recovery is the goal of treatment.

Case Report

My patient, a white, upper-middle class, 17-year-old youth, was referred to me when he was placed in an acute treatment facility by a nurse at his boarding school due to erratic and exuberant behavior. Samuel’s parents divorced when he was 3 years-old. His mother was awarded custody and he lived with her, while spending weekends and vacations with his father. Samuel has no siblings.

During his childhood, Samuel developed a repulsion to his father, who he viewed as forcing activities and values on him without explanation. This resulted in many conflicts and ultimately a total unwillingness to see his father. Consequently, he lacked a positive male role model for the majority of his young life. His mother frequently traveled around the world as she developed a highly successful interior design business. Samuel was primarily raised by a surrogate mother from Colombia. Samuel was shielded from challenges, difficult situations or any form of mental pain by both his surrogate mother who waited on his needs, even bringing him breakfast in bed each morning, and his own mother who felt guilt over putting him through her divorce and her lack of availability.
At the age of 12, Samuel began playing on a soccer team, though not competitively. He hurt himself while playing and was unable to continue pursuing any other team sport. This accident led to a high degree of social isolation because even after he healed, he was no longer able to engage in the competitive activities which endowed him with a sense of distinction and definition. At the same time, his surrogate mother was diagnosed with terminal cancer and returned to Colombia to be with her family.

After the loss of both his surrogate mother and the team activities through which he had derived a feeling of competence, a positive identity and a social network, Samuel became depressed. His mother found a therapist who continued to provide supportive therapy for the next 4 years. He was placed on Prozac and Adderall as he was also diagnosed with ADHD. In middle school, he started smoking marijuana.

In the 10th grade, after failing to adapt to his academic and social environment, Samuel convinced his mother that he should transfer to an elite private school where he imagined he would be able to become “great rather than ordinary.”

Samuel’s mother hired a test preparation center to assist him in scoring high enough to be accepted into a competitive private school. However, a lifetime of avoiding challenges, a lack of discipline and poor academic rigor led to poor scores. Despite this, he interviewed well and was accepted.

In the 11th grade, he continued to perform at a mediocre level academically. Apart from the standard curriculum, Samuel enrolled in music production and audio engineering courses. As he applied what he learned in those classes, he began to fantasize about a future as a successful music artist and producer, hopefully with his own label. Energized by his newfound motivation, he began to miss classes, lie to his friends about the success of his music, spend hours alone in his room, and stayed up through the night developing a brand for his business. To achieve this, he turned to abusing his Adderall prescription and medicating its side effects with marijuana.

Eventually this lifestyle began to take its toll on Samuel. He started seeing messages directed at him personally encoded in celebrities’ social media posts. He believed these celebrities were coming to record with him. So, he set up a studio in the cafeteria of his school. When students and the school nurse observed his psychotic behavior, he was taken by ambulance to a nearby hospital’s Behavioral Health Center. This is where I met Samuel.

On the psychiatric ward, he experienced delusions of grandeur coupled with delusions of persecution. Initially, he thought that he was a prophet and believed he was the son of Jay-Z and Beyoncé. Then Samuel’s psychosis turned dark. He thought that the other patients, staff and everyone around him coveted his ideas and skills. He was concerned that their jealousy might motivate them to kill him. To alleviate these symptoms, he was placed on Depakote and risperidone.

Samuel was then transferred to a well-known private psychiatric hospital where he expressed obsessions with various conspiracy theories. After leaving the hospital, Samuel was not ready to live at home as he was still agitated, depressed and unstable. To address these issues, his mother sent him to a residential treatment facility in California. After a 30-day stay at the facility where Samuel received medication, learned to better express his emotions and participated in group therapy, the symptoms of his psychosis receded.

When Samuel returned home, he was still emotionally unstable, inconsistent, immature and exercised poor judgment. He was lonely and dependent on his mother for such basic tasks as making his meals, scheduling appointments, and had little motivation to change. He was lethargic and had little desire to do anything. He spent most of his day sleeping, ruminating and verbalizing that “My life is over and I have nothing to look forward to. I’ve lost all my friends because they all think I’m crazy.”

Clearly Samuel was not well and needed treatment; he needed to be in a safe environment and he needed to finish his senior year in high school. Should he go to a long-term psychiatric hospital or a therapeutic boarding school? I presented a third alternative to his mother. Samuel would meet with me on a daily basis (5x per week) in a psychodynamically informed, values-driven behavior therapy. He would work on a daily basis with Ethan, my co-author, who would perform a variety of functions:

1. Deal with the negative feelings regarding his diagnosis.
2. Emphasize the necessity of staying on medication.
3. Function in loco parentis when Samuel’s mother went away on business.
4. Prepare him intellectually for his final year of high school.
5. Ensure that his sleep schedule was regular and that he got up each morning at an appropriate time.
6. Drive and then accompany him to his psychotherapy meetings.
7. Work to reinforce the messages of therapy.

Ethan was uniquely qualified for this role because:

1. He had experienced a similar illness himself, had been in intensive psychotherapy and had participated in many support group meetings – which would be an important part of Samuel’s treatment program.
2. Ethan had functioned as an educational mentor with students in the field of computer science and software engineering. He also had experience training students in the use of different cognitive strategies to improve and reframe learning.

Early in treatment, Samuel felt hopeless, depressed and confused. In Samuel’s mind, he was no longer like his peers in school or the celebrities he idolized. He was sick,
he had a severe illness and a disability. Accepting this diagnosis would mean accepting the stigma that he and most people associate with it.

To help him arrive at this acceptance, weekly Depression and Bipolar Support Alliance (DBSA) pro bono support groups have become part of my treatment regimen. Through the support group, patients are able to observe that their diagnosis is not a lifelong sentence and that others have found ways of coping with the disorder’s impact upon their lives and on their image of themselves. They have come to accept the diagnosis and often have even become empowered by the challenge presented by the illness and the steps necessary to recover from it.

Each morning, Ethan arrived at 8 AM and initially woke Samuel up. This had to change. Samuel had to learn and internalize structure. The first aspect of this was getting Samuel to wake up on his own. This took several weeks to accomplish. Next, Samuel was gradually convinced that 1 hour of daily exercise would lift his mood. Ethan took him to the gym and guided him through each exercise until he was able to do them on his own. Then he was driven to his psychotherapy session, which Ethan also attended. The remainder of the day, Samuel and Ethan spent 4-6 hours in scheduled educational activities.

Initially, Samuel lacked structure in his life. He demonstrated little or no capacity to manage his time and viewed the process of learning as something so uncomfortable that it had to be rushed. As a result, he frequently retained little information. To address this difficulty, Ethan guided him through an online course called “Learning How to Learn” – a course intended to teach people a range of strategies to optimize their learning.

The medication which had been stabilized at the residential treatment facility was continued. After several weeks the risperidone was stopped. Samuel has been maintained on Depakote since then and his blood levels have been tested at regular intervals. Part of the treatment contract which Samuel agreed to was that he would avoid self-medicating with non-prescribed substances (e.g. marijuana, alcohol and amphetamines).

Rather than merely disregarding the content of Samuel’s psychosis, we decided to honor his vision of success and this proved to be helpful in the formation of a therapeutic alliance. We explored the specifics of what success meant to him. He wanted to be strong physically, mentally and emotionally. Consequently, we designed a program which placed appropriate expectations on him in all of these areas and we then discussed his performance both inside and outside of the therapeutic sessions.

The first and most important step in therapy was the development of trust. In Samuel’s case, this was a complicated transference issue since he had such a negative relationship with his father. His father attempted to establish contact with him early in treatment. I met with Samuel and his father once. After that, Samuel refused to have any further sessions with his father or see his father at all.

Initially, Samuel saw relationships as almost entirely transactional. He often spent his mother’s money without permission or consideration of consequences. It was reported by both Samuel and by his mother that he looked at others and asked himself, “what can they do for me?” rarely “what can I do for them?” This became an important focus of his therapy and his participation in the DBSA support group which provided an important opportunity for Samuel to recognize that the experience of “giving” was significantly related both to his recovery and to his increasingly positive feelings about himself. Furthermore, as Samuel began to change his view of relationships, he started to examine and gradually change his totally materialistic definition of success.

Gradually what emerged was a much more profound concept of success – “significance” (i.e. making a difference). As new, and particularly as younger members became a part of the support group, Samuel would reach out to them on a regular basis both in the group and outside of the group to share his experience of dealing with his disorder. In this process he learned to listen, to empathize and to identify with the pain of others and share his own pain.

Like many students in their final year of high school, Samuel’s goal was to gain admission to a university. As an art student, he was required to put together a creative portfolio of his work. The top tier universities required that he structure his portfolio such that it conveyed a theme or message. Although he had evident innate talent, his portfolio lacked structure, organization, theme or vision.

One of our goals was to help Samuel become more competent as it became apparent that this was the only way for him to achieve his vision of success. Unfortunately, he initially lacked both the motivation and the skills to achieve that goal. We viewed the creation of his portfolio as an opportunity to challenge him and he ultimately developed a portfolio and a number of other impressive projects.

Increasingly, Samuel worked with determination and consistency to produce quality and professional level photography and cinematography. He learned to create and edit videos and in a dramatic departure from where he began, he started seeking out mentors with a surprising degree of courage and lack of fear of either failure or rejection, as his pursuit of excellence took predominance over his prior preoccupation with instant success.

Samuel articulated that what he believed to be his path in the past had over the course of therapy changed dramatically. His definition of success became far more complex, nuanced and dynamic. He now saw success as significantly related to hard work and not something that could be given to him, but instead as something that he had to achieve himself. Perhaps the ultimate reward for Samuel and a measure of his personal and professional growth was his acceptance, after 8 months of treatment, into the highly competitive New York University’s Tisch School of the Arts.
Discussion

The strategy utilized in this treatment clearly and intentionally went beyond a syndrome-based approach to a far more comprehensive philosophy of care. This decision was based on extensive clinical and research data which has demonstrated that a simple focus on symptomatic removal in the bipolar patient merely sets the patient up for recurrence and relapse because no fundamental change has taken place in the individual.

Successful treatment, which we believe occurred in this case, involved a fundamental change in the patient’s systems of meaning and in self/other relatedness which ultimately resulted in a more adaptive and rewarding life trajectory.

Facilitating appropriate developmental maturation was our goal. With this in mind, we developed a highly individualized approach specifically designed for this patient. Our treatment represented a collaborative attempt to understand the meaning and hopefully modify those life patterns that interfered with Samuel’s ability to live a full and rewarding life.

The Wreckage Left Behind: Psychodynamic Approaches for treating Shame and Guilt in Bipolar Patients
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Bipolar Disorder, Type I is characterized by cyclical mood swings that include episodes of depression alternating with episodes of mania. The symptoms of the manic phase of the disorder are thought to be partly a result of an overactive limbic system, that overrides the executive functions and the inhibitory capacities of the frontal lobe.

Patients who suffer from Bipolar Disorder, Type I are often faced with a deep sense of shame in the aftermath of the impulsive and reckless behaviors that characterize this phase of the condition. Upon facing the wreckage that was left behind, the individual experiences deep feelings of shame that produce a desire to hide, to cover up, or to conceal, because the person falls short of the goals and aspirations of the Ideal-Self and experiences a sense of defect. These feelings of shame are often accompanied by feelings of guilt that emerge when the individual realizes that his or her reckless behavior has damaged other persons. The feelings of guilt emanate from a Superego that punishes the Ego for the transgressions of the Id and the individual experiences anxiety about the potential retaliatory consequences that may originate from inside or from outside of the person’s psyche.

In 1926, Freud described these four prototypical anxiety-producing dangers: 1) The fear of the loss of the object, 2) the fear of the loss of the love of the object, 3) Superego anxiety, or the fear of retaliation from within the person and 4) the fear of castration, or the fear of retaliation coming from an outside source. This article addresses how two patients who suffered from Bipolar Disorder, Type I worked in psychotherapy to overcome their shame and guilt and how, through atonement, they sought forgiveness from themselves and from others for the reckless behaviors that took place during the manic phase of their illness.

Case I:

Laura, a legal secretary, came to therapy for the first time when she was 27 years old and was finally diagnosed and successfully treated for Bipolar Disorder, Type I. During her late teens and early twenties, Laura had experienced periods of euphoria and increased energy. She frequented bars and dance clubs on weekends, where she consumed large amounts of alcohol, further exacerbating her expansive behavior. She became the life of the party and she told her psychiatrist that, “they used to call me the Dancing Queen, like the song from the musical group ABBA.”

On many of these nights Laura ended up leaving with men that she had just met and waking up in bed with them the following morning feeling that they were almost-complete strangers. This filled her with shame and contempt for herself. The worst part, she said, was that she found herself inexplicably repeating these patterns of behavior over-and-over again, “not knowing what the hell had come over me.” Laura explained that she felt, “dirty, like I was damaged goods.” She very much wanted to form a family and sadly wondered “if any decent man would ever find me desirable as marriage material.”

Over the course of two years in once-a-week psychotherapy, Laura revisited and confronted her past behaviors and, in the process, she re-experienced deep feelings of shame and guilt. She also began to learn more about Bipolar Disorder, how to control it, how to anticipate the advent of depressive or manic episodes and how to take better care of herself, including protecting her sleep and avoiding excessive use of alcohol. She also began, for the first time to mourn the death of her mother to cancer that had occurred when Laura was eleven years old. She narrated how her older sister took over the maternal duties and “did a pretty good job, considering the circumstances,” adding that it had been her older sister who had expressed much concern about her inexplicable and
self-destructive behavior and had pushed her to get psychiatric help.

Laura slowly began to forgive herself for all of her past reckless and promiscuous behaviors and to cut ties with the acquaintances that formed a part of her former night-life. Laura worked hard at making new friends and one day she went on a blind date with the son of one of the female attorneys in her firm who she considered to be her mentor. Laura began to date Leonard, the son of the attorney, and they fell in love, became engaged and eventually married. In the process of the courtship with Leonard, she struggled with bouts of self-doubt and questioned how “Leonard doesn’t seem to realize that I’m a liability and I feel like I don’t deserve him.”

Laura later learned that Leonard’s father, a successful attorney, also suffered from Bipolar Disorder, so Leonard was very understanding and accepting of her condition. It has now been more than ten years since her first visit to the psychiatrist and Laura is happily married and the mother of two young children. Other than some mood lability and irritability that took place during the two pregnancies, a time when she had to interrupt her medication, Laura’s condition has remained stable. She attends psychiatric visits once every three months and views the decade in which she was known as “The Dancing Queen” as a distant and embarrassing memory.

In the case of Laura, the atonement and forgiveness that took place in the work of therapy involved appeasing her own Superego. Since Laura had lost her mother to cancer when she was only eleven years old, she had not been able to fully work-through that loss. Most of the work in the therapy involved revisiting the death of her mother and re-activating a new, more mature process of mourning. In the course of this process, we were able to examine her Superego introjects and because the loss of her mother had occurred at a time when she was not yet developmentally ready to mourn, through egocentric causality she had unconsciously blamed herself for the death of her mother.

We also examined how this self-blame became apparent in her appraisal of the relationship with Leonard. In allowing Laura to re-visit and re-work the mourning over the loss of her mother, she was able to modify earlier, more punitive and accusatory Superego introjects and to replace them with more mature, loving and accepting ones. In this way, she was also able to atone and to forgive herself for the reckless behaviors that took place during the manic phases of her condition.

Case II

William, a 56 year-old, divorced, former business executive with a diagnosis of Bipolar Disorder, Type I came to therapy to explore whether his decision to become an Episcopal Priest was the correct one. William had been divorced for almost ten years and had two adult daughters and when he was working as a business executive, he had to travel extensively overseas, crossing different time-zones that exacerbated his mood swings and his irritability. At that time, he had not yet been diagnosed with Bipolar Disorder and was puzzled and embarrassed by his verbally aggressive tirades. William described how he frequently berated employees, raising his voice at them and “wounding them with words that cut like a knife.” As a result, he made many enemies in the company. He also engaged in compulsive womanizing and extramarital affairs during his trips abroad that eroded his marriage and caused tension in the relationship with his daughters.

William’s brash, inconsiderate and self-destructive behavior was counter-balanced by his tireless energy, his long working hours and his high levels of productivity, that impressed his superiors and made them choose to look the other way with regards to his cycles of unacceptable behavior. Upon turning 52, William realized that he no longer had the energy or the desire to continue his intense life-style. By that time he was already feeling lonely and alienated and was undergoing period of deep depression. For the first time in his life, he sought psychiatric help with another psychiatrist and was diagnosed with Bipolar Disorder, Type I.

At first, William felt relieved when he learned that there was a cause and an explanation for his erratic behavior and, once he started taking medication, he began to carefully analyze and to look back at his life. William was mortified by his blemished past-personal history and decided that he needed to make drastic changes in his life. He concluded that he had enough savings to be able to take an early retirement from the company. William also began attending an Episcopal church near his home and befriended the parish priest, who was impressed with William’s intelligence, his worldliness and his motivation to become more in touch with his spiritual-self. These conversations eventually led to his decision to become an Episcopal priest. He had never been particularly religious, but he found that religion offered him a type of solace and peace that he had never been able to experience before.

At the time I began seeing William in therapy, he had already been attending seminary and was only two years away from taking his final vows in order to become ordained as a priest. In his previous therapy and with the help of spiritual counselling from his professors at the seminary, William had already begun a process of atonement and search for forgiveness, principally from his daughters and his former wife, but also from former colleagues and business acquaintances. William initially rationalized that his decision to join the priesthood was based on a search for solace and spiritual contemplation.

In therapy, we were also able to explore further his other motivations to become a priest, that included a desire for atonement and an attempt at restitution to those who had been the victims of his past verbal, psychological and emotional abuse. This atonement and restitution would be done in a displaced form, or in William’s own words, becoming a priest was a way to “make up for all the crappy stuff that I’ve done to other people over the years.”

This sublimation and altruistic resolution to overcome his feelings of shame and guilt involved taking genuine re-
sponsibility for past wrongs and embarking on a search of forgiveness through giving back to others. In his new life, William’s mission became to, “spiritually heal others” as well as also healing himself in the process. He is now serving as a priest in the Lower Rio Grande Valley, along the U.S.-Mexico border, where his almost-perfect command of Spanish that he acquired in his travels as a former executive has proven to be a great asset.

Conclusions:

Experiences of shame and guilt following acts of aggression against others, or sometimes against the self, leaves the aggressor feeling alone, vulnerable, exiled, in moral-danger and at the mercy of a punitive Superego. The aggressor has lost the provisions of well-being, protection and security offered by the Superego and is then left with a need for “atonement,” a word that signifies “at one with…or in harmony with…” So, in a desperate regressive effort to maintain his psychological survival in the face of shame and guilt anxiety, the aggressor embarks on a mission to restore the lost relationship with the real, imagined or fantasied internalized object that plays the role of the disapproving parent or victim in the aggressor’s representational world.

Seeking forgiveness emanates from a capacity for remorse and a capacity to feel for the victim, so in order to atone and seek forgiveness, it is necessary for the aggressor to possess a capacity for empathy that allows the individual to experience compassion and concern for the well-being of others. The perpetrator seeking forgiveness must genuinely own the responsibility for the wrong not only privately, but also sometimes in public form, because atonement taken on the victim’s behalf represents a type of “revenge against the self.”

The aggressor seeking forgiveness must tolerate humility, because by admitting guilt, expressing remorse and asking for forgiveness, the aggressor is creating a shift in the power differential. Now the atoning, remorseful and repentant aggressor no longer oppresses the victim, but instead the victim has become “one-up on the aggressor.” In assuming this position of humility and owning the responsibility for the wrong, the past impulses of cruelty are turned into compassion for victim, as the aggressor seeks forgiveness by magically becoming “one-with-the-victim.”

In terms of the victim, forgiveness cannot be granted until the perpetrator has earned it, and when the victim receives an apology, this adds to the perceptual clarity of the victim’s ego and acknowledges the reality that a wrong has been committed. An apology filled with remorse, humility and repentance, and with a promise or attempt at reparation or restitution on the part of the aggressor, facilitates mourning on the part of the victim and helps the victim experience concern for the opponent. Forgiveness emanates from the identification with the kindness of the parents and the need of the individual for the survival of the object.

In essence, the atoner recognizes that a wrong has been committed and that the perpetrator wishes to restore the pre-existing relationship. Once forgiveness is received, the next step is acceptance. Literary fiction is replete with novels in which a perpetrator shares the secret of his guilt with another person, depositing in the other person the critical Superego function of self-punishment. In therapy, the patient deposits the secret of his guilt on the therapist and this offers the therapist the opportunity to begin the work of therapy with the patient. Object Relations Theory offers an important theoretical guide that can serve as valuable tool in the work with these patients.

In summary, every individual’s Superego structure is different and complex and is composed by the combination of temperamental factors, relationships with the person’s early attachment figures, life experiences and cultural influences. Similarly, the work of atonement and the search for forgiveness, either from an external object or an internalized object, is a multiply determined process of compromise formations that take place once the aggressor identifies with the victim and attempts to repair the damaged object and his relationship with it.
the spy. Psychologists in the intelligence services of the USA have traditionally invoked MICE- Money, Ideology, Compromise, and Ego - as driving forces of the person that becomes the spy.

I proposed that a spy’s traits of sociopathic/psychopathic personality must have their origin in divided loyalties growing up. I began to imagine the spy’s psychological development in childhood in the midst of his family. Likely there were children with a conflict of loyalties created by very dysfunctional parents who forced the child to choose between antagonistic desires and interests.

I asked myself and my profession, “what is the origin of loyalty?” and I answered that it originates in the loving relationship of mother and child, which is then transferred to the family group, to community, and society. Broken mothers, defeated mothers, abandoning mothers threaten the healthy growth of loyalty in their children. Violent fathers, authoritarian fathers, manipulative fathers threaten the development of loyalty in the children as well.

When father and mother are engaged in constant fighting and the child feels forced to side with one or the other in a pendular fashion the result is a sense of constant loyalty and disloyalty. Reading the autobiography of John Le Carre and his biography by Adam Sisman, I found that this was true in his case.

Of course, in the life of Le Carre, the dilemma of loyalty was not just about his mother and father in different “enemy camps,” but it was more complicated, as these things usually are. It was the conflict of his mother and then his German-Jewish caretaker versus his despotically, user, manipulative, egocentric father. As stated before, loyalty and disloyalty are at the core of espionage not only as a moral issue but at the base of tactics and techniques.

All spies are double spies because to enter the field and live of the subjects of his endeavors, the spy necessarily begins to feel attracted to them. In order to be convincing, this attraction needs to be genuinely felt as a matter of tactics and techniques. There is a moment in which the perfect spy becomes enamored of his target and sees life and the world also from his point of view and with his eyes. This creates enormously confusing emotions, which are best described by Le Carre in The Perfect Spy. The study of loyalty dialectically implies the study of betrayal. Le Carre says “evasion and deception were the necessary tools of my childhood and adolescence. I was a veteran master of them.”

Another motivation for the spy is the powerful attraction of secrets. The spy novel is such a popular genre, because it exploits our natural attraction to secrets. All human beings have this as part of our developmental psychology because we all have gone through what Freud called Oedipal Stage around the age of five. The five-year-old has just discovered secret parts of the body, the silences and secrets around sexual issues, and has the powerful drive to see what happens in the parent’s bedroom at night. Perhaps he has caught a little of the secret of what Freud calls “primal scene” when he enters the parents’ bedroom while they’re making love. Curiosity is at the root of all science and all knowledge. Curiosity is the fundamental human positive drive that channeled appropriately, leads to all progress and to all discovery. However, curiosity can also be a destructive emotion when it becomes an addictive drive to find out “secrets” by destroying its object.

In the case of John Le Carre, who did not defect to the enemy and actually completely left the field of the intelligence service, his few traits of sociopathic/psychopathic personality, were originated in a successful adaptation to the very authoritarian regimes of schools, military academies, and the relationship with his egomaniac father. He came from the background of a cold, broken and disloyal home with a defeated, broken mother and broken female caretaker figures whom he nevertheless deeply loved.

For Le Carre, as he tells us in his fascinating autobiography, the way to survive his divided loyalties and the relationship with his psychopathic con man father was through acquiring some of the “trade of con and lying.” Very often disloyalty is an art and trade that is learned from role models. In the case of Le Carre, his father was a con artist with a very charming, charismatic personality who made fortunes from betraying admirers (women and men) who put their trust in him and who believed in his grandiose persona. His promises of making these people rich through his financial adventures always ended in bankruptcy and, a couple of times, in prison. In childhood and adolescence, Le Carre’s father was not just a role model, but actually a teacher and mentor in the art of relating, attracting, and betraying his victims.

John Le Carre made a career out of his knowledge of the German language. He acquired his knowledge of German through his father’s mistress and caretaker, Lipsy, who protected him, consoled him, and very much played the role the role of a mother. She was of course one of the many women that his father destroyed and, ultimately, she committed suicide, inflicting a big trauma to his young mind. German language and love of the German culture since an early age in his life was, of course, a treacherous trait for a British gentleman and even though he refers to it as an attraction that he doesn’t quite understand, it is very clear that as a young boy was one of the many ways of deep rebellion against his father’s aesthetics and pretensions of Britishness and the Anglo-Saxon misogynist structure.

An important aspect of this autobiography is how Le Carre was “healed” from his extreme difficulty to commit to loyal relationships and to get out from the profession of spying. He attributes this veritable therapy to his first and mainly his second wife and to his children. “My sons were my teachers and healers.” In the autobiographical novel, The Perfect Spy, Magnus Pym, his character, cannot de-tangle himself and commits suicide at the end as an act of tragic loyalty to both his antagonistic allegiances. On the one hand, the main character loves and feels profoundly loyal to his children and country and, on the other hand, he loves and feels loyal to his friend of adolescence, Alex, a
Czechoslovakian man and spy of the Eastern Bloc whose activities are not motivated by money but by a strong ideological commitment to socialism.

In real life, fortunately, Le Carre did resolve his conflicts of loyalty and at the ripe age of 84 he regales us with his magnificent memoir full of psychological insights and beautiful, poetic language.

The Red Book of C.G. Jung: A Journey into Unknown Depths, Walter Boechat, M. D.
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Book Review by Alvaro A. Giraldo M.D., Senior Jungian Analyst

The Red Book of C.G. Jung describes and illustrates Jung’s most intimate experience in confronting his unconscious. Jung relates that experience in a series of active imaginations in which he dialogues with figures that appear from his unconscious. The Red Book is an oversized, red leather-bound and richly-colored volume that Jung calligraphed to give it a medieval look. Written in German, its content is based on notes that he kept in his Black Books since 1902. He stopped work on the apparently unfinished Red Book in 1959. Jung circulated at least parts of this book among his friends and Jungian analysts. However, it was finally decided that the book would not be published during his life, because its contents could misrepresent Jung as being mentally unstable. The book remained in a vault for many years until the Philemon foundation approached the curator of Jung’s library in Switzerland. Jung’s grandson then granted permission for the book to be carefully photocopied for publication in 2010. The Red Book is accompanied by an English translation made by historian and Jung scholar Sonu Shamdasani. This book was later translated into Portuguese by Walter Boechat, M.D., a psychiatrist and Jungian Analyst from Brazil and the author of the present book.

After translating The Red Book into Portuguese, Dr. Boechat wrote the present book in which he offers some order and structure to facilitate the reading of The Red Book. Otherwise, non-Jungian readers might find it a chaotic collection of figures and dialogues somehow relevant to Jung’s encounter with the depths of his unconscious. Using his background as a Jungian analyst, Dr. Boechat includes his own account of the inspiration that he found in The Red Book.

Dr. Shamdasani provides a preface to Dr. Boechat’s book, and its first chapter serves as an introduction and relates historical events surrounding The Red Book. In this initial chapter Dr. Boechat defines the purpose of the book as offering a way to raise important issues that enhance our understanding of Jung’s work as well as his unique way of confronting his unconscious. In the second chapter, “The Gestation of the Book,” the author weaves the historical events of Jung’s life as detailed in Memories, Dreams, Reflections (1963) with the origins of The Red Book. In this chapter, he explains the origins of Jung’s midlife crisis and associated events. In the third chapter, “The Structure of the Book,” Dr. Boechat addresses the medieval structure of the book as symbolic of the introspective silence of the Middle Ages. In this chapter, he deals with the process of the creation of The Red Book. He shows that it is based on Jung’s notes in the “Black Books,” which have been carefully revised, edited, and illustrated to form a collection of spontaneous active imaginations.

The author uses information from Memories, Dreams, Reflections as well as Jung’s Collected Works and concludes that Jung’s intention was to let us know that “in the middle of the journey a time for reflection emerges, a descent leading to a renovation.” Dr. Boechat argues that later formulations found in Jung’s writings emerged from his experiences and communications with his inner images. Jung’s concept of the two types of thinking that he described in Symbols of Transformation, the linear and circular thinking, act as ways that lead to the dialogue of consciousness with the unconscious powers in the psyche.

Chapter four, “Heroism and Heroes in The Red Book,” details the descent into the unconscious and the motif of death and resurrection. These motifs lead to Jung’s visions and images where the hero appears in different forms. The hero’s fall and the appearance of the trickster as a compensatory principle provide the psyche with a chance to renovate and for the repressed to be manifested. The restoration of the hero takes place through a non-verbal approach to express unconscious content used by Jung through the images of Siegfried and Izdubar. Chapter five, “The Limits between Creativity and Madness” deals with the process of becoming immersed in the unconscious. In this chapter Dr. Boechat explores the main theme of The Red Book, and he gives an insightful analysis of Jung’s experiences. The watershed area between the “psychotic” and “normality” (a fiction) during the exploration of the unconscious is masterfully described in this chapter. The presence of reality, pragmatism, and contact with worldly matters is a balancing act that is carefully and succinctly addressed.

Chapter six, “New Perspectives in Jungian Clinical Practice,” attempts in part to fulfill one of the main objectives of this book. It addresses the future of Jungian psychotherapy by applying the contents and concepts found in The Red Book. One would expect this chapter to be one of the last chapters rather than in the middle of the book. Nonetheless, it addresses important themes such as the concept of The Transcendent Function and the process of symbolic integration. The Transference/Countertransference and the process of confrontation with the inner images of the unconscious, a process that Jung called Active Imagination, facilitate this process. Four verbs define it: empty (the mind), let go (of the conscious), impregnate (the conscious
with the unconscious) and confront-ethically (avoid identification with internal images).

Chapter seven, “Legacy of the Dead,” discusses what the author calls “the intense presence of the dead in The Red Book.” It uses “dead” experiences in the life of Jung that were described in his Memories, Dreams, Reflections and some writings from the Collected Works. He uses this material to analyze the symbolic interpretation that Jung gives for the “dead.” Chapter eight, “The Search for the Center,” is dedicated to the explanation of the mandala as a symbol of the Self, the center and totality of the psyche. It describes the calming effect on emotional anxiety and the, always present, inward direction from the periphery towards the center. It points out that mandalas that appear in dreams and phantasies are usually simpler, not always in a circular form, and appear during the psyche’s search for centralization and ultimately for totality. At times, they appear also as a compensation during times of psychological crisis. This chapter includes a detailed analysis of Jung’s drawing of his first mandala in 1916, the Systema Mundi-totius and his search for the roots of his spirituality.

Chapter nine, “Philemon,” deals with the equivalent of a Guru in Indian religion. This figure appears in Jung’s psyche as the principle of reflection that he describes as the “archetype of the spirit” and as an unfolding of the figure of Elijah that he initially encounters in the early pages of The Red Book. Philemon is Jung’s inner teacher, the Wise Old Man archetype. This is the figure usually projected onto the analyst during the early stages of the transference. Once internalized, he appears as a guidance principle. He provides a detailed analysis of this figure with its wings of a messenger but with a face much like Jung’s in old age. Chapter ten, “Final Conclusions,” deals with the time after the author has visited, reflected, and, in part, organized the themes addressed by Jung in The Red Book. In his book, Dr. Boechat makes an effort to find the practical value of The Red Book in contemporary Jungian Analysis.

After reading this book, I remembered Jung been quoted as saying “My work will not end when I die, it will be continued by those who suffer.” I believe one of the reasons why I enjoy reading Jung so much is because I can feel his struggle as he attempts to dig line by line deeper into both himself and the unconscious. He relentlessly continues this in the pursuit of objectivity, in spite of his self-confession and underlying awareness of the impossibility of any real objectivity. Yet in spite of this, he still searches. It is his rare unflinching ability to continue to suffer in the midst of this paradox that I admire. I often have to remind and encourage myself to move down the same road after countless moments of weakness. His writings serve as a quiet declaration to me to continue to work hard.

Dr. Boechat certainly achieves the same spirit in this very well-written book. I do not sense the same sweat and struggle in other writings. Instead, I tend to see someone comfortably staring at an already discovered aspect of the psyche, of the collective unconscious, or simply describing their own reflections. I highly recommend this book to anyone as a beautiful guide that decides to the dive in to their own unconscious through the experiences that Jung found in the pages of The Red Book.
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