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**Cover Photo by David L. Lopez, MD**

“Sex & Oreos” (2017), from the Sigmund Freud Park in Vienna.

In the image you can appreciate the statue titled “The Broken Globe”, by Karl Anton Wolf (1975) with graffiti by an unknown artist (2017). The Votive Church is in the background, a neo-Gothic church built in 1853 by order of Emperor Maximilian I of Mexico, brother of Franz Joseph I, Emperor of Austria.
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 of the American Academy of Psychoanalysis and Dynamic Psychiatry including medical students, psychiatric residents, academic psychiatrists, research psychiatrists, psychiatrists in private practice, and psychiatrists working in the public sector.
4. Articles should be educational, new, informative, controversial, etc. Adequately disguised case vignettes with an informative discussion are welcome.
5. Although we edit and proofread all articles, PLEASE spellcheck your document before submitting it for publication. Be especially careful with names and titles.
6. Please use a word processor such as Microsoft Word and do not attempt to do fancy formatting. It does not matter whether you use a PC or a Macintosh computer. Do NOT use old, outdated programs as we may not be able to open the files.
7. Any photographs being submitted for publication must be clear and have excellent contrast. Please include a note with names of people in the photo or a description of what it shows.
8. Electronically created images should be in JPG format at 300dpi. JPG formatted images should be actual size or larger. Small JPG images will distort when enlarged, but larger ones look fine when made smaller.
9. Since editing submissions for publication is time consuming, we ask you to:
   a. Never use the space bar more than once in succession. This includes at the end of a sentence after the period.
   b. If you want more than one space, use the tab.
   c. Space once before or after using a parenthesis. For example: (1) Freud or Freud (1)
   d. Space once before and after using a quotation mark. For example:
   John said, “Your epigenetic model was spot on.” Then the research ended.
   e. Any articles that contain pictures of any kind must include the actual picture file in addition to the article.
   f. If something comes up at the last minute, call or email to see if you still have time to submit your article for that issue.

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

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The Academy Forum is a journal of news and opinion published by the American Academy of Psychoanalysis and Dynamic Psychiatry. Opinions expressed in the Academy Forum are not necessarily those of the Executive Council and do not represent the official policy of the Academy.

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: Gerald P. Perman, M.D. at gpperman@gmail.com.

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Dear Angela,

How lucky you are to have accepted the Editorship of the Academy Forum!!!

The Academy is a fantastic organization for a multitude of reasons and, being Editor of the Academy Forum – I can think of little better than that!

You asked me to write something about my 10 years as Editor and, after giving it some thought, I decided to let you know how I did things that might be helpful to you going forward.

First, being the somewhat obsessive person that I am, I tried to stick closely to deadlines and to the publication schedule of the Forum. When I would solicit articles from members, either contacting them directly one-on-one, or sending a blast email using the member list-serve, I would let potential authors know what kinds of articles I was seeking, the word-length range for articles, and by when I would need to receive their submissions. Another treasure trove of potential authors would be presenters at our annual meetings. Almost immediately after each meeting had ended, I requested a list of all of the presenters and their email addresses from Ms. Marie Westlake and I would email most of them, letting them know that I was interested in a written form of their publication for the Forum, if it was not destined to be submitted to Psychodynamic Psychiatry or another publication.

As you know, the first half of the Forum has contained communications from our president, program chairs, etc., and I would try to give these folks about a six-week deadline to receive their articles. Almost none of these individuals ever turned down a request from me! It’s your option, of course, whether you want to continue to organize the Forum in this way going forward, and you’ve shared a number of exciting ideas about possible new initiatives!

Second, I considered each submission to the Forum as a precious gift that needed to be treated with the utmost respect. I took great pains to let each potential author know that I was accepting her or his emailed contribution “for consideration only” for publication, and not as a fait accompli, to not allow hope to rise unrealistically. Since the Forum publishes a wide range of articles and opinions, I wanted to accept everything our members sent me. If the article was poorly written (infrequent, but this did happen), I sent the piece back to the author with suggestions for revision. If I believed that the topic was too far removed from what I thought would be of interest to the highly erudite and astute members of our psychodynamic organization, this could be a reason for rejection. I always replied to potential authors immediately upon receiving their submission, letting them know that I received it, when I expected to have time to read it (I read all articles immediately upon receipt, if possible), and when the person could expect to hear back from me. This because each of them had entrusted their precious young child, so to speak, into my care, and I needed to let them know that their offspring was safe and in good hands!

I probably turned to the Forum Editorial Board much too infrequently. I sometimes sent a sanitized (removing the author’s name) copy of the article to the members of the Board for their opinions, and to help with editing. Some authors were such excellent writers and thinkers that I knew, as soon as I received their emailed attachments, that their articles would require virtually no editing and would be of considerable interest to our readers. I won’t say who these authors were, since to name them could risk making some of the other fine contributing authors feel envious. But, if I was to name them, and their last names happened to be Chessick, Schwartz and Bacciagaluppi, I could not be accused of being a liar. I too have contributed an article or two to the Forum over the years, and I refrain from putting myself into their category. Astrid Rusquellas, Elisabeth Frischauf, Joe Silvio, Cesar Alfonso and Ron Turco, among others, have graced the covers of the Forum with beautiful and thought-provoking artwork during my ten-year tenure (nice alliteration, if I do say so!).

Third, I worked closely and well on the Forum with several members of the Academy staff over the years. In recent years, Ms. Marie Westlake has been the dedicated Academy Forum staff member to work with me. I cannot say enough good things about Marie and what a pleasure it has been to work with her. She has a light sense of humor that I’ve always enjoyed, she is ridiculously efficient, and I have joked that she has often replied to my emails before I clicked the “send” button. Marie has interacted seamlessly between me and the printing company the Academy uses (we acquired a new one about a year ago) to get the Forum to press and mailed out to our members.

Fourth, being Editor of the Forum has been a great learning experience! I think of it as having been a part of my “non-accredited CME activities” over the years that has given me the opportunity to read many interesting and informative articles. I also need to take my hat off to the Forum Editor before me, Mims Cohen. Mims was an excellent mentor. In particular, she introduced me to E. B. White and William Strunk, Jr.’s The Elements of Style. Originally written by William Strunk, Jr. in 1918, and now in its Fourth Edition, it was a tremendous help over the years, and I have recommended it many times to psychiatric residents I have supervised to help them improve their own writing abilities. I mentioned this book to you soon after we first met, and you immediately expressed your familiarity with it. Only later did I learn that E. B. White was also the author of the beloved children’s book, “Charlotte’s Web.”

So, enjoy your time as Editor. You know where to find me if, for any reason, you need me.

Warm regards,

Jerry Perman
This is my first message as editor of the Forum. All I can say to my predecessor Dr. Gerald Perman at this point is that he made it look very easy. The Academy Forum is a publication that is different from a newsletter or a journal and the work of the editor is different too. In preparing to serve as editor I asked myself the question: what does an editor do? My answer to that question is below in an opinion piece of the same name. But now it is time to preview the offerings of this issue.

In her President’s Message this fall, Dr. Downey reports on the two news items from the executive committee meeting in San Diego: where we stand with respect to the name change and news about an exciting proposal by the American College of Psychoanalysis to join with our organization. In the Articles section Dr. Douglas Ingram introduces us to the Psychoanalytic Consortium. His article works well as an orientation to this important body. As one who sometimes finds the workings of organized psychodynamic psychiatry and psychoanalysis opaque, complex and difficult to map, both Dr. Downey’s description of the College and Dr. Ingram’s overview of the Consortium offer welcome clarity. Dr. Gene Della Badia headed the Program Committee for the 2016 meeting in San Diego. I served as his understudy. We wrote a report on the meeting together. Next, we have the preview of coming attractions for the upcoming New York meeting in 2018. The Program Committee is headed by Drs. César Alfonso and Javier Jimenez. The theme of the meeting is timely: Pain and Distress: Psychodynamic Aspects and Collaborative Models of Care.

The mission of this magazine has been to provide a place where members can develop pieces for publication. In this issue Dr. David Lopez writes his first article on how to write for publication. His piece is based on his presentation at San Diego. We look forward to hearing more on this topic in future issues. Along a similar vein Dr. Perman’s article on his favorite analogies explores the uses of analogy in treatment.

Dr.s Greg Mahr and Jamie Sweigert’s piece on Factitious Disorder was also developed from their presentation in San Diego. The article explores the complex countertransference issues that arise in working with patients who feign illness for no other purpose than to enact the patient role. The paper explores challenging developments in the literature around the issue of sadomasochistic enactments between clinicians and family members on the one hand and the patients on another. In our Book Review Section Jo-Ann Elizabeth Leavey, NP, EdD, C. Psych. reviews an interesting work on the interrelationship between mind and body in memory and depression. The review provides another interpretive framework for understanding the meaning of patients’ physical and neurological symptoms. Dr. Fructuoso Irigoyen-Rascon writes a reflection on a topic that will be familiar to almost every mid and late career psychiatrist: the suicide of a patient starting with the paradox of the patient who seems to get better just before they kill themselves without warning.

In our Book Review Section Dr. Cassandra Klyman reviews a new book about Winnicott and the contemporary understanding of the interface between play and reality. Dr. Klyman’s review of the work provides us with a very useful summary that describes how psychodynamic psychiatry and psychoanalytic theory has evolved with respect to these phenomena in the decades since Winnicott first presented his ideas. Dr. Michael Blumenfeld - Past President of the American Academy of Psychoanalysis and Dynamic Psychiatry, reviews Cinema as Therapy in a way that in fact corrects a major short coming of this book. The book in question assumes knowledge of the films reviewed. Dr. Blumenfeld starts his review by providing us with a list of the relevant films so we can watch them before reading what is otherwise a book that will be of interest to many. Dr. Ron Turco reviews an important monograph on the organization of the psychotic core from the perspective of the interplay between genetics, environment and fantasy. Finally, music, like language, narrative and cinema are of special interest to Forum readers if past publications serve as a guide. In this issue Dr. Astrid Rusquellas reviews what sounds like an intriguing book on brain science, music and obsession.
Dear Academy Members,

Since becoming President of the Academy in May of 2016, I’ve made an effort to use these Forum and Newsletter messages to share important developments in our organization. Today I’d like to share with you news of recent decisions of the Executive Council. As you know, Council consists of Academy officers (voting members) and certain individuals who serve the Academy in other ways such as Editors of our publications, as Chairpersons of committees. Past-Presidents may also attend. Only the officers can vote, however. The Council Meeting takes place in May before the official Annual Meeting begins. A second Executive Council meeting occurs in the Fall. After the May Council meeting our Annual Conference usually begins the same evening with a plenary address, followed by a reception. This year Eric Plakun gave a wonderful talk, “The Difficult Patient: Making the Alliance, Taking the Transference, and Facing our Vulnerabilities.”

At the Council meeting this year we had two big things on the agenda. The first was the renaming of our organization. You will remember that last summer the membership voted overwhelmingly in support of a Bylaws amendment to change our name to the American Academy of Psychodynamic Psychiatry and Psychoanalysis. We changed the name in two ways: “Dynamic Psychiatry” was changed to “Psychodynamic Psychiatry” because Psychodynamic has become common usage whereas the term Dynamic could mean many things to non-psychoanalytically trained people. Secondly, we have now put Psychodynamic Psychiatry first in our name before Psychoanalysis. The decision to do this reflects our belief that Psychodynamic Psychiatry is the broader term. Psychodynamic Psychiatry encompasses concepts from psychoanalysis such as the importance of development in the formation of the personality, the power of the dynamic unconscious as a motivator of human behavior, and the value of understanding transference and counter-transference to enhance clinical treatment. Psychodynamic Psychiatry, however, derives information and insight from other sources as well - from neuroscience, from academic psychology and psychiatry, from research, from psychopharmacology, and from descriptive psychiatry. Psychoanalysis remains in our title, not just because of historical reasons (our organization began as a group of psychoanalysts and many of us underwent rigorous psychoanalytic training), but because it provides vital intellectual bedrock for the larger field of psychodynamic psychology. When the Task Force to consider a Name Change for the Academy met, the members were unanimous that Psychoanalysis needed to remain part of our name. Psychoanalysis—to use the jargon of our time—is part of our DNA.

Once the membership had approved the new name for the Academy, it was necessary for us to engage a lawyer and change our Articles of Incorporation to reflect our new name and address. At the Business Meeting of the Academy on the Saturday of the 2017 May meeting, by unanimous vote, we approved these Articles. It will be just a few months now until the title of our Academy becomes the new one—The American Academy of Psychodynamic Psychiatry and Psychoanalysis.

Another important change is afoot at the Academy. In June of 2016, the American College of Psychoanalysts approached us about possibly joining with our organization. The College is an honorary group of medical psychoanalysts who hold a very interesting conference each year. Although a number of Academy members (25) also belong to the College, usually we were not able to attend both meetings as they occurred on the same days. In any case, the College with about 65 members found that it was not feasible to continue to maintain a separate organization. They embarked on a search for another psychiatric group with which to join forces. Leadership of the Academy (Drs. David Lopez, Eric Plakun, and I) thought that our organization might be a good fit and invited them to make a proposal to us.

Fast forward to December 2017 when the College came back to us suggesting that we consider joining their organization with ours. With Drs. Doug Ingram, Richard Friedman, and David Lopez as our negotiating team, a series of conversations took place; and a memo of understanding was created proposing how the College might join us at the Academy. In May, our Executive Council approved this proposal, and the College’s leadership also voted to move ahead.

I have myself been a member of the College for many years. I know the organization to be small, but the members are highly capable senior psychoanalysts who put on thoughtful and compelling meetings. Like us, they are concerned that psychodynamic teaching is falling out of psychiatric training programs and last year started their own distance-learning initiative for early-career psychiatrists. Financially they are not in debt and will bring some funds which will be available for special projects.

It is my belief that the Academy will benefit from this partnership. We will be joined as one organization under our name—American Academy of Psychodynamic Psychiatry and Psychoanalysis. We will gain a group of sophisticated members to make a bigger “critical mass” of psychoanalysts in our Academy. We will have new members to join with us in the many exciting projects we have going on in the Academy now. The history of psychoanalysis is one of conflict with groups dividing and forming smaller groups. In this case, I am delighted to report that we are doing the opposite—we are joining forces to become more effective. We are coming together, not splitting apart!

There are a number of details of a legal and administrative nature currently being worked out. I will keep you informed.
Pain and Distress: Psychodynamic Aspects and Collaborative Models of Care

Program Co-Chairs: Xavier F. Jiménez MD, MA and César A. Alfonso, MD
Chair of the Scientific Program Committee: Joanna E. Chambers, MD
CME Committee Chair: Silvia W. Olarte, MD

SUBMISSION DEADLINE IS OCTOBER 15, 2017

Introduction:

Patients seek help and healing when they experience pain and suffering. As physicians, we are tasked with assessing, treating, and alleviating symptoms, and yet the predominantly medical model we work within often focuses solely on biophysiological drivers and solutions. However, many will feel only partially attended by this approach, and refractory pain and distress often persist when inadequately addressed by the biomedical model. We are faced with a strained, ineffective, costly, and at times dangerous medical system, resulting in isolation, alienation and disability. Providers are also suffering from burnout and disillusionment while practicing rigidly and defensively. When a dissatisfied, afraid, fixated, or overwhelmed patient with persistent symptoms is in our care, we must explore deeper psychodynamic forces causing, fueling, or maintaining pain and distress. And when strained physicians, colleagues, and trainees are distressed by our care options, we similarly must consider dynamic approaches and creative solutions.

The questions generated by these dilemmas are many: What is a given patient’s core or underlying pain? Does physical pain (or any other “medical” symptom) often or always represent more? What intolerable experience is informing the preferable yet painful current presentation? And how do these surface manifestations change over the lifespan? Beyond physical pain, what is there to be done about the pain of loss, shame, rejection, isolation, disability, and helplessness? And what function does distress serve? In such distress, what is being communicated, in what manner, in what context, and for what reasons? We may argue that the human experience - behaviorally, attitudinally, cognitively, emotionally - all stems as a tangled reaction and consequence to primordial pains as well as accompanying distress. Cultural idioms of distress vary widely and must be understood in a sensitive and sensible way. Interoceptive awareness modulates the perception of nociceptive and neuropathic stimuli, and mentalization and the dynamics of self-other boundaries are important to understand experiences of pain and distress.

This year we examine the role of psychodynamic psychiatry in elucidating and alleviating the many protean presentations of both pain and distress, not only in our patients but also in ourselves as healers. Psychodynamic psychiatrists may be equipped to lead collaborative care models and liaise with other physician specialists to properly care for patients with complex multimorbidities.

Program:

We would like to explore how psychodynamic psychiatry can be helpful with pain and distress of many types and presentations. We are seeking submissions that address psychodynamic drivers of chronic unrelenting pain or other medical/physical symptoms, latent forces behind psychological distress, defenses and coping behaviors related to pain and distress,
personality organization and how it informs pain and
distress, transference and countertransference reactions
emerging from work with pain and distress, and implications
for training and supervision. We will also welcome
presentations describing collaborative models of mental
health care that are psychodynamically informed and could
be practically implemented to better serve patients with
complex multimorbidities, chronic pain and distress.

Our opening night speakers will include introductory
remarks by Joanna Chambers, AAPDP chair of scientific
programs, and Jennifer Downey, AAPDP president, who
will describe the strategic position of psychodynamic
psychiatrists in the care of patients with complex
multimorbidities. Helen Herrman, president-elect of the
World Psychiatric Association, will present in some detail
the WPA Action Plan and public health agenda and discuss

Forms for abstract submission can be downloaded from the AAPDP website (www.AAPDP.org) or contact the
Executive Office at info@AAPDP.org or 888-691-8281 for assistance.
WE HOPE TO SEE YOU IN NEW YORK IN MAY!

Psychodynamic Psychiatry and the “Difficult” Patient
61st Annual Meeting of the AAPDP
Eugene Della Badia, DO and Angela Hegarty, MB BCh
Meeting Co-Chairs

The American Academy of Psychoanalysis and Dynamic
Psychotherapy held its 61st Annual Meeting May 18-20,
2017 at the Hilton San Diego Bayfront Hotel. Exploring San
Diego was a must. We were a short walk from the historic
“Gaslamp” District with its renowned restaurants and shops.
Visiting Balboa Park and San Diego’s historic Seaport and
Zoo were on the agenda for many of those who attended.
Others stayed at the hotel and enjoyed the beautiful spa
and pool with its magnificent views of San Diego Bay and
Coronado Island.

We had 140 registrants for the conference. We had
attendees from 27 states in the United States, as well as
Canada, Germany, the Philippines and the United Kingdom.
They came to explore working psychodynamically with
difficult situations, difficult systems and difficult therapists
that contribute to the problems with our patients. The sharing
of cases was incredible and the atmosphere extremely
supportive. One of the real values of our programs is the
willingness of the participants to openly share their triumphs
and failures so all may learn. We would like to thank all the
presenters for an outstanding effort. We would also like to
applaud the work of the Academy staff especially Jackie
Coleman and Marie Westlake whose work made this meeting
possible. The Program Committee under the direction of
Joanna Chambers, MD was extremely helpful with their
suggestions and guidance. Looking back there was only
one problem: there were too many excellent presentations
running at the same time. Our greatest challenge continues to
be an abundance of riches!
San Diego Meeting (continued from page 9)

The program opened with Eric Plakun, MD setting the stage for the entire program. He discussed the difficult patient from his vast experience at Austin Riggs. He shared cases and recent research which clearly showed the efficacy of psychodynamic work with these patients. He emphasized the ability to manage the transference and deal with our own vulnerabilities. An elegant reception followed, on the terrace outside the Hotel, where participants had a chance to discuss the evenings presentation and reunite with old friends and colleagues.

The Friday morning program began with a three-hour panel discussion on the assessment and treatment of Borderline Personality Disorder from a psychodynamic perspective. This comprehensive and scholarly presentation was given by Richard Friedman, MD, Jennifer Downey, MD and Michael Stone, MD and was very well received by the membership. At the same time, a paper session was chaired by Marianne Cohen, MD on different ways of looking at difficult patients. Papers were presented by Nadia Friedman, MD, Joseph Kugler, MD and Helen Ulrich, MD which lead to a lively and informative discussion.

Later in the morning there were two workshops. The first presented by Jeffery Smith, MD on a novel approach to transference with difficult patients. In the second Richard Brockman, MD used his literary and theatrical knowledge to discuss Medea as a difficult patient. At the same time Joseph Silvio, MD Chaired a paper session and discussion on difficult situations with difficult patients. Papers were presented by Ronald Abramson, MD, Briana Locicero, MA, read by Joseph Silvio, MD ) and Gregory Mahr, MD.

Friday afternoon began with a Plenary session delivered by Mardi Horowitz, MD on personality growth in psychotherapy. He discussed how long-term psychotherapy would improve emotional control, self-concept and capacity for relationships in our difficult patients. This was followed by a paper session on difficult situations that effect working with difficult patients. This was chaired by Richard Brockman, MD. Drs. Reimer Hinrichs, Douglas Ingram and Elizabeth Haase, presented papers. The remainder of the afternoon was filled with four Workshops. Juan Condemarin, MD and Antonio Bullon, MD led a discussion on the successful integration of clinical care inpatients with complex psychiatric, medical and substance abuse conditions. Sheila Hafter Gray, MD with Drs. Soniga Hirachan, Frooq Mohyuddin and Cristina Secarea discussed the ethical challenges in supervision: How can we balance education and clinical requirements. Eva Szigethy, MD and Sylvia Olarte, MD revisited cognitive psychoanalysis with some modern twists.

David Lopez, MD and Allan Tasman, MD talked on writing short clinical vignettes for publication. Dr Tasman who is the editor of Psychiatric Times would like to publish short articles from our membership. If anyone is interested these could be submitted to Dr. Lopez for review.

The day ended with a presentation by our Keynote Speaker Glen Gabbard MD who is well known to members of the Academy. His presentation was titled “Hatred and all its Rewards”. After an audio-visual debacle, Dr Gabbard masterfully lectured without his slides. He gave an outstanding presentation including a review of one of his most difficult cases. He discussed how he managed boundaries and his countertransference impressively without acting out. This led to a discussion with members of the audience who shared their own difficult cases and the problems that occurred.

Saturday morning started out with a symposium. Erin Seery, MD, David Mintz, MD, Barri Belnap, MD, Samar Habl, MD and Elizabeth Weinberg, MD presented on The Difficult Situation: The Problem of Treating Psychosis with a Narrow Lens. The presenters talked on more comprehensive ways of managing psychosis with a psychodynamic understanding of the process. At the same time Drs. Ronald Turco, Klaus Schrieber and Meera Balasubramaniam presented papers on conditions that make patients difficult. Dr Turco led an interesting discussion. Paper session V was chaired and discussed by Eugenio Rothe, MD dealing with the difficult therapist as well as the difficult patient. Papers were presented by Drs. Roman Anshin, Kimberly Best, Rahul Gupta and Gerald Perman. A series of workshops completed the morning. Drs. Christian Neal and Kathryn Johnson discussed counter-transference process groups in psychiatric residency training. Michelle Friedman, MD discussed pastoral counseling psychodynamic psychiatry. The feedback on this discussion was very positive and members asked if this topic could be included in future programs. Drs. Joseph Silvio, Juan Condemarin and David Mintz gave their yearly pharmacology peer supervision workshop which has been very well attended by the members. Co-therapy with a difficult adoptive family was presented and discussed by Drs. Bridget Bailey, William Lee and Adina Campbell. The final workshop was the Residents luncheon. Jeffery Katzman, MD presented on “The History and Current Understandings of Attachment Theory”. The feedback was by the residents.

Saturday afternoon included a symposium on identifying and understanding depression in colleagues. Drs. John Tamerin, David Lopez and Eugenio Rothe presented. Clarice Kestenbaum, MD led the discussion. Two panel discussions followed. Joanna Chambers, MD chaired and Drs. Danielle Patterson, Ryan Harris, Kevin Masterson, Morgan McCormick and Yo Na Kheir discussed boundaries and difficult patients from a residents’ perspective. Panel V was presented by Scott Schwartz, MD where candidates from his psychodynamic psychotherapy program presented on different therapeutic difficulties from their perspective. Drs. Kathryn Tylor, Jessica Harroche and Marina Rozenberg gave presentations which were discussed by Drs. Douglas Ingram and Sylvia Olarte. Giving young trainees a forum to present their work in a scholarly way is another one of the strengths of our programs. After our business meeting concluded Jennifer Downey, MD presented the Presidential Award to Margaret Spinelli, MD who then gave the Presidential Address entitled “Perinatal Psychiatric Illness and the Psychodynamics of Pregnancy” Dr. Spinelli gave
San Diego Meeting (continued from page 10)

an outstanding talk on problems surrounding pregnancy and
shared a few of the famous cases in which she was consulted.
This was followed by a beautiful reception out on the terrace
of the Hotel. This reception was graciously sponsored by
Dr. Jennifer Downey. We would like to thank her not only
for her financial support but for all of her work and support
throughout the planning and presentation of the program.

We hope to see you all at our annual program in New York
next year.

Opinion: What Does an Editor Do?

Angela Hegarty, MB, BCb

I have had the pleasure of following along as Dr. Perman
prepared the texts for publication in the Forum for quite
a while. He made it look easy. Like the help of Marie
Westlake, Dr. Perman’s advice and counsel have been and
continue to be indispensable. The first lesson I took away
from my understudy of Dr. Perman is that an editor’s work is
always collaborative.

In preparing to take on the role I found myself asking one
question: beyond proof reading, what exactly does an editor
do? When a writer works on an existing text to make it more
readable, to tell the story or make the point in a better way -
we call this editing. But there is more involved. I found an
interesting article on the subject by Dr. Joseph Alpert posted
at Elsevier Connect in May of 2013. According to Dr. Alpert
the name for the person who sponsored gladiatorial and other
games in ancient Rome at the Colosseum translates as “the
editor.” Like the sponsors of those Roman games, it is the
editor who decides what pieces are included and which are
not.

According to the career website sokanu.com an editor is a
gatekeeper who helps writers produce texts for publication
with the interests of readers in mind. This is consistent with
the two-fold mission of this magazine as I understand it: the
Academy Forum is first and foremost offered as a benefit of
membership to readers and help writers develop ideas and
drafts for publication.

So, texts must be readable and of interest to the
membership first and foremost. Authors can and should
contact me, as editor, with ideas for pieces - at any stage of
development. It is most definitely the work of a good editor
to help shape an idea or even an initial draft into a text that
will be of interest to our readers. Please contact me with
your ideas and send me your drafts and sketches no matter
how preliminary. The opportunity to assist a writer develop
a piece from the initial ideas to the final article is a privilege.
My message today is that when it comes to editing, I am here
to help.

There are ethical dimensions to the job as well. The
Academy Forum does not normally accept pieces that have
been published elsewhere. The issue concerns copyright
infringement. Some editors have to deal with issues like
plagiarism. Sometimes different authors dispute who
deserves credit as author and who does not. When the
subject is psychodynamic psychiatry the scope of the ethical
conscience goes beyond issues of authorship or copyright.
Psychiatrists speak from a position of authority when they

speak about an individual or group and as attention to the
Goldwater Rule last year reveals, writers and the editors that
accept their work can do harm when we forget the power
we wield. For example in helping prepare the program for
our recent meeting in San Diego, there was some concern
about the title of the program the so called difficult patient.
As I began to incorporate people first language into the text
of the call for papers I noticed how the complexities of the
situations involved in what are often painful encounters
emerged with greater clarity. The problems no longer resided
solely with the patient. People first language does not work
well in all contexts and in all discourses. Disability rights
advocates have explored the down side of this approach.

There is no need for another rule. The issue has to do
with the power of language particularly as wielded by a
psychodynamic psychiatrist. My interest is in good writing
not in universal agreement on various issues. Bias is of
particular concern not because there is only one way to
understand a given issue but because there are many. Bias
in writing - assuming it is detected at all, works like a set of
intellectual blinkers. As Daniel Kahneman demonstrated in
his wonderful book “Think Fast, Think Slow” when we are
biased we tend to succumb to a problem Kahneman dubbed
“what-you-see-is-all-there-is” even or especially when key
data are missing. Besides, I was raised on classical rhetoric.
The argumentum ad hominem (also known as attacking the
messenger) and its close companion the argumentum ad
vericundium (also known as the appeal to authority) are the
rhetorical equivalents of the bronx cheer (a vulgar sound
without semantic content that sounds a bit like a kazoo).

Though these rhetorical moves generate arguments that are
entirely spurious they have one advantage: anything and
everything can be asserted with certainty and great brevity.
Perhaps this is why we see such pieces prominently featured
in magazines sold on the checkout line at the supermarket
where evidence or argument in the old-fashioned sense is
not so much in demand as the conclusions that confirm what
some of us know to be true already. Writing ultimately is a
tool to help us to think. Any piece that does this is of interest
to the Forum.
What Is the Psychoanalytic Consortium?
A Guide for Academy Members
By Douglas H. Ingram, MD

From time to time, I hear bewildering queries: Just what is this “Psychoanalytic Consortium?” To answer this for Academy members, I am borrowing from an official Consortium document. I am omitting attributed quotation. For the actual Consortium document, feel free to reach me at DHIngramMD@aol.com.

The Consortium is a kind of formalized discussion group consisting of a few leaders from each of five-member organizations who come together to discuss issues of mutual concern. All the organizations except the Academy are what we call umbrella organizations. That is, each of the other four is an association of societies, individual member groups, and institutes affiliated more or less formally with its umbrella organization. The Academy is solely an organization of members. The five-member organizations of the Consortium are the Academy, the American Psychoanalytic Association (APsaA), the psychoanalytic component of the American Psychological Association known as Division 39, the American Association for Psychoanalysis in Clinical Social Work (AAPCSW), and the Confederation of Independent Psychoanalytic Societies (CIPS). The mission of the Consortium . . . is to promote excellence in psychoanalytic training and practice. The component organizations of the Consortium affirm that a broad background in mental health and a course of postgraduate psychoanalytic training conducted in conformity with the highest standards of psychoanalytic education are requisite preparations for the competent practice of clinical psychoanalysis. Mindful of political, economic, cultural and professional factors that impact mental health practice, the constituent Consortium organizations plan and implement individual and collective action, including public and professional advocacy, to advance our common and consensually determined goals.

The Consortium traces its origin to a phone call in 1991 from George Allison, M.D., then President of APsaA, to Jonathan Slavin, Ph.D., then President of the Division 39. Earlier, the Group for the Advancement of Psychoanalysis and Psychotherapy in Psychology, (GAPPP) with the support of Division 39 had filed a lawsuit against APsaA for anti-trust practices because analytic training and certification was limited to physicians. The lawsuit had recently been settled and Allison called Slavin to initiate a more collegial and cooperative relationship. Division 39 was receptive.

An initial meeting between Allison, Slavin and others soon took place in Washington DC. These initial discussions were followed by the first official Consortium meeting. Representatives attended from the four organizations: APsaA, Division 39, the Academy, and AAPCSW. Later, CIPS would become the fifth member.

The Consortium established bylaws, which included the provision that a consensus would be required from all organizational members for an action to pass. As with the permanent members of the UN Security Council, any group could veto any action. Each organization had to agree on every motion, opinion or written document the Consortium produces.

At first, the Consortium met only once or twice a year, but much later when work began on what became the Standards of Psychoanalytic Education the meetings increased to four times a year. Once the Standards document was completed the Consortium settled into a schedule of twice-a-year meetings, one in the fall and one in the spring. The Chair of each meeting rotates among the organization members.

The Consortium versus the National Association for the Advancement of Psychoanalysis. At first, the Consortium focused on responding to the proposed Clinton Health Care reforms. The group wrote an extensive mental health benefits proposal. However, when the Clinton health care reforms failed to be enacted by Congress, the Consortium coalesced to oppose the effort of the National Association for the Advancement of Psychoanalysis (NAAP) which sought to become the sole federally-approved accrediting body for psychoanalysis.

Before continuing, we need to take a short detour to consider some terminology. Accreditation refers to the legitimacy of a teaching facility. Applying certain standards and through site visits, the accrediting arm of an umbrella organization may accredit its affiliated institutes. This provides internal accreditation. But only an accrediting agency that is clearly separated from any umbrella organization can legitimately hold itself out as providing true external accreditation. By the way, certification is the term applied to individuals who meet broadly accepted professional criteria. In a word, accreditation is applied to institutes and certification is applied to people.

This effort by the Consortium member groups to oppose NAAP’s efforts would prove so considerable that later it would mistakenly seem that the Consortium was founded initially to oppose NAAP. The Consortium and NAAP differed in significant ways regarding institute training and accreditation criteria. The Consortium, following a definition initially regarded psychoanalysis as an advanced specialization of the mental health professions. According to this early model, psychoanalytic training should follow the completion of training in a one of the three mental health disciplines: psychiatry, psychology and social work. In addition, the Consortium established national training
What Is the Psychoanalytic Consortium? (continued from page 12)

standards endorsed by all its member groups, and codified these in its Standards of Psychoanalytic Education. These included the principle that psychoanalysis is a treatment characterized by depth and intensity, and accordingly, should be conducted at a frequency of three to five times per week. The Standards document also defined who can supervise and analyze candidates. NAAP, by contrast, asserted and continues to assert, that psychoanalysis is an independent profession and sets no standard regarding prior mental health training, licensure or frequency of weekly sessions of psychoanalysis.

In the end, the U.S. Department of Education disqualified NAAP as a potential national accrediting agency because NAAP conducted only internal accreditation. NAAP had no means to establish external accreditation of institutes. When NAAP failed on the federal level, it moved to a state-by-state approach, working through state legislatures. NAAP was successful in New York, New Jersey and Vermont in legislating a definition of psychoanalysis by its criteria, criteria far less rigorous than those of the Consortium. In 2000 the Psychoanalytic Consortium representatives agreed on wording for The Psychoanalytic Consortium Guidelines for Establishing Certification for Licensing of Psychoanalysis. However, not all the boards of the member organizations ratified the document. Consequently, it was put aside. When a New York bill for the licensing of psychoanalysis based on NAAP standards was introduced and passed, the Consortium members recognized that the Guidelines would have been helpful in opposing this legislation. To prevent being in this position again, the Consortium organizations passed the Guidelines in 2004. These remain in place to oppose unacceptable licensing laws in other states where this matter may arise. Nevertheless, the absence of federal regulations governing psychoanalytic training has continued to hinder efforts to oppose NAAP at the state level.

The Consortium’s Standards for Psychoanalytic Education and the Accreditation Council for Psychoanalytic Education

By the 1990s it was evident that consensually accepted standards for psychoanalytic education would be beneficial. Drafting such a document was challenging. The Consortium bylaws required unanimity for approval of actions. Thus, in order for the standards document for psychoanalytic education to be ratified, all member organizations had to be in total agreement and pledge to maintain these standards. Each umbrella organization could have its own standards, but none less than the Consortium standards. The Consortium was able to reach a critical agreement that frequency of analytic sessions for candidates in training would be 3-5 per week. No statement could include any wording that favored one level of frequency over another. Furthermore, ‘analyst of candidates’ replaced the term ‘training analyst’. This was needed to eliminate the concerns that one organization’s preference for a specific system to designate training analysts not be imposed on all. Remarkably, the compromises passed and the organizations comprising the Consortium ratified the Standards of Psychoanalytic Education.

In 1994, the Consortium sought to establish a not-for-profit body that would accredit psychoanalytic institutes. This independent corporation became the Accreditation Council for Psychoanalytic Education, Inc. (www.ACPEinC.org), incorporated in 2001, the same year the Standards of Psychoanalytic Education were ratified. As soon as it became independent of the Consortium, the new corporation had responsibility for maintaining or amending the Standards. It was established as an accrediting agency providing true external accreditation. The ACPE maintains standards and performs site visits, accrediting institutes in keeping with its mandate. The current president of ACPE is Sheila Hafer Gray, a former president of the Academy. There are currently 12 institutes accredited. Recently, the ACPE received what is called a “federal link,” which is the first step to recognition by the U.S. Education Department. Federal recognition enables acceptance of federal funds that institutes accredited by ACPE can receive. To assure complete independence for ACPE, a firewall has existed between the Consortium and ACPE since its incorporation in 2001.

Additional Consortium Accomplishments

The Consortium had successes in areas beyond the Guidelines and generating consensual standards for training psychoanalysts and engendering the agency for accrediting psychoanalytic institutes. APsaA invited all the member organizations of the Consortium to join them in their submission of an amicus brief in the Supreme Court case, Jaffe v Redmond, which involved the privacy of therapy records. The Court found for the plaintiff. Consequently, therapy process notes are regarded legally as personal to the therapist and as separate from patients’ medical records.

The component organizations of the Consortium along with the International Psychoanalytic Association participated in the publication of the Psychodynamic Diagnostic Manual, referred to as PDM-1. The effort was spearheaded by Stanley Greenspan who invited the Consortium’s component organizations to nominate members to join subcommittees examining aspects of psychodynamic diagnosis. The final document was largely written by Stanley Greenspan and Nancy McWilliams. A second edition, PDM-2, edited by Vittorio Lingiardi and Nancy McWilliams, published by Guilford Press, appeared in 2017.

Additionally, representatives from the four component organizations edited Freud at 150: 21st Essays on a Man of Genius, published in 2008 by Jason Aronson and Roman & Littlefield in collaboration with the Austrian Embassy. Among the editors were. Joseph P. Merlino, a former Academy President. The book was composed of proceedings of a daylong symposium organized and hosted by the Austrian Embassy in honor of Freud’s 150th birthday. All member organizations of the Consortium participated in the symposium.
Introduction

From the point of view of countertransference patients with Factitious Disorder are very difficult to treat. These patients seem to frustrate us at every turn. They seem to lie about history, symptoms, past treatments and diagnoses. Their motivation is unclear perhaps beyond making fools of their doctors! For most doctors they are more frustrating than patients who malingers. Malingerers lie as well, but for a clear purpose. Patients with Factitious Disorder seem to have no obvious reason to lie. The deception can even feel like spite.

Severe Factitious Disorder is called Munchhausen’s Syndrome, a term coined by Asher (Asher, R., 1951, Munchausens Syndrome, The Lancet, 257(6650), 339-341) when he described four such cases. He expressed the wish that the “psychological kink” that these patients suffered from could be better understood. The metaphor of the psychological kink is an elegant term that reflects Asher’s intuitive understanding of the complexities of the volitional aspect of the disorder and the fact that he did not think of it as a disease.

Deception is at the very heart of even the eponym associated with this disorder. Baron von Munchhausen was a retired German military officer who lived in Bavaria, and was known as an excellent storyteller. A neighbor named Raspe, who was in financial difficulty, wrote a book under the Baron’s name, describing preposterous comic adventures of the Baron as he traveled through the Near East. The Baron was outraged, he sued and lost; the Adventures of Baron von Munchhausen became a very popular and financially successful book. The poor Baron would be upset to know that his name, because of Raspe’s deception, is associated with Factitious Disorder (Fisher, J. A., 2006, Investigating the Barons: narrative and nomenclature in Munchhausen syndrome. Perspectives in Biology and Medicine, 49(2), 250-262).

Deception evokes special countertransference issues. Patients with this disorder present complex and unusual symptoms. The presentation is often dramatic. The presentation elicits an intense response in both professional and non professional caregivers. Some become angry with the patient. Some do not but feel betrayed when the fabrication of the symptoms is revealed. The conditions elicits an heroic response in others. This heroic response is what I will later describe as pathological caregiving.

Clinical case

When I first met a woman I will call Lorie she was in a day treatment program where I served as the medical director. She had cut herself, superficially but extensively, in the bathroom of the program, where she was found by the resident who was treating her. The resident was quite upset and could not continue treatment, no one else would see her, so I took on her treatment. At that time in her treatment she was describing so called recovered memories of very traumatic and bizarre cult abuse - allegedly perpetrated by her father. After a few weeks of treatment, sensing that I showed little interest in the abuse, she asked suddenly, “Do you believe me?”

Discussion

That of course is the central issue in Factitious Disorder, “Do you believe me?” While it is appropriate, in general, to believe the histories that our patients share with us, when those histories are obviously implausible and factitious then to simply accept them will, in fact, endanger the treatment. To accept Lorie’s literal account of her symptoms might destroy the therapy. Like patients who malingers, factitious patients know they are lying Unlike malingers patients with Factitious Disorder are motivated for reasons that are not self-evident or obvious. When we accept factitious symptoms as authentic the patient may be gratified but he or she cannot be helped. Freud faced similar questions early in his career as he treated patients with hysteria. At first he thought all these patients had been victims of sexual abuse as children. Then he decided that these patients were actually not victims of abuse, but were reporting sexual fantasies from childhood as if the events described had actually occurred. Patients suffering from hysteria in the classical sense could also be said to be falsifying symptoms. The sole distinction between a Conversion Disorder and a Factitious Disorder is that patients suffering from the latter are aware that the symptoms are fabricated.

Lying or intentionally falsifying symptoms creates interesting and profound philosophical diagnostic puzzles. While all the DSM’s since DSM 3 have attempted to strip the “mental world” from diagnoses and to avoid reference to a patient’s intentionality, the nature of this diagnostic category requires thoughtful acknowledgement of the patient’s psychological world. So what is the “psychological kink” that drives this disorder? Jill Fisher and others have...
Factitious Disorder and Pathological Caring (continued from page 14)


Sadomasochism, in current psychoanalytic usage, is more broadly defined than as a sexual perversion. To quote Gabbard, “We have moved beyond the idea that masochism should be narrowly construed as only a perversion in which one gains pleasure from pain. For most masochistically organized individuals, it is more useful clinically to see them as having a need to experience painful, humiliating and self-destructive relationships or self-states.” (Kattlove, S., 2016, The Clinical Problem of Masochism, edited by Holtzman, D. & Kulish, N., Rowman and Littlefield, Maryland). That is, the patient with factitious disorder likely subconsciously creates illness symptoms to play out an underlying fantasy. Figuratively speaking, in factitious disorder who is the top and who is the bottom of this power dance?

Sadomasochism is dyadic, and Factitious Disorder also involves a complex counter-therapeutic dance between physician and patient. In many important ways it is an iatrogenic disorder; without an inappropriately involved partner there is no Factitious Disorder. In a complex set of role reversals, the factitious disorder patient impersonates a sick person - which is a role of apparent powerlessness. The patient becomes the one who knows and the doctor is rendered powerless. But by fooling the doctors, he or she then becomes their master. Often this role reversal infuriates their medical team; physicians are inherently used to a patriarchal position of power. Conceptually it may be more accurately described as factitious patients “dominate from the victim position.”

Sadomasochistic fantasies, however bizarre, are fairy tales of love. The sadist wants his victim to love him, and usually in the fantasy the victim comes to love and desire the tormentor. Similarly, the dominatrix succumbs, in love and desire, to the perfect submission of the masochistic victim.

I have come to view factitious patients as living out fantasies of unrequited love. They are in a pathological love relationship with the medical profession. Buried somewhere in their symptoms is a wish to heal. Having seen so many of these patients over so many years I have come to genuinely honor that wish to heal that brings them, over and over again, to hospital and emergency room. When we work with them ruthlessly but with caring we might, when the stars are aligned just right, align with that genuine wish for recovery.

Caregiver Roles in Factitious Disorder

This observation of the dyadic nature of the disorder extends to families and caregivers as well. We remember most vividly the chronic, peripatetic Munchhausen’s patient who wanders from hospital to hospital. These individual have often become socially isolated, potential caregivers have been burned out.

Much more common, however, are milder forms of Factitious Disorder. Anecdotally, what is very striking about these patients is that they tend to be childlike in manner; coming in to the ER, for example, with a big stuffed animal. Another clue to their pathology is the presence of a “hovering” caregiver. Usually a parent or spouse, this loyal support person hovers continuously at the bedside, many times at all hours of day and night. They get pillows and ice water, provide back rubs, act a spokesman for the patient, and validate their insatiable demands for ever greater nurture and attention – all as part of the patient’s sadistic power play, exploiting the caregiving of the support person.

What would motivate a caregiver to stay in a role that is not substantially validated by medical evidence? An extreme, but not atypical case is that of a woman we will call Joanna, who was reportedly “quadraparetic” since an episode of meningitis. She had a long stay in rehab, where she learned how to type with a pen in her mouth. I first saw her about 5 years after her paralysis, where she was being evaluated for seizures. Since paralyzed people don’t move their bodies during seizures, the very history was suggestive of non-epileptic or factitious seizures. The patient lived with her mother, who performed all of her toileting. Joanna had even written a very dramatic autobiography of her struggle with paralysis.

As expected, the seizures turned out to be non-epileptic in nature. The epilepsy monitoring included a continuous video, and the patient was observed frequently and volitionally moving normally often adjusting herself in the bed for example. The patient was not paralyzed at all. The treatment team confronted the mother and the patient with the video tapes as evidence. Joanna’s mother was not angry. She wasn’t even surprised. She said: “Oh, I knew she could move sometimes, but at other times she can’t.” The neurologist and I looked at each other astonished. The mother was so entrenched in her caregiver role that she was unable to confront her daughter or change her own behavior pattern. The gratification associated with the role of heroic caregiver is such that under certain conditions it can lead to another disorder called Munchausen’s by Proxy. Unlike the situation in Joanna’s case, patients suffering from Munchausen by Proxy fabricate the illness in the person for whom they care.

While much attention has been devoted to what motivates the factitious patient, less has been devoted to what motivates the caregiver in these situations. Sometimes caregiving is motivated by love and caring, and is gratifying and meaningful for both the recipient of care and the caregiver. However, as described in the case above, it can at times be pathological and in fact help maintain the pathology in the patient suffering from Factitious Disorder. Pathological caring is related to lay terms like “codependency” and technical terms like masochism. What factors drive pathological caring?

1) Persons who show pathological caregiving fear abandonment, feel undeserving of real love, feel real love is impossible and settle for a “bad enough object.” They fear confronting the person they care for, afraid of anger and afraid they will be abandoned. As Gabbard describes, “Rather, by seeking and attaching to objects that will
Factitious Disorder and Pathological Caring (continued from page 15)

2) They feel guilty. They fear that they will face retaliation for successful change in their own lives, and they expect that shame or humiliation will follow if they were to have a healthy, non-sadistic partner.

3) They share a family of script of pathological caregiving. For example, a patient of mine in his 50’s had finally coming to terms with his pathological caregiving for his wife after he had sent a letter his grandfather had written him when he was in his late teens. Instead of words of wisdom, the letter conveyed that he was a good son for staying home and helping with his mother who suffers from somatic complaints whilst his brothers were on a spring break vacation. According to the grandfather staying home to care for a sick mother is what a good son does. The exploitation served the purposes of the family as a whole and is thus normalized and reinforced.

4) Cultural attitudes glorify caregiving. As CS Lewis points out in his book, The Weight of Glory, the original Christian view of love has been distorted since the Middle Ages and equated with selflessness. “If you asked twenty good men today what they thought the highest of the virtues, nineteen of them would reply, Unselfishness. But if you had asked almost any of the great Christians of old, he would have replied, Love. You see what has happened?” (Lewis, C. S. 2013, The Weight of Glory and Other Addresses (p. 25) William Collins, London). When love is equated with selflessness, then caring for another is considered to be the highest form of love, at the expense of neglect for oneself.

5) Trauma tends to generate pathological caregiving. Gabbard and others have described the dissociative mechanisms that can occur in trauma. In trauma, the need for loving recognition becomes uncomfortable, shame-ridden and dissociated. Love and affection is still innately sought, but naively, through an “exciting inner object” which is projected onto others. The internalized rejecting object becomes a kind of internal nemesis that undermines and destroys any attempts at genuine mature gratification. Intimate dyads become a kind of sadomasochistic foursome, with idealized objects interacting through projection, then brutally undermined by sadistic internal shame-filled forces.

While the care partner in Factitious Disorder can display some of the most egregious forms of pathological caregiving because the illness itself is a lie, pathological caregiving occurs in “real” disorders as well. Someone may, for example, care for a spouse or parent with dementia at home beyond what is really good for the patient or the caregiver out of guilt. Parents and spouses of addicts can also display pathological caregiving in the form of enabling behaviors. These forms of pathological caregiving are beyond the scope of this paper.

The relationship with the medical professional in Factitious Disorder is a reenactment of the relationship with the pathological caregiver. Caregivers, both personal and professional are externalized versions of the exciting inner object that the factitious patient tries to please. The internal nemesis or critical self has, however, set up a false relationship with false information, and takes pleasure in the either duping the caregiver, or in activating the internal critical self of the caregiver and being rejected.

Treatment

How is Factitious Disorder best treated? First of all, the countertransference expectations of treatment must be managed. The severe Munchhausen patient will never leave the hospital grateful and satisfied. If we have that as unconscious treatment goal we will never muster the proper ruthless that is required to act in accordance with the truth and with the patient’s best interests.

With my patient and her factitious stories of abuse we are in a slightly different situation. She and I had a reasonably strong therapeutic alliance, and she was relatively psychologically healthy. I answered her question about whether I believed her by saying that I believed that she had suffered in her childhood, and that it was important to understand and deal with that, but that it was difficult for either of us to know, reliably, what happened in her life so many years ago. I added that I hoped we could work together on that basis.

She was angry, insisted that I did not understand her, did not believe her, and was betraying the truth of her abuse. But she stayed in treatment. We both understood that those memories existed in that mythical space that Campbell identified, where words like true and false don’t readily apply, where memories are meaningful and important but not provable. Now, more that 10 years later, she acknowledges, on those rare occasions when the issue comes up, that those memories perhaps were not true, that “maybe they happened to me in a past life.” I am comfortable with that explanation, and she can save face; the meaning of things in that mythical space can be preserved. I think, actually, that she stayed in treatment with me because I did not pretend to believe her. Like most factitious patients, she wanted to fool me, but also desperately wanted to be understood.

Pathological caregivers tend to act out of pity, and pity implies being “one-up” on the recipient of care. To act without pity is to act ruthlessly and pathological caregiver, need at times, to act ruthlessly. This is not to say that they must be cruel or attack the patient. The caregivers on the other hand must be ruthless in honoring the truth and in caring for themselves. Ruthlessness is the only possible response to the boundless needs of patients with factitious symptoms, and ruthless love may be the only salvation for both parties in the masochistic dyad.

In the case of Factitious Disorder, the treatment team faces
the same paradox that the pathological caregiver faces. Self-defeating behavior, such as displayed by the patient with factitious symptoms is other defeating as well. Ruthlessness in this sense is neither cruel nor sadistic or intentionally hurtful - it is simply honest. With appropriate support, a mother of a patient with factitious paralysis might, for instance ruthlessly withdraw all help and support from the patient while they continued to display paralysis. This radical realignment of the relationship can be helpful to both parties.

A patient with factitious symptoms I saw today presented the usual lament of the factitious patient, “No one cares about me.” I reminded her without anger that “because we care about you we understand that your body expresses emotional pain in physical symptoms, we know that to test and retest you for every symptom is not to care about you.” The recurring question, “Do you believe me?” cannot be answered because both yes or no are wrong answers. “Yes” is wrong because it means you are indulging my fantasy and are stupid enough to be fooled by me. “No” is wrong because it means you don’t care about me or hear my pain. The correct answer is to raise the question to the meta-level, “I believe in the meaning of your story, but I understand that it is a story.”

### Suicide: A Reflection

*By Fructuoso Irigoyen-Rascon, MD, DLFAPA*

Almost without exception psychiatrists carry with them a story of suicide. Recently I had a patient who had a long history of anxiety and depression. When we met he was often distressed. The last time I saw him he declared that he was doing very well that he had never felt better in his life. The next thing I heard about him was that he had hanged himself.

The only way I know how to make sense of this loss is to review what we know about suicide risk. Patients feeling bad for a long time sometimes kill themselves. It is disturbing to think that the patient who comes to the office feeling much better might be thinking of doing the same. Colleagues and supervisors told me this was not at all unusual. They described how patients in grave distress will feel much better once they decide to end their lives. Many of the things we know about suicide risk seem to make no sense. I used to think that people killed themselves because they were suffering. I had no reason to expect that a patient who told me he was feeling so much better was about to end his life.

What causes a person to commit suicide? Many problems like anxiety, medical problems, recent stress are listed but the greatest threat is caused by depression. Are all people who commit suicide depressed? Labelling such patients as depressed gives those of us left behind a possible explanation as to why someone killed themselves. But it is not that simple. Anti-depressants - the cure for depression, often come with black box warnings about the increased risk of suicide. A puzzling interpretation of this bit of information in the black box is that the same products that can alleviate depression can also increase suicidal ideation and perhaps suicide. Things we do to help end up increasing the risk for suicide sometimes. Could this be true?

When it comes to suicide, help may not be helpful in some cases. In a recent study published in JAMA Psychiatry by Mark Olison patients are more likely to kill themselves following discharge from a psychiatric inpatient unit. The risk is even greater for patients who have received less psychiatric care prior to hospitalization. Were these patients discharged too soon? The author of the article highlights that psychiatrists are under great pressure to shorten inpatient stays. Psychiatric hospitalization is meant to be lifesaving for patients whose lives are in danger. When a patient says they are no longer suicidal the obvious next step is discharge, assuming that a patient’s report that the suicidal ideation is gone means the threat of self harm has passed.

Unfortunately this is not the case: to make matters more complicated, in a study done at Doctors Hospital at Renaissance in Edinburg, Texas, of the patients that declare themselves suicidal (by having suicidal ideation with or without plan; or recently attempted suicide or having commanding hallucinations compelling them to attempt suicide) on the day of admission, more than half of them deny any thought of suicide by the second day. A patient’s desire to kill themselves at any given point in time seems to depend on what is happening in the moment.

In another study, Simon et al. showed that for 25% of patients the average time it takes between deciding to attempt suicide and doing it was only 5 minutes. As the authors discussed, suicide attempts often are impulsive. Little is known about the characteristics of impulsive suicide. The authors examined impulsive suicide attempts within a population-based, case-control study of nearly lethal suicide attempts among people 13-34 years of age. Attempts were considered impulsive if the respondent reported spending less than 5 minutes between the decision to attempt suicide and the actual attempt. Among the 153 case-subjects, 24% attempted impulsively. Impulsive attempts were more likely among those who had been in a physical fight and less likely among those who were depressed. Relative to control subjects, male sex, fighting, and hopelessness distinguished impulsive cases but depression did not. The authors concluded that inadequate control of aggressive impulses might be a greater indicator of risk for impulsive suicide attempts than depression. Psychodynamic psychiatrists have long recognized suicide as a hopeless and aggressive act. This data possibly should bring out old questions about suicide, such as how dependent is suicide of the diagnosis of major depression? Many professionals simply assume that if someone died of suicide that person suffered from depression. Depression and suicide are linked but that is
Suicide: A Reflection (continued from page 17)

different from saying that depression causes suicide. People are also likely to end their lives after receiving a diagnosis of schizophrenia, of a serious medical or neurological illness or Alzheimer’s Disease. Other medical conditions associated with an increase in suicide risk includes unremitting severe pain left untreated and or uncomfortable or disabling medical problems that are not controlled by treatment with no end in sight. Most of these patients would have met the criteria required by the DSM’s for a diagnosis of major depression. People without depressive symptoms kill themselves following public humiliation or loss of status or following major disappointments the importance of which can only be understood from the individual patient’s perspective.

The issue of suicide has been of interest to scholars for decades. Erick Fromm writing in 1965 states that the only indicators to assess the mental health of a country are the available indexes of suicides, homicides and alcoholism in its population. He noted the high incidence of suicide in the Scandinavian countries and the United States. From Fromm the causes of suicide are complex related to economic factors and psychical health as well as factors related to depression.

More recently, addressing what the New York Times characterized as the epidemic of suicide by firearms, in a January 2017 editorial, the Times reported that more than 60% of the thirty thousand gun deaths that occur every year in the United States, are suicides. Eighty five percent of people who attempt suicide with guns succeed in killing themselves.

Reading articles about suicide I realized that many factors contribute to the risk of a person taking his or her own life. Complex and deep-rooted problems—such as depression and other mental disorders, drug and alcohol abuse, family violence, and a family history of suicide—often shadow victims. But that is not the whole story.

One point is that perhaps suicide prevention should take more than the diagnosis of depression the assessment of anxiety, unexplained improvement, interpersonal conflict, recent hospitalization for any reason, having a gun, impulsivity, traumatic experiences and history in account to prevent a suicidal event. Another is that we have a lot to learn before we can be sure of recognizing all those at high risk in time to do some good.

How to Write a Short Column for a Newsletter:

The Psychiatric Times Collaboration

By David L. Lopez

In May 2017, at the San Diego Annual Meeting, APA past-president Allan Tasman presented a workshop on how to write short clinical vignettes that could be published in the newsletter Psychiatric Times. Allan is the Editor-in-chief of this publication, which reaches 40,000 psychiatrists (not a typo, it is forty thousand!). As a long time Academy member, he felt we had much to contribute to the education of our fellow psychiatrists.

Gone are the days in which most psychiatrists were critical about psychodynamic psychiatry. Most of our members were witnesses to when biological psychiatrists were fighting to gain notoriety, and eventually dominance. Nowadays, biological psychiatry, pharmacotherapy, and statistics are kings. So much that the older generations no longer need to be critical of psychodynamics. Yet, a remarkable inverse phenomenon is happening. The younger generations are interested in subtler, close-to-experience, and personally interesting outlooks. This is exactly what we can offer to this group.

A Psychodynamic Psychiatry Column for General Psychiatrists

In addition, the current void in psychiatric treatment left by the rejection of psychoanalysis by academic psychiatry in the later part of the 20th century is now being filled with shallow interventions. Concepts mostly derived from pop psychology like “mindfulness”, “relaxation techniques”, and “self-reflection” seem to offer a glib substitution of what psychodynamic psychiatrists can offer. Psychodynamic psychiatry on the other hand, presents a sophisticated, clinically relevant, and evidence-based way of working. Our approach greatly enriches our treatments and our ability to engage with our patients and better understand their ailments. This is what we need to convey in a clinical column directed to general psychiatrists. This is what psychiatrists nationwide could get from our intervention at this public relations level.

Showing the General Psychiatrist what Psychodynamic Psychiatry has to Offer

The new Academy/Psychiatric Times project is part of this public relations initiative to reach out to the psychiatric community at large and give a glimpse of how psychodynamic psychiatrists think and treat patients. The project consists of publishing several times a year short clinical vignettes of about 2000 words (8 double-spaced pages) at Psychiatric Times.

Developing a Project for Publication

So, what should we be thinking of writing for this column? This is what Allan Tasman presented in his workshop.

1) First decide on a single take home message. What is the single most important point you want your readers to understand? Many writers mistakenly think of a series of important ideas they want to convey. This could be distracting or dilute your main message when you present the clinical material. During the workshop the effect of focusing...
How to Write a Short Column for a Newsletter (continued from page 18)

on one key idea made organizing the material much easier.

2) Keep in mind your audience. This column is directed to general psychiatrists, some of who may have not recently, or perhaps rarely if ever use psychodynamic concepts and techniques in their daily practice. A good way to think about your readers is to remember most of them will have learned this knowledge and skills base during training but may be practicing in a setting where they do not routinely use this capability.

3) Organize the content of the column before you start. Introduce the idea you want the reader to learn. Give a general background of the concept and then use the clinical example (or series of examples) to illustrate the main concept. The conclusion could be a paragraph connecting the concept with the example you presented and explain how this enriches the psychotherapy.

In San Diego, Allan asked our audience to move their seats to form a circle around him, and to think about an example of what they would like to present in a column. A member of the audience thought that his message could be how when working with an opioid-addicted patient it is helpful to try to feel what the patient might be going through. He knew this was important and what should be left out.

What ensued was a lively discussion based on this psychiatrist’s patient. A patient who few would consider a good way to think about was excited about this project, which we hope to continue to flourish as it already has.

My Favorite Analogies in Psychodynamic Psychotherapy
By Gerald P. Perman, M.D.

Over the several decades that I have been in the practice of psychodynamic psychotherapy, I have found a number of analogies helpful in making patients feel understood and in addressing certain anxieties that arise during treatment. The analogies that I am describing are the ones I have used most frequently with patients and have been helpful across genders, different age groups, and even different psychopathologies, since they address basic human experiences related to a desire for safety, attachment anxieties, separation and loss, dependency and the management of aggression, how long treatment may take, and what the patient can expect when treatment is over.

The six analogies presented below relate to the beginning of treatment, the fact that psychotherapy is a process that takes place over time, that progress does not occur in a straight line but that difficulties can be expected along the way and will need to repeatedly be overcome, that the theory behind psychodynamic psychotherapy can be easily explained to patients, that patients who are having difficulty extricating themselves from enmeshed dependent relationships can take steps to help themselves, and that there is a certain wisdom that patients who have a borderline or other severe personality disorder can achieve that so-called “normal” people can never expect to appreciate.

1. To build a house, we start by constructing the foundation, then putting up the walls, windows, doors and roof, and later we add the furniture.

This analogy is applicable with patients who are curious about how the early stages of psychotherapy works, with patients who have been psychologically traumatized and have difficulty trusting others, with patients who are anxious about sharing too much too soon in treatment, and with patients who have excessive anxiety in general about meeting and talking with a psychiatrist.

The message that I want to convey with this analogy is that we have to first create a solid foundation to our therapeutic relationship within which the patient can feel safe and on solid ground (another analogy). This implies that it can take time sometimes weeks or months before the patient can feel safe enough to discuss some of the things that are troubling
My Favorite Analogies in Psychodynamic Psychotherapy (continued from page 19)

him or her, and that the initial focus of treatment may need to
be on our relationship with the patient determining if she can
trust me enough to freely talk about what is on her mind.

There are multiple implied analogies within this analogy.
For example, the patient will decide whether to open
the door to the house, who to let in and who to keep out
(i.e. also which repressed thoughts will be allowed into
consciousness), if there will be sufficient light shining
through the windows to illuminate what is inside, and how
solid and waterproof the roof is, etc. This analogy also
corresponds to houses that appear in dreams, in which the
house stands for the person, i.e. we live in our house/our
self. Patients who dream of well-constructed mansions with
many rooms and many fine people living inside generally
have greater self-esteem and are less schizoid than those who
dream of living in a one-room broken down shack with the
rain and snow coming in through the windows and roof, and
that are devoid of human or animal inhabitants. The writer,
Salman Aktar addresses this issue in his book Mistrust

2. Therapy is like being on a big ocean liner that, in the
moment, feels as if it isn’t moving at all, but after a while,
you can look over the back of the ship and see that it has
indeed moved quite some distance from the shore. I turn
to this analogy when patients are anxious about needing to
measure immediate progress they are making in treatment.
This is similar to a small child in the back seat of a car on a
family vacation, repeatedly asking: “Are we there yet, are we
there yet?”

This analogy gives the message that the expected results
of therapy will take time to effect, but that they are likely
to occur if the patient is willing to give herself up to the
process, and put aside the concern that they must know in the
moment if progress has taken place. We will reach for this
analogy most often with the obsessively anxious patient who
worries about what they are getting out of treatment.

Apart from the content of any of these analogies, the act of
telling them to the patient is analogous to a mother reading
a bedtime story to her child and this in itself will have a
reassuring aspect to it. This ocean liner analogy is uncannily
accurate in that we all know how astounding it is, if we
have been on a cruise, how we can eat a meal, play a game
of tennis, and do many other activities without any sense of
movement of the ship. The analogy can even be extended
to being on earth itself, in that we consciously know that is
rotating on its axis 24 hours each day and revolving around
the sun each year without any sense of movement in the
moment.

3. Psychotherapy is like weeding a garden. Initially, there
are a great many weeds that are quite tenacious and difficult
to dig out. After the garden has been weeded repeatedly,
however, there will be fewer and fewer weeds that come
back, and those that do will be smaller and easier to get rid
of.

This analogy has been attributed to Anna Freud (citation
not found) and, like the previous analogy, is for the patient
who wants to know how psychotherapy works, whether
it occurs in “eureka!” moments that we see in the movies
(although these sometimes do happen!), and whether the
person will be “perfect” by the end of treatment. Extending
the analogy, weeds will ALWAYS come back but they
hopefully will be increasingly manageable over time, and
the patient will no longer be in need of a gardening assistant
(the analyst or therapist). Digging in the dirt also refers to
the unconscious with the metaphor of underground (and
underwater) standing for the place where repressed ideas
reside.

4. The mind is like an iceberg with a small part of it above
the surface of the water and the vastly larger part of the
iceberg below the surface of the water.

This is an old analogy but for many patients who are
naive to the process of psychoanalytic psychotherapy, and
especially for those who are curious about how this treatment
works differently from, e.g. CBT, I let patients know that this
speaks to a “theoretical model of the mind” that seems to be
helpful in thinking about how the mind and how treatment
works.

I continue with my explanation, saying that “the part of
the iceberg that is below the surface of the water represents
your thoughts that are outside of conscious awareness. When
these thoughts that are outside of your awareness are in
conflict with one another, they create problems above the
surface of the water, so to speak. Through meeting with me
and having us both pay attention to what you are thinking
about while you are here, we will be able to resolve some
of these conflicts over time and things will go better in your
everyday life. I avoid the use of the word “unconscious”
since this it can be confused with being unconscious and in
a coma. I also don’t use the layman’s term “subconscious”
since this work, to my mind, implies something lurking
beneath the surface in an anthropomorphic fashion, an idea
that I don’t want to convey.

5. If you are on an ocean liner and a storm is raging with
waves crashing over the side of the boat, and someone has
fallen overboard, you have two choices. You can jump into
the ocean and try to save the person, in which case you and
the other person will almost certainly go down together and
drown, or you can throw the person a life preserver attached
to a rope (a lifeline) and, if the person is able to grab hold,
you will do your best to pull the person back onto the ship to
safety.

This second ocean liner analogy is useful for patients who
are enmeshed in relationships in which they have allowed
themselves to be taken advantage of by others, but from
which they have been unable to extricate themselves. These
patients derive unconscious pleasure from the uncomfortable
situation they are complaining about since it allows them
to feel sorry for themselves as a victim and a martyr. For
example, these patients have often made loan after loan to
relatives or friends who are “down-on-their luck,” and who
are doing little to take care of themselves (because they have
perfected the art of leaning on others).

These patients complain about being “trapped” by the
other person, feeling that there is no alternative but to
continue to give to the dependent individual with little hope
My Favorite Analogies in Psychodynamic Psychotherapy (continued from page 20)

of recompense. At the extreme, they worry that if they shut off the financial spigot, the person will commit suicide. Such an attitude masks their tremendous hostility under the guise of kindness toward the dependent other. It is helpful to point out to the patient, the damage they are doing to the other person over the long run (often a dependent child in his or her 30’s) because they are depriving the other person from developing his or her own tools to separate, grow up, and stand on their own feet.

6. The Parable of Two Flower Vases.

This last analogy comes from Salman Akhtar’s book “Broken Structures: Severe Personality Disorders and Their Treatment.” In recent years, I have taken to paraphrasing this parable to patients who feel that they are “broken” and have no hope of ever feeling well again or achieving a good enough life for themselves in the future. Many of us, too, feel as if we are “broken” in our lives in various ways and, when I tell this story to patients, I am often so moved that I come close to tears myself. I quote Akhtar’s parable in its entirety:

“This incident happened about 10 years ago. I was teaching a course on severe character pathology to a group of psychiatric residents and clinical psychology interns and usually ended each session by taking questions from the group. One afternoon, after I had spoken enthusiastically about psychoanalytic treatment of such conditions, a young man posed this question: ‘After the successful completion of a most intensive psychoanalytic treatment conducted by a most skillful psychoanalyst under the best of circumstances, would an individual with severe character pathology become indistinguishable from a person who has always been psychologically well adjusted and healthy?’

I thought for a moment. Then, prompted by an inner voice, I spontaneously came up with the following answer: ‘Well, let us suppose that there are two flower vases made of fine china. Both are intricately carved and of comparable value, elegance and beauty. Then a wind blows and one of them falls from its stand, and is broken into pieces. An expert from a distant land is called. Painstakingly, step by step, the expert glues the pieces back together. Soon the broken vase is intact, can hold water without leaking, is unblemished to all who see it. Yet this vase is now different from the other one. The lines along which it had broken, a subtle reminder of yesterday, will always remain discernible to an experienced eye. However it will have a certain wisdom since it knows something that the vase that has never been broken does not: it knows what it is to break and what it is to come together. Does this answer your question?’

In conclusion, patients describe their symptoms and their lives to us in the form of stories (although they may not think of them as such), and in our effort to let them know that we are good enough witnesses and that we understand and appreciate what they are telling us, we sometimes rely on analogies and metaphors. I have given you some of the analogies that I have used over the years in my own practice and perhaps the reader will find some of these helpful in your own work with your patients.

BOOK AND FILM REVIEWS

Playing and Reality Revisited, A New Look at Winnicott’s Classic Work
By Gennaro Saragnano and Christian Seulin
Reviewed by Cassandra Klyman, MD, Psychoanalytic Fellow

One of the pleasures of growing older is the ability to have a long look backwards giving one the sense of wonder and appreciation for life’s ironies. One such irony is how parochial my Michigan psychoanalytic training had been in the early 70’s and how ecumenical it has become—with myself and several colleagues belonging to the Chinese American Psychoanalytic Association. But back then we studied Sigmund and Anna Freud. Mahler’s (1975) The Psychological Birth of the Human: research on separation and individuations with its five subjects studied in their sub-phase development passed for evidence-based material. Mahler and the then-consensus felt Winnicott’s view of good-enough mother was too simplistic since even in that small sample there were three interdependent variables; 1. the mother’s personality structure 2. the developmental process of her parental function (Benedek 1959) and 3. the mother’s conscious, but particularly unconscious, fantasy regarding the individual child. (p202). She concluded that the English school was wrong as was part of her own hypotheses and concluded that the drive to individuate is innate.

Melanie Klein, Bion and Winnicott were dismissed as the English School that was too highly speculative about the psychic development occurring in the pre-verbal infant and toddler. To paraphrase Anna Freud, in the Introduction to H. Nagera’s book (1966)—“he’s got it right, the infantile neurosis is not the base but the final, complex apex.” And when the idealizing or mirror transference shows up it must have understood to be generally deficient in libido and the analyst is important only so far as she is “felt to fulfill or to frustrate the patient’s demands for an echo, approval and confirmation of his grandiosity and exhibitionism.” Then
Kohut came to the forefront and was avant-garde and yet he believed (The Analysis of the Self 1981) that Winnicott did and could not go beyond the descriptive empathic level since there was no language and early on no real libidinal cathexis. Further, “while it is true that all transferences are repetitions not all repetitions are transferences” Kohut 1959, p472 (JAPsa 7:459-83).

Also experienced guest lecturers like Lichtenberg showed amateur videos of their work which caught the importance of gaze as well as feeding between mother and child. Unforgettable grainy films by Spitz reminded us how important touch was. So multi-sensorial evidence was there but oral, anal and pre-oedipal stages were all just preliminary opening acts. Beebe’s recent book, (2014) The Origins of Human Attachment uses micro video technology to follow mother-infant pairs to document and predict disorders of attachment that we see so much more now in our consulting rooms than classical cases of neuroses.

Kernberg discussing the Borderline Personality in Love Relation: Normality and Pathology p61, refers to Winnicott as understanding that symbiotic fusion yields to erotic desire at the end of separation and individuation stage when there is the beginning of object constancy and the capacity for care— with toleration for aggression— in mature love.

As part of a Neuroscience Study group I familiarized myself with many authors who were intrigued with consciousness, memory, and emotional, cognitive and behavioral development. Fonagy and Target (2002) in Affect Regulation, Mentalization and the Development of the Self demonstrated Winnicott’s prime statement— “there is no such thing as a baby”, meaning that a baby cannot exist without its mother. And Kandel (2006) might ask, if the Aplysia snail can have memory why not an infant? And why can’t an infant have an illusion that turns into “let’s pretend” and that turns into playing where reality and make-believe can co-exist. But in those same book portions Winnicott is not mentioned— one must go round about to the index, at least in Fonagy’s book, to find attribution for these ideas. Neither is he mentioned in Gerald Edelman’s 2000 book A Universe of Consciousness subtitles, How Matter Becomes Imagination nor in Daniel Siegel’s new book MIND the journey to being human. (2016)

Yet here is the Publication Department of the International Psychoanalytic Association presenting its first in a series of great psychoanalytic writers and featuring a Festschrift for Donald Winnicott’s Playing and Reality. Is it because PEPWeb cites Winnicott 3 times in its list of ten most popular journal articles or that, despite my experience, he is the second author most cited? Or is it that our widening scope of analysis requires us to revisit great thinkers who may be so open-minded as to allow that neuroscience and psychoanalysis to find common ground and that would be facilitate our understanding the mind as it forms for health or psychopathology in the 21st century?

The two editors of this volume are a Roman—Gennaro Saragnanno and a Parisian—Christian Seulin. They invited thirteen others, an International grouping from North and South America, Spain, France and Italy to contribute chapters that roughly follow the arc of mental development from birth to adolescence, from the breast to contemporary 21st C cultural concerns. As expected the first half of the book is highly theoretical and just when you think you’ve understood here comes Chapter 8 by Wilfrid Reid on “The Use of the Object and Ternary Thought.” He introduces the reader to a philosopher named Morin who wrote an encyclopedic work, La Methode (2008), about “complex thought” something Reid (p129) feels Winnicott intuited years earlier when he said, “don’t reject but use the absurd logic -that what we create is already there.” For Winnicott, to find and create are simultaneously antagonistic and complementary. Initial it is the breast and gradually the world - if mother is a G-E-M—a good-enough-mother. The second principle is organizational recursivity—the mother creates the child who creates the mother in a virtual continues movement. The third principle of complex thought is explained by the symbol of the hologram where the part is in the whole and the whole in every part in understanding the” theoretical first feed” (p129). There are invaluable comparisons with regards to drives in Freud’s terms and the novel interpersonal, relational inscription that Winnicott observed in his pediatric population and wrote about.

Freud’s (1920) in Beyond the Pleasure Principle, throughout, is given credit for bringing psychological meaning to his grandson’s high-chair game “Fort-da” of throwing a thread spindle and enjoying its retrieval or as a toddler, playing with his appearing and disappearing reflection in a large hallway mirror. Playing –with the emphasis not on the noun play but playing, the gerund— reminds us how primal activity is for humans. (I am so much more tolerant and non-apprehensive about my great-grandchildren jumping and wrestling than I ever was about my own children—it is developing their brain and worth the price of a bruise). Panksepp understood drives as a seeking, so do other neuropsychoanalysts so that Winnicott’s—creating-found and destroying-found has contemporary affirmation. This can only happen if the potential aggression is recognized and defused by a mother who is mature enough not to retaliate but to give words and meanings to the infant’s experience. The true versus false self occurs if the G-E-M will permit the baby to be who he/she is; the false self develops if the baby needs to take on the reverse role and be consoling, containing and holding for his anxious or depressed mother. The baby, as the nascent scientist, draws on the whole “arsenal of concepts he absorbs virtually with his mother’s milk” (Albert Einstein 1954) or to go back to Helmholtz— “without imagination…we could not be able to see what is there to be seen.”

Rene Roussillon, in Chapter 6, elaborates on the difference between Freud’s and Winnicott’s view on creativity. For Winnicott it is not a sublimation of drives. Rather it is an absolute fundamental aspect of mental life defining the relationship between the individual and his/her internal and external world. The baby hallucinates, has an illusion of the breast and by virtue of having a G-E-M it appears and the
baby finds, has in his hands, what he created. The various scenarios of a child’s creativity are objects that become subjects in playing and dreaming—certainly these processes are now accepted as biological phenomena. That some of this is poetry—imaginative rather than documented—we must admit since not all healthy-to-be babies are breast fed. Also questionable is how true and necessary is mother’s gaze—we know some cultures carry their babies so that gaze is not consistent, if at all with papooses and other types of body wraps and in the Amazon it is the chief who owns and feeds all the infants with mashed banana. Are we only talking about Western/European mothers and children who develop a mental, internal states? Of course not, so we must remain humble and skeptical and maintain an heuristic outlook.

This is especially true for our clinical work and several chapters in this edition address that directly. From Buenos Aires, Zak de Goldstein addresses the abundance of therapeutic failures which may be reduced if the analyst is more attentive to micro-lapses of empathy that enact the nameless trauma of the past; to regard them as “a fortunate mistake” to unfreeze the anger contained in the repetition (p7). To see it as playing out the painless pain of those contemporary patients who come to consult analysts “without commitment, but certainly with suffering—looking for someone to listen” (p8).

If we consider the hallucinated construct of the baby to be the transitional object we can enter and better understand the world of the patient who is neither neurotic, nor predominantly narcissistic. A Borgess, 1960 poem, entitled Chess, is quoted to give us an idea of the potentiality of play—“The player also is a prisoner of another board”—so one must both note and abandon the rules of the game and follow the lead. This is beautifully narrated and illustrated by a case of an 8-year-old boy thought to be on the autistic spectrum who shed his defenses through “play therapy” where the analyst was a dedicated participant in his listing and drawings of animals and monsters where there were sequences of identification and dis-identifications, projective identifications and role-reversals until a healthy regression could lead to safe sleep. (Vigna-Taglianti, Chapter 11).

Nicolo, an Italian child analyst, Chapter 2, comments that the difference between Winnicott’s idea of play and that of Klein and Anna Freud is that while they see play as an expression of conflicts and unconscious fantasies and used it as a channel for communication and interpretation, Winnicott “looked at it as transformatve and a becoming (p24). Sapisochin, Chapter 3, from Madrid, underscores the enactment dimension and feels it reveals the behavior of the environment in the individual’s personal development. It is this third space co-created by the mother who allows the baby to have the illusion that her breast is part of her infant and the illusion that there is an external reality that corresponds to the infant’s own capacity to create(p25). This gives rise to the Winnicottian paradox: ONLY BY CREATING AND RE-CREATING ILLUSION ARE WE GIVEN ACCESS TO REALITY.

Schact (1999) is quoted, “play arises from an oscillation between liberty to do so and an inner necessity to do so...and this is preserved with the sphere of creative life that is the realm of culture, in which novel or artistic creativity is generated out of internal necessity” (p202). Significantly the artist has an audience—real or imagined and that coupling is the matrix of creativity; it may be one’s double or the unknown with whom he experiments - with progressive disillusionment to bring back parts of himself to acquire new meanings. Our patient-artists can use the small stage of our consulting rooms to enact their mini-dramas and like in the theater we are asked to be quiet, to identify, to react emotionally and receive the communication before we go out to write our review or make interpretations. Further, “let’s play” for the analytic session has the beauty of a set time so that whatever terrible or wonderful occurs does not belong to everyday reality. “It’s only a game” allows the danger of destruction, the fragility/ resilience of the object to be explored and the player to be certain of safety. For young children Winnicott used very simple playthings—a tongue depressor and the Squiggle game where alternatively patient and analyst would continue on the same drawing. And note the caution that the analyst should not be hunter or farmer—for both take the initiative—instead he should be the object to revive creativity, to have the true self be found. (Nicolo p39)

Though Winnicot was analyzed by Melanie Klein he repudiated her concepts of envy and death instinct but felt the father—as an intruder in the basic mother’s primary preoccupation with her baby, King Majesty, provided protection and security for unhealthy merging or destructiveness—much like the analyst’s professionalism. Instincts, in Chapter7, by Abram on “Use of an Object” have no duality and become significant only when the self is achieved—before that the body can only react and be traumatized. After it becomes a mind it can recognize that others have a mind too. Initial aggression has nothing to do with sadism, envy or hate. He believed it was only muscle eroticism—a symptom of aliveness. Unger, in the last chapter on 21st century culture elaborates that without a paternal limit on aggression, with an abdicated father, the adolescents’ skin may become limit setting and get violated by the current epidemic of delicate skin-cutting.

I felt defensive about Chapter 9 by Laurie Wilson—who was the only contributor from the US and an art historian who received psychoanalytic training at the NYU Psychoanalytic Institute. She claims, in serious error I believe, that Freud did not take account of culture in his writings. She disregards the naming of the Oedipus and Narcissus complex; his papers on Michelangelo and Moses and Monotheism. There are many references to Goethe. Most significantly is the impact he and all his contemporaries experienced from two World Wars giving rise to Civilization and Its Discontents. However, I can understand her point of view that Freud ultimately saw the individual psyche as creating the environment and gave less attention to the co-creativity of environmental factors—whether it be infant-parent, infant-sibling or Child-Internet or whatever new
technology is present.

The final chapter by Unger addresses the challenges and opportunities of the new modes of communication and virtual reality that face us and our patients. She concludes by suggesting we neither demonize them or idealize them but conceive of them as a transitional place where an adolescent may play anonymously as any gender, age, or appearance and deal with possibilities of omnipotence or dangers of humiliation. Real privacy and intimacy for the true self may have its last bastion in our offices. This is particularly relevant because of the changing nature of the traditional family that Winnicott knew forty years ago. There are fewer rites of passage and many young adults in Argentina, as in US, are still living with their parents, remaining identified as much younger than their chronological age. They are still children-living-at home—a home where job-dependent or career-bent parents are mostly absent players—an abdication, voluntary or otherwise that may unleash aggression outwards or towards the self. Unger describes that latter as self-cutting but it can explain the ever-increasing rates of depression and suicides. So this revisiting, and I have not had space to mention them all, has theoretical and clinical portions the American reader may ask to have “put in a box to take home”.

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Cinema As Therapy: Grief and Transformational Film by John Izod and Joanna Dovalis
Reviewed by Michael Blumenfield, MD, Past President of the American Academy of Psychoanalysis and Dynamic Psychiatry

Dr. Blumenfield regularly reviews movies at FilmRap.net

This book discusses the following 9 films:

Birth (2004)
Tsotsi (2005)
Million Dollar Baby (2004)
Trois Couleurs: Bleu (1993)
Trois Couleurs: Blanc (1994)
Trois Couleurs: Rouge (1994)
The Son’s Room (2001)
Spring, Summer, Autumn, Winter… and Spring (2003)
Morvern Callar (2002)
The Tree of Life (2011)

I am listing all the films covered because unless you are intimately familiar with these movies (which I was not), I believe it will be very difficult for you to appreciate and follow the detailed discussion of each of them in this book. The authors carefully dissect each movie, often scene by scene, sometimes discussing the camera angles, the music, certainly the dialogue (sometimes word by word), and most importantly their detailed understanding of the psychodynamics of each character and their interaction with each other. There are frequent references to psychoanalytic writings with a heavy emphasis on Jung.

The difference between this type of an approach compared to a case study is that the latter would be presented in an organized manner where we might have a context to examine the details. In this book, the author assumed that their interpretations and their psychodynamic formulations are correct and they continually build and elaborate on them in their ongoing dissection and discussion of the movie. We have to accept that their understanding of every nuance is valid. Did the screenwriter who created the characters and storyline consciously plan every symbolic twist and turn of the story, choice of phrase, meaningful color of clothes or sky or flowers, appearance of animals or birds,
all of which were interpreted by the author of this book as having special meaning. Even if we assume that the psychodynamics are flowing from the unconscious of the screenwriter and director, we still have to do a reality check on how movies are actually made. Sometimes the clothes chosen by wardrobe people based on availability as might be a particular location, which may not be chosen because of symbolic meaning. The red color of the sky may be an artistic coincidence and not a symbolic choice to express anger, etc.

Even if what I believe is a great deal of over-interpretation was valid, it would be difficult to understand most of it without knowing the past history and insight into each character. When we are studying a case history in a conference or supervision, the presenter has given us a context by providing the background (parents, youth, previous interaction, etc.) and usually an insight into a psychodynamic formulation, which the presenter wishes us to consider. If we are treating a patient and are formulating our understanding of the psychodynamics, we do this through a process of learning past history and early relationship, transference manifestation and the patient’s response to our interpretations. This is in contrast to having the author unfold a movie story and provide detailed interpretation of nearly every piece of behavior which is unfolding before us on the screen without a previous context.

In the introduction to this book, the authors note that they have chosen to emphasize grief in cinema and they imply (as does the title of the book) that cinema can be used in grief therapy. They seem to be suggesting that transformation and perhaps working through might be achieved by cinema. They note that film allows the viewer to more freely surrender themselves to their feelings. They elaborate that the audience might share a common trait with the character in the movie, which evolves into particular patterns of grieving caused by a devastating and undigested loss. The idea would appear to be that the movie experience would be therapeutic in working through the grief. While some of the movies discussed in the book did have grieving and loss as part of the theme, I did not feel that the authors returned to this idea in any depth in showing how viewing the film might be therapeutic to the audience.

Having said all of the above, I do believe it would be a wonderful experience to attend the movie with the authors and have a subsequent discussion with them about the film that we just experienced. I also believe that the authors would be ideal teachers to discuss the film that students or colleagues who have all viewed the film and could interact with each other about their interpretations. This book could be a textbook for a psychoanalytic class that was going to study one of the movies and have a sophisticated dialogue about possible psychodynamic interpretations. It would be even more of a challenging endeavor if a psychoanalyst would embark upon teaching a group of film students about psychodynamics and use this book and the particular movies as subject matter. In addition, it certainly would be fascinating if the authors could present clinical material where a movie had become a therapeutic experience to a particular patient in helping them work through their grief or other issues.

Finding the Body in the Mind: Embodied Memories, Trauma, and Depression
by Marianne Leuzinger-Bohleber

Marianne Leuzinger-Bohleber, in Finding the Body in the Mind, provides us with a generous retrospective on a collection of clinical case studies that offer how psychoanalysis reveals the “neuro-cognitive-brain” experience in the body.

The author begins by reflecting on the value of psychoanalytic narrative and the complex meaning structures that can only be “told” not “mathematically measured”. She outlines how neurosciences, the “hard science” of the brain is always seeking to measure experience.

Prove/disprove. Leuzinger-Bohleber considers the idea of the equation feedback of prove/disprove and through Freud’s tenants of psychoanalysis explores the mind body experience beyond “proof”. She enlightens the reader by outlining that experience “is”. The effect of experience is essentially the “proof” of occurrence.

Leuzinger-Bohleber takes us through Mark Solms’s twelve central psychoanalytic concepts of Freud which sets the stage for the rest of the case explorations and articulately describes why the brain is not “just an organ” to be observed. Solms’s arguments include pointing out how cognitive neurosciences in their “hard sciences” view see that brain as an organ much like a liver, or a kidney and so on. Neurosciences to date has treated the mind as an object and ignore its subjectivity, or dynamic, therefore the brain from a neuroscientific view is an object from which information is processed, it does not recognize the subjectivity of the mind’s “experience”. Oliver Sacks (1985) opines that a human being is a subject, not an object….it is the subject, the “I”, which is excluded from neuropsychology. Leuzinger-Bohleber conceptualizes that the brain is unique in its capacity for subjectivity, feelings, and agency. No other organ or mechanical device possess these qualities. For example, the brain has free will. Therefore, one can deduce that the brain is subjective, and a machine is objective. A machine or non-brain organ cannot feel or experience, whereas a brain can.

The text proposes a comprehensive and interesting framework from which to consider the neuropsychoanalytic movement and its aim to break down barriers between neuroscience and psychoanalysis. Guterl, 2002, p.63 purports
that the neuroscientific and psychoanalytic fields still need to prove or disprove Freud, that we have not finished Freud’s job. Kandel (1988) states that Freud’s remains the most satisfying view of the mind.

In her book, Leuzinger-Bohleber takes on the monumental task of trying to integrate an understanding of the mind/body through the disparate lenses of psychoanalytic theory/experience and the “hard science” of neuropsychology. In this vein, the book is intelligent, thorough, and thought provoking. It may provide theorists and clinicians a pathway from which to consider the intersection between the objective/subjective experiences of the mind/body. A deep, and considered text; highly recommend it for students, clinicians, researchers, and theorists of psychoanalysis and neurocognitive sciences alike.

This book is based on a study of “madness” and how a “mad seed” develops from a “normal core,” without reduction to formulations based on genes, biochemistry or brain anatomy. The various authors develop insights from the latest neurobiological and psychological research and it is especially pertinent in understanding severely regressed patients. Hereditary, constitutional, environmental issues and unconscious fantasies are explored in the development of the psychotic core of such patients and associated issues of therapeutic response and therapy guidance.

This volume is divided into three parts and eight chapters involving seven authors. Chapters one and eight complement one another and help synthesize the contents with a conceptual integration of the psychotic seed in personality organization (chapter one) and the constitution, environment and fantasy contributions to the psychotic core (chapter eight).

In chapter one Dr. Volkan explores in depth primitive ego functions, self-image and object representations and the first cycle of fusion-diffusion, which occurs when the self-image is not differentiated from the object image. The second cycle, the introjective-projective cycle is a term that covers various forms of introjections and projections, including projective identification with a more stable differentiation of self-representation from object representation.

The nature of affects in the core structure of infantile depression as well as schizophrenia is discussed as they relate to taming “bad” affects. The infantile psychotic self is formed during the early interaction of mother and child or during marked regression in the developmental years during which a child’s self-representation can be saturated with “bad” affects, for example by unbearable psychic trauma. Although the “seed of madness” differs from one patient to another they are all alike in the utilization of the primitive ego mechanisms of fusion-diffusion or introjective-projective cycles and the reactivation of transitional objects to control object relations.

The five fates of the infant psychotic self include: (1) shrinking and disappearing,(2) a psychotic seed persisting into adult life actively dominating the rest of the personality organization with childhood schizophrenia or other primitive mental state or three outcomes pertaining to “encapsulation” – (3) a partial encapsulation with a psychotic personality organization as an adult, (seemingly normal at one level but with a secret life dominated by fusion-diffusion and or introjective-projective cycles, (4) the eruption of a formerly encapsulated psychotic self without causing a psychotic condition but rather bizarre behavior or the fifth being the development of adult prototypical schizophrenia.

Both nature and nurture are involved in the etiology of schizophrenia and the formation of the psychotic seed. How a child experiences interaction with the environment and how he assimilates experiences determines the the point at which disposition and environmental influences meet.

The mixing of the components passing through the mother-child experiences sets the foundation of the child’s psychological structure. The genetic-biological disturbances thus influence the infant’s fundamental mental functioning potentials, as some biological determinants might not allow the evolution of healthy self-representation. This book explores these issues.

Chapter two by Johannes Lehtonen, M.D. deals with the origins of body ego and psychotic vulnerability. The ego, first as a body ego, is a psychical projection of body surface experiences in the earliest phases of life, associated with the basic layers of personality born of the early interaction between the infant and the mother. There arises a self-object fusion and simultaneously with the infant a fusion between affective experience of satisfactions associated with sense impressions and perceptions, all taking place first and foremost in breast-feeding and forming nuclear events which precipitate the birth and development of the body ego, a psychic projection of the body surface. Dr. Lehtonen explores the early satisfactions and the development of reality testing. This, of course, is unconscious, as the body ego is not yet connected with verbal communication in the context of the fusion between perceptual experiences, affects and the self-object fusion, all within the context of interactions between infant and mother. The author differentiates between the concepts of body ego and body image, the later a more developed phenomenon than body ego and requiring more articulated and verbalizable interactions between infant and mother. The Isakower phenomenon and its derivatives is discussed in terms of perceptual memory of the infant’s experience and their
later appearance in the analytic experience. A regressive, defensive retreat from threatening incestuous impulses activated by masturbation. The dream screen and primary oral satisfactions support a double cathexis—a narcissistic one and an object related real person one. All of this is based not on the physical boundaries of the body but on the durability and strength of psychic satisfaction. The early differentiation of the mind to the topographical organization begins only after consolidation of the primal pure pleasure/affect organization. Affective experiences create neural pathways in the developing nervous system contributing to the emergence of dreams which always have an affective experience as a focus. Interestingly he notes that depression and suicide attempts involve a desire for satisfaction comparable to the primordial sleep and undisturbed rest, and thus a close tie between pleasure and the death-wish. This is demonstrated by ac clinical vignette involving the bare and symbolic expression in a dream connecting it to the sexual body ego level of self-experience. Further discussion summarizes that the body ego and body image are in relation to each other in a similar fashion as that of the latent and manifest dream.

These concepts are explored in the context of schizophrenia as a predisposition to psychosis involving the splitting of the early body ego state remaining split and separated to unintegrated ego nuclei. The affective experience and perceptual processes have fallen apart resulting in uncathed internal perceptions experienced as real perceptions coming from without. This is an excellent psychodynamic explanation of hallucinatory phenomena as well as body image distortions. The patient cannot calm down, fall asleep, enjoy rest or have dreams suggesting that the capacity to regulate basic vital psychic functions and economy is out of order. The body ego is thus seen as a natural psychological context for binding together the implications of nature and nurture, bearing in mind that the body ego, unlike the body image, is always nonverbal and unconscious.

Chapter three by Simo Salonen, M.D. deals with issues of humiliation and dignity and ego integrity, deeply rooted in unconscious conflicts and instinctual dangers. An extensive case study involving a sadomasochistic struggle and dread of rejection is presented. During the analysis the analyst was able to reconstruct the patient’s sensual longing for the other’s intimacy and her breasts and her urge to exploit her early mother. Mother’s psychic trauma is associated with the patient’s own oral frustration and hunger for bodily intimacy with the resulting failure at satisfaction resulting in a helpless ego and a destructive maternal fusion. Early psychic trauma resulted in splitting and a main obstacle in integrating trauma. Resulting anxiety subjected the patient to sadomasochistic suffering and accentuated panic in confronting the unconscious idea of castration in the outside world. In working through painful disillusionment in the analytic relationship that patient was able to realize that the loss of an unattainable love does not signify losing human dignity. With a level of integration there is a painful acceptance of the reality principle and the establishment of new avenues of inner reflection. The patient had been unable to represent her violent affects psychically and they had become resomatized with threatening consequences. In addition to this clinical material the author present a cogent discussion of man’s atrocities as an attempt at intrapsychic adaptation and the ego dealing with traumatic helplessness and resulting malignant depression.

Chapter four by Mauric Apprey, Ph.D. is a labyrinthine discussion of the sense of disappearing in schizophrenia. The world of the schizophrenic is noted to be fraught with feelings of of vagueness, unreality, the perceived threat of disappearance and ostracization based on the imagery of abandonment by loved objects and therefore subject to inevitable predators just outside the protection of the family or group. The exclusive family hypotheses suggests that the future schizophrenic is selected as the “human sacrifice” by the family system and becomes “notarized” by siblings and peer groups. An excellent definition of phenomenology is described on the basis for looking at conflicts/problems in human sciences by looking at problems and asking questions. It is not a label for a philosophical school. The author writes that Franz Brentano, a Catholic priest, a philosopher and mathematician taught philosophy to both Freud and Husserl, and yet the latter went in the direction of pure description and the former in the direction of interpretation. Brentano antecedeed Bion’s elaboration of “container-contained.” There are approximately sixteen pages of a discussion of Phenomenological Praxis and an eventual discussion suggesting that descriptions must precede interpretation and that both are continuous. In a fascinating discussion the author places the parents in a transgenerational context, thus avoiding the easy temptation of blaming mothers. Insightfully, he notes that the transference is a two-pronged experience in which the analyst is invited to collude in the sacrifice of the analysand! (Emphasis mine). Through careful observation one sees what preemptory summons are in the sacrifice of the analysand! (Emphasis mine). Through careful observation one sees what preemptory summons are conveyed in psychotic transferences in which patients treat clinicians as though they were assassins.

Dr. Apprey describes a comparison of an anorexic, transsexual and schizophrenic. The anorexic receives the injunction to die but protests the injunction and lives constantly at the brink of death. The transsexual psychically dies in one form but by stealth survives in another form. The schizophrenic submits to an injunction to die and a simultaneous complicity in feigning a restoration, a repair of the damage done to one’s life. These conditions are horizontal (in the phenomenal world) but not interchangeable. They are horizontal in terms of experience to submit to an errand toward death but different in terms of how they choose to live out their precarious existence.

Chapter five is co-authored by Drs. Volkan and Ast and examines how the core of the infantile psychotic self is observed in a clinical setting. A fascinating and extensive clinical case is presented and other case material is noted such as that of a patient who had six reconstructive surgical operations in an attempt to make her body resemble that of
a cat, the animal she associated with her infantile psychotic self to find a fit between her seed of madness and external reality. True transsexuals have infantile psychotic selves and do not simply want to become a person of the opposite sex but want to be an idealized version of the “good” mother unit. Obviously surgery does not provide lasting intrapsychic change and among “true” female transsexuals the authors find a fantasy of responding to their mother’s perceived sexual hunger by having a penis. We find acts of “disappearing” associated with new birth fantasies. Disappearing and pleasing a parent or parent’s and being reborn to repair them. Extensive treatment description is included in this chapter.

In chapter six Dr. Ast presents clinical illustrations of the theoretical concepts discussed in the preceding four chapters-the infantile psychotic self, early body image, and intergenerational transmission. There is an abundance of clinical case description. In chapter seven L. Bryce Boyer, M.D. focuses on countertransference clearly demonstrating that the working through of countertransference is indispensable for a favorable therapeutic outcome. Emphasis is placed on the interaction of patient and analyst at an intrapsychic level and the crucial importance of how the therapist uses his own conscious and unconscious responses to the patient, whether psychical, somatic, verbal or nonverbal. Countertransference is viewed as the mutual introjection of the analyst and analysand’s projective identifications and the unconscious interpalyer. The author introduces a verbal version of Winnicott’s “squiggle game,” creating drawings verbally. Substantial case material is presented demonstrating that analyzing countertransference experience has had salutary effects during the analyses of regressed patients in the context of helping the patient recover repressed memories of early psychic trauma. Also noted is a refreshing approach of treating the interview as a dream and applying the tenets of dream analysis to the flow of associations obtained through the subjective-intersubjective process.

Chapter eight by Salman Akhtar, M.D. provides a detailed and conceptual follow-up on the ideas of Dr. Volkan presented in chapter one noting that what is inherited is a predisposition to psychosis and not the psychosis itself. Environmental contributions, affective turbulence and problematic objects relations and inadequate differentiation are expanded upon. The psychotic core can have a variety of outcomes ranging from seeming normality to focal or generalized taking over of the ego by the manifestation of psychotic processes. Important distinctions of psychosis and the “as if” personality are discussed. The question of genetic vulnerability, environmental failure and intrapsychic fantasy are taken into account in understanding regressed psychology and its amelioration. This chapter highlights and refines these concepts. All chapters include an extensive bibliography.

Clearly this is a very significant book for anyone working with severely regressed patients.
The ear and the auditory system is complete by the fifth month of pregnancy and the child is exposed in utero to the music and sounds his mother hears. Even though he could be directed to enjoy Indian music or other cultural patterns, this flexibility stops at an early age. Later in life it would be only with effort that he would be able to enjoy foreign music.

My son told me about placing headphones to his wife’s belly throughout her pregnancy, playing a soft melodic Brazilian song by Caeteno Veloso. The baby was born February 6, 2017 and when she was two weeks, during an especially loud crying spell, he played Veloso’s song near her. She stopped crying at once, turned her little head towards the music source with her eyes wide open and in her face there was something akin to a smile. There was no more crying for a while and the new father was convinced that the little girl had recognized the song.

Levitin says that acquiring headphones during his teenage years completely changed and deepened his experience of music. My musician son also has on several occasions introduced me to the use of headphones and maybe after reading this book I will start trying. My skepticism for this technological advancement comes from the effect of isolating listeners. I worry that in this mode, music becomes rather than a communal experience where everyone participates and moves together in dance, one step forward toward an individualistic autism.

I always remember a patient in whose treatment I participated in medical school during my year of psychiatry at the Lanus Hospital. It was the end of the 1950s and headphones were uncommon among the musical people except, perhaps for a radio broadcasting technician. This patient whom I will call Manuel was a 27-year-old paranoid schizophrenic. It was his first break of a late onset schizophrenia and he was cooperative and still rather organized. After some prompting from the professor, he would show the students his “invention to isolate myself from the world and its stupid voices and distractions” and achieve a connection with “Sublime”. The “ingenious device” that he invented, consisted of a flexible wire with two huge cotton balls that he applied to his ears and... voila..., he was in connection with “sublime” words of poetry and “cosmic music” and thus could avoid the connection with the ordinary prosaic and even, disgusting world.

The first time I saw someone wearing headphones and up until this day, I think of Manuel and it gives me pause. I can see the benefits of this technology and the anecdote of my grandchild listening to her father’s music in utero, appears like a very positive way to communicate. Therefore, maybe both Levitin and my son are right about headphones as a new and improved way to experience music.

The role of memory in music is understandable to all of us. The more we listen to a song or when it is played frequently on the radio, we are able to increasingly enjoy it more deeply. In my own life, during my childhood when I had trouble enjoying Prokofiev, for instance, my father insisted that I should listen to his music several times in order to “understand it” and therefore enjoy it. Of course it worked. I did not need that insistence for Mozart or Bach, probably because I grew up from the cradle listening to the classics. The emotion that music evokes, has to do with connections with happy moments and happy periods of our life. In Levitin’s opinion, that is why people can get deeply moved by a forgotten song that is connected with their youth or adolescence. Memory is central for the enjoyment of music. In many occasions it is brought about by repetition and by taking us, as stated before, to previous periods of our life which brings about comfort and joy.

Repetition and expectation are at the core of our enjoyment of music. Violation of expectation and the norm are used to avoid boredom. The author uses the Surprise Symphony by Hayden as an example of an extreme violation of expectation, when the whole orchestra plays an extraordinary loud cord. The previous adagio did not make it predictable. A violation of the expectation then, it is a way to keep music alive and the reason why we don’t tire with certain pieces that contain violated expectations. He hints to the fact that the balance between the repetition, expectation and violation of the expectations are that the core of successful musical composition.

One remarkable aspect of this book is the description of the function of the cerebellum in music. Levitin reminds us that the cerebellum is involved in emotions and the planning of movement. Of course, it is the oldest part of our brain which is present even in reptiles that lack the higher regions of the cortex. Indeed, when we listen to music, it starts with the subcortical structures, the cochlear nuclei, the brain stem, the cerebellum and then moves up to the auditory cortices. When we tap along with music either with our foot or just in our minds, the cerebellum timing circuits are involved. When we perform music no matter what instrument we play or whether we sing, our conduct involves the frontal lobes for the planning of our behavior. It becomes clear that music coordinates more desperate parts of the brain than any other experience, especially if you play music in which case the connections are over encompassing.

Levitin states that statistically musicians have a bigger than normal hippocampus and not surprisingly a bigger than normal corpus callosum as the connection between the hemispheres are more abundant, because of frequent lateralizations that occur during their life. I was reviewing the writings of Oliver Sacks about music and the mind and was reminded that he says that the brain of a painter or engineer or architect have no particular distinctive features; however, the brain of a musician is instantly recognizable by the modern technology of fMRI, Positron Emission Tomography, etc.

A particularly interesting section is Chapter Nine, on the evolutionary aspect of music for humans and for animals. The author reminds us that Darwin thought that music developed through natural selection as part of human or paleo human mating rituals. He discusses the fact that some scientists such as Steven Pinker disagreed with Darwin’s concept of the evolutionary purpose of music. Pinker states that music is just a bi-product of the development
of language without evolutionary meaning. Others like psychologist Dan Sperber and John Barrow have said that music has no role in the survival of the species and is an evolutionary parasite. Daniel Levitin passionately argues that these scientists are wrong. He reminds us that Darwin recognized the implication of his theory of Natural Selection and came up with the idea of sexual selection because an organism must reproduce to pass its genes on. Thus qualities that would attract a mate should eventually become encoded in the genome. Darwin wrote, “I conclude that musical notes and rhythm were first acquired by the male and female progenitors of mankind for the sake of charming the opposite sex. Thus musical tone became firmly associated with some of the strongest passions that an animal is capable of feeling and are consequently used instinctively.” In summary, Darwin believed that music preceded speech as a mean of courtship, equating music with the peacock’s tail. He posited that the emergence of a feature that served no direct survival purpose other than to make oneself attractive was evolutionary useful “to enhance one’s genes”. In the same vein the author argues that if music is just a pleasure seeking behavior, we would expect it to not last very long in evolutionary time which contradicts the fact that music “has been there forever”.

When I started reading this book I had to confront my life long reluctance to learn/know how music is made and where it comes from. When I was four years old, I created my first and last musical composition, which consisted in a scale from lows to highs: do re mi fa sol la si do-- do si la sol fa mi re do” ending in the cord “domisol” repeatedly. I created the lyrics as well, that in Spanish went “ un tremendo verdulero, sale a comprar la fruta, ta, taa.” (a tremendous green grocer goes to buy fruit, fruit, fruit). I was marveled at my own talent and played this song on the piano to my parents when they came from work. They laughed until tears were running down their cheeks and then I was immediately engulfed in an unbearable shame. Since that time, I have refused to relate to the subject of what makes music good or even magical. I didn’t want to hear how a musician composed or about Bach using syncopation or anything that could be analytical of music because I felt it would completely destroy the magic.

Also at the age of four I read my first book cover to cover on my own. It was a biography of Mozart for children, with lots of pictures and a few musical staffs with Mozart’s easier passages, so that the little readers could play them on a keyboard. At that time, I thought that Mozart and his music were supernatural and so was Johan Sebastian Bach and later Beethoven and Schumann. In those years, I was a very mediocre piano, harmonica, and xylophone player and now, I am just a devoted listener. However, Levitin’s book helps to understand the science behind music’s magic without destroying the magic.

In summary, this is a fairly easy to read, delightfully written book, which synthesizes the author’s two fields of expertise. His knowledge of classical music, blues and jazz, and his understanding of the functions of the brain, places him in a unique position to tackle the subject of what is music and how does it exert its power. It conveys a great amount of information while summarizing the answers to centuries old questions.
Welcome New Members!

We are pleased to welcome the following new members to the Academy:

**Psychoanalytic Fellows**

*Andreas Kraebber, M.D.*
New York, NY
Sponsor: Dr. Jennifer Downey

Dr. Kraebber is a graduate of Yale College and Temple University School of Medicine. He completed Psychiatric Residency at the Columbia College of Physicians and Surgeons and St. Luke’s – Roosevelt Hospital Center. He is currently on staff at Columbia University Center for Psychoanalytic Training and Research and in private practice in New York. He is enthusiastic about Academy membership and comes highly recommended by his sponsor.

*Philip R. Muskin, M.D., M.A.*
New York, NY
Sponsor: Dr. Jennifer Downey

Dr. Muskin is a graduate of Cornell University, NY Medical College, Columbia University College of Physicians and Surgeons Psychiatric Residency and two Fellowship Programs. He is currently Secretary of the APA previously served as Chair of the Scientific Program Committee. Dr. Muskin is on the medical staff of the NYS Psychiatric Institute and has many publications. He is highly recommended for membership by his sponsor.

**Psychiatric Fellows**

*Geraldine S. Fox, M.D.*
Oak Park, IL
Sponsor: Dr. Debra Katz

Dr. Fox comes highly recommended by her sponsor. She is currently Special Assistant to the Senior Associate Dean of Educational Affairs at the University of Illinois at Chicago College of Medicine. She previously served as Assistant Dean for Graduate Medical Education and Associate Dean for Wellness and Resilience at that facility. In addition, s is Professor of Clinical Psychiatry in the Department of Psychiatry at the University of Illinois at Chicago College of Medicine. Dr. Fox has been an award-winning teacher and mentor of medical students and residents throughout her career and, in addition to several other awards, has received the highest award for education from the APA – the Vestermark Award.

*Harvey A. Horowitz, M.D.*
Villanova, PA
Sponsor: Dr. Eugene Della Badia

Dr. Horowitz is a psychodynamic psychiatrist who is in private practice in Ardmore, Pennsylvania. He is a graduate of Temple University and completed residency training at the Institute of Pennsylvania Hospital. He served as Regimental Surgeon in the US Navy Reserve from 1969-1971. Dr. Horowitz is given the “highest recommendation” of his sponsor.

*John S. Tamerin, M.D.*
Greenwich, CT
Sponsors: Drs. David Lopez, Eugenio Rothe and Scott Schwartz

Dr. John Tamerin practices clinical psychiatry in Greenwich, Connecticut and serves as a Clinical Associate Professor at the Weill/Cornell Medical College. He has been chosen Teacher of the Year twice by graduating residents in the Department of Psychiatry. Dr. Tamerin has been involved for several years in the practice and teaching of Psychoanalysis and Dynamic Therapies and comes highly recommended by all sponsors.
Psychiatric Members

Benjamin Israel, M.D.
Baltimore, MD
Sponsor: Dr. Jeffrey Katzman

Dr. Israel is this year’s recipient of the Scott Schwartz Award. He has had substantial training in psychodynamic psychotherapy through his residency at the University of Maryland and continues his work as a psychodynamic psychotherapist and attending psychiatrist at Sheppard Pratt. Dr. Israel attended the AAPDP 61st Annual Meeting and is very enthusiastic about joining and contributing to the Academy.

John Sloan Hopkins, M.D.
Northampton, MA
Sponsor: Dr. Ronald Turco

Dr. Hopkins currently serves as Associate Residency Program Director and Staff Psychiatrist in the Department of Psychiatry at Baystate Medical Center-Tufts University School of Medicine. In addition to his experience teaching and supervising residents, he is widely published and is the recipient of many honors. Dr. Hopkins is highly recommended for membership by his sponsor.

Jacqueline D. Pardo, M.D.
Chicago, IL
Sponsors: Drs. Elizabeth Kieff and Elizabeth Steinhauer

Dr. Pardo is a pediatrician and child psychiatrist by training. She uses her understanding of psychodynamic frameworks to the service of her patients and is interested in deepening her understanding of psychodynamic theory and practice. She is in peer supervision groups and is an avid reader of the medical literature. She comes to the AAPDP highly recommended for membership by both of her sponsors.

Brian Keith Sparks, M.D.
Woodland Hills, CA
Sponsor: Dr. Jeffrey Katzman

Dr. Sparks completed medical school at St. George’s School of Medicine in Grenada, West Indies and residency at the University of New Mexico Health Sciences Center. He is currently a Fellow Physician in Psychosomatic Medicine at the University of Southern California Keck School of Medicine, and has been offered a position as faculty member at that facility. He has a strong interest in psychodynamic psychiatry and hopes to be an active member of the Academy if accepted for membership.

Amy Yang, M.D.
Chicago, IL
Sponsor: Dr. James Edwards

Dr. Yang received her BA in Chemistry from Cornell University and completed her residency at SUNY Downstate Medical College. She has served as staff psychiatrist and clinical faculty at Loyola School of Medicine and is currently on staff at Jesse Brown VA Hospital in Chicago. In addition, she is in private practice where she incorporates combined medication management and individual and group psychotherapy. She is interested in applying dynamic concepts to her group psychotherapy.

Members-in-Training

Dileep Borra, M.D.
Philadelphia, PA
Sponsor: Dr. Kimberly Best

Dr. Borra is a PGY-4 at Einstein Medical Center in Philadelphia. He has an interest in dynamic psychiatry and is a participant at Einstein Medical Center’s dynamically oriented classes and case conferences. He is very enthusiastic about AAPDP membership and looks forward to gaining additional knowledge and experience through the Academy.

Viviana Ines Chiappetta, M.D.
Bronx, NY
Sponsor: Dr. Scott Schwartz

Dr. Chiappetta is currently in residency at Bronx Lebanon Hospital and has been accepted to begin dynamic therapy training at NY Medical College Institute. She is very interested in joining the Academy and continuing her education in psychotherapy. She comes highly recommended by her sponsor.
**Jessica E. Eisenberg, M.D.**  
Scarsdale, NY  
Sponsor: Dr. David Lopez

Dr. Eisenberg is currently a resident in Child and Adolescent Psychiatry at New York-Presbyterian Hospital. She is a graduate of Barnard college where she graduated Summa Cum Laude. She completed Medical School and residency at New York University. Dr. Eisenberg has served in numerous leadership position and received several recognitions during her training years. She plans to pursue psychoanalytic training in the future. Dr. Eisenberg is highly recommended for membership by her sponsor.

**Kyle J. Gray, M.D.**  
Chevy Chase, MD  
Sponsor: Dr. Shah Nadeem

Dr. Gray is a resident psychiatrist at Walter Reed Hospital. Dr. Gray states that she has a deep interest in dynamic psychiatry. She is recipient of several professional honors and recognition, has served on advisory board and committees. In addition, she is an ad-hoc reviewer with *Psychiatry: Interpersonal and Biological Processes*, and has been involved with teaching medical students and presenting workshops at various symposia in recent years. Dr. Gray is very enthusiastic about AAPDP membership.

**Joe Yun Hong, M.D.**  
New York, NY  
Sponsor: Dr. Scott Schwarz

Dr. Hong completed his second year of residency in Psychiatry at Metropolitan Hospital in New York and is currently at NY Medical College Psychoanalytic Institute. He has become fluent in the English language and has found interest in using language in dynamic therapy. He is highly recommended for membership by his sponsor.

**You Na Kheir, M.D.**  
Indianapolis, IN  
Sponsor: Dr. Joanna Chambers

Dr. Kheir completed her internship at Thomas Jefferson University Hospital and is currently a resident in Psychiatry at Indiana University School of Medicine. Dr. Khier presented at the Academy’s 61st Annual Meeting and comes highly recommended for membership by her sponsor.

**Anna Mégane Kim, M.D.**  
New York, NY  
Sponsor: Dr. Mary Ann Cohen

Dr. Kim comes highly recommended for membership by her sponsor as she has a special interest in all aspects psychodynamic psychiatry including learning about, teaching and practicing. She graduated from New York University Medical School and is now in residency training at Mount Sinai. During her residency, Dr. Kim has actively participated in teaching medical students and residents, doing community service work, and research on schizophrenia. She looks forward to making contributions to psychodynamic psychiatry and to the AAPDP.

**Morgan Amelia McCormick, M.D.**  
Indianapolis, IN  
Sponsor: Dr. Joanna Chambers

Dr. McCormick completed her PSY-3 year in Psychiatry at the Indiana University School of Medicine. She serves as onsite weekend physician at Riverbend Hospital in Lafayette, Indiana, and Selah House in Anderson, Indiana which is an inpatient facility for adult and adolescents with eating disorders. Dr. McCormick presented at the Academy’s 61st Annual Meeting and is interested in continuing to contribute to the activities of the AAPDP.

**Nitasha Shetty, M.D.**  
New York, NY  
Sponsor: Dr. Kestenbaum

Dr. Shetty received her undergraduate training at Columbia College with a BA in sociology before attending SUNY Buffalo Medical School. She completed General Psychiatry Residency at Yale with special training for treatment of opioid disorders, mentalization-based treatment and cognitive processing therapy for PTSD. Dr. Shetty has received commendation for exceptional dedication to her work. She is extremely interested in psychodynamic psychiatry and hopes to pursue psychoanalytic training in the future. She is recommended without reservation by her sponsor.
**Medical Student Members**

**John Michael Huff, M.D.**
Village, OK  
Sponsor: Dr. Katzman

Dr. Huff is currently a medical student at the University of Oklahoma Health Sciences Center. He has received many awards and is very active in volunteer work. He is very interested in psychodynamic psychiatry and has been working with Dr. Katzman by phone as the training was not available through his PGY-2 didactic experience or through his clerkship. Dr. Huff attended the AAPDP 61st Annual Meeting in San Diego and looks forward to attending the 62nd Annual Meeting in New York.

**Marco Christian Michael, M.D.**
New York, NY  
Sponsor: Dr. Alfonso

Dr. Michael is a medical school graduate of the University of Indonesia international program that is linked to Australia. He is currently applying for psychiatric residency in the USA to begin as a PGY-1 in 2018. He has published in peer reviewed journals and is second author of a paper that will appear in a 2018 issue of Psychodynamic Psychiatry. Dr. Michael is a member of a panel submission being considered for inclusion in the AAPDP 62nd Annual Meeting.

**Brian Wu, Ph.D.**
South Pasadena, CA  
Sponsor: Dr. Ning

Dr. Wu is a graduate of Keck School of Medicine at the University of Southern California. He is currently a Researcher at Epstein Department of Industrial and Systems Engineering at USC, Los Angeles, and the Department of Orthopaedic Surgery at Keck School of Medicine. Dr. Wu will be continuing at the University of Southern California for his residency training. He originally learned of the Academy through PsychSIGN. He is very interested in psychodynamic concepts and is look forward to learning more about and becoming active in the AAPDP.