# Table of Contents

President’s Message: In Search of a Cultural Psychiatry Paradigm Based on Psychodynamic Theory ..................................................... 3  
César Alfonso, M.D.  
Psychodynamics in Contemporary Psychiatry & Mutual Influences: 56th Annual Meeting ................................................................. 5  
Eugene Della Badia, D.O. and Kimberly Best, M.D.  
Looking Back: After the 55th Annual Meeting ......................................................... 6  
Marianne Eckardt, M.D.  
Report from the Chair of Programs ........................................................................ 8  
Eugenio Rothe, M.D.  
13th Joint Meeting with OPIFER ............................................................................ 9  
Joan Tolchin, M.D.  
19th Annual CPRinc Research Conference ............................................................... 10  
Gerald P. Perman, M.D.  
A CAPA Experience: Not Your Momma’s China ..................................................... 12  
Sally Rudoy, L.C.S.W.  
An Italian Commemoration of Jules Bemporad .................................................... 13  
Marco Biacciagaluppi, M.D.  

## Articles

World War II, Freud and Vienna ................................................................. 14  
Samuel Slipp, M.D.  
The Usefulness of the Manifest Dream Report .................................................... 15  
Milton Kramer, M.D. and Myron Glucksman, M.D.  
Trauma in the Life of “Shakespeare” and its Impact on his Works ...................... 18  
Richard M. Waugaman, M.D.  
Autobiographical Notes of a Psychoanalyst ......................................................... 20  
Marco Biacciagaluppi, M.D.  
Finding the Real Enemy in the War on Drugs: Disorders of American Character . 21  
Peter Alan Olsson, M.D.  
Medieval Chronicles I .......................................................................................... 23  
Richard D. Chessick, M.D., Ph.D.  

## Book and Film Reviews

*Descent into Darkness, The Psychodynamics of Mental Illness: An Introduction and Illustration in the Form of a Novel* by Richard D. Chessick, M.D., Ph.D. .................................................. 26  
Reviewed by Joseph Silvio, M.D.  

*The Jewish World of Sigmund Freud: Essays on Cultural Roots and the Problem of Religious Identity* Edited by Arnold D. Richards, M.D. ........................................................................ 27  
Reviewed by Samuel Slipp, M.D.  

*The Jung-Kirsch Letters: The Correspondence of C.G. Jung and James Kirsch*  
Edited by Ann Conrad Lammers ......................................................................... 28  
Reviewed by Ladson Hinton, M.D.  

*Dreams from My Father: A Story of Race and Inheritance* by Barack Obama ............................................................................. 31  
Reviewed by Joan Tolchin, M.D.  

*Back to Life: Getting Past Your Past with Resilience, Strength, and Optimism* by Alicia Salzer, M.D. ...................................................... 32  
Reviewed by JoAnn Elizabeth Leavey, Ed.D.  

*Anonymous* the movie ................................................................................. 33  
Reviewed by Richard M. Waugaman, M.D.  

*The Help* the movie ......................................................................................... 35  
Reviewed by Cassandra Klyman, M.D.  

## New Members

### Front Cover

This is a pair of portraits that are tiny (2.5” x 3”) (Quarter for comparison) in Flemish style, showing the couple reading illuminated prayerbooks, overlooking towns of the period. The woman was painted about 1 month after 9/11 when things in New York started calming down, or maybe we all simply sought serenity. The man was painted about 3 months after when life had once again adopted its self-centered selfish attitude, and complacency replaced community. Both were painted in tempera on wood. Scott C. Schwartz, M.D.
Can psychodynamic psychiatry serve as a conduit to revise our antiquated and clinically ineffective cultural psychiatry paradigms? For the past two years I have been pondering about this question and will share in this column some recent thoughts derived from quite a bit of traveling, lecturing, and treatments across geographical boundaries.

In my opinion, DSM culture-bound syndromes, ending up in an appendix almost as an afterthought, are not particularly clinically useful. Culture-bound syndromes run the risk of intensifying negative cultural stereotypes and internalized racism. The way we teach cultural sensitivity and proficiency is usually experienced by trainees in the classroom or individual supervision as cumbersome, offensive, reductionistic, and usually met with yawning, dissociation, avoidance, jitteriness, grimacing, or eye-rolling.

There is some wisdom in the general critique that contemporary psychoanalysis, just as psychiatry, places more emphasis in understanding pathological states rather than attempting to comprehend normal development and ego-syntonic adjustment to the demands of our ever changing cultural milieu. Even the term “cultural idioms of distress” assigns specific characteristics to ethnic and racial groups, bypassing other culturally relevant socioeconomic, intergenerational, individual, and interpersonal dynamic features.

I have found inspiration in the work of Akhtar, Bullon, Cabaniss, Czarnowski, Condemarin, MA and M Cohen, Davidson, Du, Eckardt, Lana and Ralph Fishkin, Garza, Griffin, Hernandez Delgado, Hoare, Hyun, Kitt, Kent, Qizhuang Jiang, Lefer, Leli, Lopez, Marumoto, Olarte, Pernman, Perry, Schwartz, Rangsun Sithichai, Sam and Sandy Slipp, Siriluck Suppapitiporn, Rothe, Snyder, Taketomo, Tutman, Umaporn Trangkasombat, Waits, Wells, Zaphiropoulos, Jingyan Zhang, and many other colleagues who have examined cultural paradigms using alternative frameworks, such as my preferred Eriksonian prospective contextual development theory, rather than perpetuating retrospective meta-psychological hypotheses or succumbing to stale mainstream psychiatric nosology. I am grateful to colleagues for stimulating my mind, and to patients for helping me learn to listen to what is culturally relevant in treatment, to identify what is not culturally relevant, what may be nothing more than countertransferential overinvestment via extreme cultural curiosity, and what may be thinly disguised as cultural resistance in transferance analyses. Psychodynamic concepts can be helpful in reframing psychotherapy interventions, separating the wheat from the cultural chaff.

A year ago at a grand rounds presentation at Harvard’s Latino Mental Health Clinic I prefaced my thoughts tentatively by saying that “...now I will begin to swim in shark-infested waters, with my critique of extreme culturalism...” To my surprise, the audience then was quite receptive. I remember seeing heads nodding as I spoke. What a relief to find out that I was not being controversial after all! Not that I am averse to controversy, but it is so much easier to effect change when ideas resonate with enthusiastic open-mindedness. To the sophisticated Latino professional audience, I did not speak of ataque de nervios, susto, fatiga, marianismo, machismo, somatization, hysterical personality traits, low physical pain threshold, paternalism, martyrdom, and other reductionistic stereotypes, but rather proposed that a psychodynamic anamnesis, when carefully crafted, may suffice to create cultural alignment. Succumbing to the temptation to categorize symptomatology or personality

continued on page 4
characteristics within psychiatrically sanctioned cultural idioms of distress may be misguided if other relevant data is ignored, such as intrapsychic, interpersonal and intergenerational conflicts, transference, countertransference, resistance, and defensive/adaptive functioning. Cautiously, I repeated my position and have continued to incubate these ideas, presenting them to professional audiences in New York, Buenos Aires, Boston, Bangkok, Lexington, and San Diego. Later in 2012 I will speak in Philadelphia, Prague and return to Southeast Asia. Perhaps what you will read in this column will permutate into a more cogent proposal as I continue to learn with humility during my transcultural academic expeditions.

Erikson was one of the most influential American psychoanalysts. Although perhaps he is best remembered for having won both a National Book Award and Pulitzer Prize in 1970 for his work: Gandhi’s Truth: On the Origins of Militant Nonviolence, his contributions to our field were quite original and clinically useful. He believed that traditional psychodynamic models tend to be excessively retrospective, and criticized the notion that most important aspects of development are set in early life experiences (I am not denying the importance of early attachments and critical periods in development during infancy and childhood, but psychoanalyses should also emphasize reparative and life-enhancing experiences in adulthood). A new paradigm that considers developmental milestones in all age groups is needed, as longevity has become a reality. When psychoanalysis was developed in Europe, most people did not live past their mid fifties. More patients now seek treatment when faced in mid to late life with states of stagnation, emptiness, lack of direction, attempting to seek solace, engaging in prosocial behaviors, while negotiating friendships and family relationships in more adaptive ways.

Erikson’s concepts of prospective and contextual development imply that there are developmental milestones that need to be attained throughout all phases of adulthood. Some, but not all of these milestones are culture-specific. Erikson’s concept of contextual development stresses the importance of the social milieu in a person’s life trajectory, and the importance of the need for adaptation, as one is faced with changes in society. Think of what is happening in China, where soon 50% of the country will live in cosmopolitan globalized international megalopolis and 50% of the population in remote rural areas. While learning about filial piety, the tenets of Confucianism, Buddhism and Taoism, Chinese mythology, or even how contemporary soap operas reflect sociologic and anthropologic realities, framing treatments with Chinese or Chinese American patients strictly within such parameters may deflect from affect-laden conflicts that may not be culturally exotic. While cross-fertilization with allied disciplines in the humanities definitely enhances our understanding of cultural and historical contexts, the realities of each treatment dyad most often will not reflect cultural differences. Globalization may have changed the way we practice, bringing us back to emphasizing the fundamental processes common to all psychotherapies, enhancing supportive interventions with psychodynamic exploration, with cultural similarities often outweighing differences in the therapeutic dyad.

Acculturation and assimilation may be understood as efforts at adaptation.

My position on acculturation vs. assimilation is pro-choice — just as individuals have the right to autonomy and self-determination, acculturation and assimilation are choices that individuals and or groups will make, at different points in time, depending on a multiplicity of variables. There is no right or wrong when it comes to acculturation and assimilation and I believe that as therapists our position should be neutral rather than directive or encouraging of syncretism, blending or isolation. In New York, the Puerto Rican El Barrio is no longer Puerto Rican – now renamed East Harlem, it is predominantly gentrified with yuppies intermixed with new groups of immigrants from Mexico and Central America. Millions of Puerto Ricans have crossed-over and blended within the New York amalgamated megalopolis. Once a year, during the Puerto Rican Day Parade, I am reminded of how rich a part of American culture Puerto Ricans are, as Fifth Avenue is flooded with over three million people, and hundreds of floats demonstrating sensational music, political, religious, and other cultural icons. Chinatown, in New York, as in other US cities, retains cultural boundaries without much renunciation of immigrant traditions or adoption of host attitudes. In the 1980s and 1990s very few would have predicted the degree of acculturation and assimilation of the Puerto Rican community in many US cities.

Intergenerational conflicts surge as families relocate, regardless of the lesser or greater extent of the geographical transposition. These interpersonal conflicts very much permeate the treatment discourse of psychodynamic psychotherapy with our patients. I firmly believe we should make efforts at decoding intergenerational conflicts, but these efforts should not be reserved exclusively to recent immigrants. Explorations of intergenerational conflicts are clinically valuable in all analyses and treatments, regardless of chronological imminence.

Bullon and colleagues (Harvard Review of Psychiatry, 2010, 18:247-253) wrote about the vicissitudes of cultural sensitivity and cultural competence training of health professionals. In the old prevailing paradigm, basic assumptions include that there are disparities in access to treatment (which is true and validated by research) and existing treatments are ineffective and need to be “culturally” modified (I would be cautious to think of this latter assumption as a truism). What I want you to consider is the following: obsessive cultural competence discourse may lead to over-generalizations and stereotyping.

Is language or cultural affinity necessary for psychotherapy? A categorical answer would be no, not essential, but definitely helpful at times. However, we have all probably experienced that some degree of cultural familiarity helps strengthen therapeutic alliance and improve adherence to care. In the same way that as clinicians we are not ethically allowed to express sexist or homophobic attitudes, we need to be culturally sensitive rather than xenophobic or racist. We should desensitize ourselves not to fear our neighbors or those who come from different backgrounds and have had different life experiences.

I will end this column with a tale that symbolizes globalization. Chilies are an American fruit, known to exist in the wild for 12 millennia and domesticated for at least eight millennia. Chile, the name of the country, is derived from the Quechua word chiri (cold), the Aymara word ichilli (snow), and the Mapuché word chilli (meaning “where the land ends”). Chile and chilli share no etymological antecedents. Chilli, the spelling of the fruit in Nahuat, rather than the conventional spelling ‘chili’,
Psychodynamics in Contemporary Psychiatry: Mutual Influences: 56th Annual Meeting

by Eugene Della Badia, D.O., Kim Best, M.D., Co-Chairs

Philadelphia, PA
May 3-5, 2012

We welcome you to Philadelphia for the 56th Annual Meeting of AAPDP, Thursday, May 3 – Saturday, May 5, 2012. The theme of this meeting will emphasize the importance of psychodynamic thinking in the practice of psychiatry. We will also be looking at discoveries in neuroscience and how they have influenced psychodynamic psychiatry. Our meeting will explore social, cultural, biologic and psychological problems in modern psychiatry. This meeting will continue the Academy’s mission of leadership in dynamic psychiatry.

John Oldham, M.D., President of the American Psychiatric Association, will be our Opening Night Speaker. He will present his work with the DSM-5 task force on personality disorders. Henri Parens M.D. of Jefferson Medical College will give a Plenary Session on Resilience from his experience as a holocaust survivor. Prolific author Salman Akhtar, M.D., also with Jefferson Medical College, will give the Keynote Address entitled “Psychoanalytic Perspectives on Human Goodness: Theory and Technique.”

Andres Pumariega, M.D. Chairman of the Department of Psychiatry at Cooper Medical School, and members of his faculty, will participate in a panel discussion on culturally-informed psychotherapy with children. Eugenio Rothe, M.D. and Jaun Raul Condemerain, M.D. will also participate in this presentation. Mary Ann Cohen, M.D. has put together a distinguished panel to update us in HIV and AIDS psychiatry.

Many of our members have written papers, which we have grouped into panels, workshops and paper sessions. is the preferred spelling as per the Oxford Dictionary. Please make an effort to add the extra “l” from now on... Aji, the word for chilli in the Caribbean, is of Taíno origin. Ajies tend to be milder in flavor since they contain less capsaicinoids.

How chillies traveled around the world and influenced other cultures could be viewed as a metaphor of globalization. Chillies are no longer an exclusive or predominant American staple. They arrived in Asia not so long ago; believe it or not, even in the Indian subcontinent, South Asia and Southeast Asia, there were no chillies in Asian cuisine until the 17th to 18th century.

I remember having a conversation with friends in Thailand about the history of Thai food, and they were quite aware that old imperial Thai cuisine was quite bland until American chillies arrived to the old capital of Ayutthaya. My friends also told me that sushi originated in Thailand. I did not believe this but was too polite to argue. I looked it up later in the book The Zen of Fish and corroborated they were right.

The next time you order a vindaloo dish at an Indian restaurant please remember the following and you will impress your guests. The Portuguese, who brought chillies to India, also brought their other traditional dishes. Vindaloo derives from a traditional Portuguese Christmas dish, “carne de vinha d’ahlos,” which basically translates to pickled garlic pork. Indians in the Goa region spiced it up by adding American chillies. A few centuries later, vindaloo curries stand among the spiciest. As Akhtar poignantly states in his recent book Freud and the Far East, psychoanalysis is no longer Eurocentric or an American phenomenon and our academic exchanges should renounce colonialist attitudes. We learn from each other and psychodynamic practice takes on the color of its host countries, with ensuing modifications of theory and practice. Exchanging psychoanalytic theories with international colleagues should occur with respectful reciprocity.

Traveling around the world is no longer necessary to teach or treat. Distance learning through videotelephony technologies and clinical encounters using SKYPE™ or ooVoo™ are now well established and accepted by most clinicians. Research validating the effectiveness of these efforts is under way and I predict will corroborate that technological advances are effective and can be integrated into our clinical and didactic armamentarium to reach undeserved areas or supplement our local endeavors.

To conclude, unaltered psychodynamic theoretical concepts and technique may provide a balanced framework to work through resistance and avoidance behaviors when these are disguised as cultural differences. Cultural humility rather than excessive countertransferential investment, which primarily reflects the therapist’s cultural curiosity and not necessarily relevant aspects of the process, may protect the integrity of treatment by allowing the therapist to work with the material that is of greatest relevance to the patient. A new paradigm that takes globalization into account will help cultural psychiatry evolve to enhance our therapeutic actions. Psychodynamic psychiatry may well serve as a solid substrate for cultural psychiatry to build upon.
Panel discussions include New Frontiers in Psychodynamic Psychiatry. In this panel there will be paper presentations by several members of the Academy and a discussion by Gerald P. Perman, M.D. Another panel will present issues in child and adolescent psychiatry, which will deal with foster care, adoption, attachment and precursors of personality disorders. David Lopez M.D will discuss these papers. There will also be panel presentations on the interface of psychodynamic and biologic psychiatry for which Matthew Tolchin, M.D. will be the discussant.


Debra Katz, M.D., residency training director at the University of Kentucky, will give the Presidential Address entitled “Inspiring Interest in Psychodynamic Psychiatry and Psychoanalysis: National Survey Data and Implications for the Future.”

There will be additional quality presentations in the tradition of the Academy as well as programs for residents and medical students. On Saturday residents will have the opportunity to attend a free luncheon at which resident Heather Forouhar-Graff, M.D., will discuss the nocebo effect. Later that evening Dr. Forouhar-Graff will receive the first Annual Scott Schwartz AAPDP Award. This award was created by colleagues to honor Scott Schwartz, M.D., a dedicated mentor of residents and junior colleagues. The award is given to the resident or fellow submitting the best psychodynamic paper.

There will be two special workshops. The first will be given by Richard Friedman, M.D., the new editor of the Academy Journal. He and three of his co-editors will work with participants on the plans for the Journal and to help them develop opportunities in writing for a scientific publication. The second is a workshop by Douglas Ingram, M.D. and several faculty members of the New York Medical College Psychoanalytic Institute on peer supervision. This workshop will feature several presentations with comments by senior clinicians.

On Saturday May 5th there will be a dinner honoring Life Members of AAPDP and Douglas Ingram, M.D. for his years of service as Past Editor of the Academy Journal. It will be held at R2L on the 37th floor of Two Liberty Place. This is one of the most scenic restaurants in the city. Its huge glass windows give you a 40-mile view of the city from 500 ft up. The food is outstanding as Chef Daniel Stern gives a creative twist to traditional American cuisine. We will have our own space and be able to socialize and enjoy the evening with the usual collegiality of our members.

Philadelphia is the 6th largest city in the United States although for those of us who live here it has the feel of a small city. It is a friendly city of neighborhoods, each with its characteristic culture and ambience. We will be located at the Loews Philadelphia Hotel which is only a few blocks from the Avenue of the Arts where there is a variety of concert halls and theaters. In the opposite direction is the historic area where you can visit Independence Hall, the Constitution Center and the Liberty Bell. There are many museums throughout the city including the Philadelphia Art Museum, the third largest in the country. The Van Gogh exhibit will be featured at the time of our meeting. Philadelphia is also known for its great restaurants.

We look forward to seeing you at our Annual Meeting and we hope you will take the time to explore and enjoy our city.

---

Looking Back

On the Occasion of the 55th Annual Meeting in Hawaii

by Marianne Horney Eckardt, M.D.

Dear Dr. Alfonso, Dr. Silvio, Dr. McDermott, colleagues and guests,

I am being honored as an accident of history, as I happen to have been president of this Academy when we last met in Hawaii in 1973, and also because I am one of a very few surviving founding members of the Academy. I am pleased to be representing this link to our history, for I believe this American Academy is a most remarkable and unique organization which has been able to maintain a spirit of congenial creative vitality for 56 years and has been able to remain true to its original goals of intra and inter-disciplinary communication.

I am filled with overwhelming gratitude when I think that the Academy has been my professional home for these 56 years. I thank fate for this gift. What a wonderful home it has been, providing a sense of belonging, a professional identity, stimulation, encouragement to develop my own ideas, responsiveness, and as our president César Alfonso rightly stresses, so many opportunities for exciting mentorship.

In contrast to many students of psychoanalysis at that time, I was never weighted down by Freudian orthodoxy. In fact, it was the reverse. I learned about enthusiastic new ground breaking before I discovered Freud and before I began to appreciate his genius and what he set in motion. I heard my mother’s (Karen Horney’s) innovative exciting lectures at the New School for Social Work in New York. I heard a few lectures by Harry Stack Sullivan who rewrote psychiatry as the pathology of interpersonal relations with anxiety (not libido) as the causative agent. I owe more than I can say to my analyst Erich Fromm. I was intrigued by the reading of Wilhelm Reich, C.G. Jung, and...
especially Otto Rank, whose ideas on guarded creativity and individuality as a source of neurotic development were and still are undervalued. I swam in a sea of impressive innovations with as yet little of a structure that I could call my own.

So the Academy with its free spirit of inquiry and more questions than answers was the most ideal place for me. There I continued to be enriched by the smorgasbord of ideas. I learned to appreciate issues of adaptation emphasized by Sandor Rado, the notions of systems theories by Roy Grinker and John Spiegel, the ever youthful endeavor of Franz Alexander to give relief to patients in shorter periods of time. He coined the phrase “corrective emotional experience” to characterize what we were aiming at in our psychotherapy. Wanting to refresh my memory of his concept of “corrective emotional experience,” I glanced at his book *Psychoanalysis and Psychotherapy* published in 1956, the same year as the Academy was founded, where, to my delight, I came across what he saw as controversial issues at that time. They well reflected the inquiring atmosphere of our new Academy.

Alexander was impressed with the many patients who with therapy improved rapidly. He began questioning the invariable necessity for years of analysis. He emphasized that change did not occur by insight alone but by making new experiences when becoming open to novel explorations and with change in one’s behavior. He encouraged experimentation with shorter periods of therapy, with lesser frequency and with occasional interruptions of treatment. This notion of benefits from temporary lulls in or vacation from therapy was based on his belief in the regenerative power of the organism, which we see in healing in all fields of medicine. Even now this generative power of our organism is not being given enough consideration. Through therapy, Alexander explained, we open up the nature-given channels of learning. Once opened, the patient can learn again from life. He thought that too much dependence on the therapist may even retard his or her progress. Though believing in the use of transference when conducting therapy, he dared write about the potential of overdosing the focus on transference. He emphasized that every patient needs individual evaluation for what works best, and that we have to be flexible in the conduct of therapies. He saw dynamic psychotherapy not as a separate form of therapy but a desirable continuum of the more orthodox ways of treatment.

This book was written in the beginning of his emancipation from the orthodox establishment, and in subsequent years he became more flexible, more creative and outspoken.

Gradually, through experience, my own ideas began to crystallize. I certainly believed in the importance of being exposed to many ideas in our field as well as the adjacent sciences and art. I knew that ideological entrapment was to be avoided. Yet I appreciated schools of thought, though they were ideologically inclined. I saw them as important dramatic presentations of a particular view of human, and specifically neurotic, development that highlighted different aspects of conflicting, dramatic personae of solutions and therapeutic approaches. They are conceptual creations, serious conceptual art, and essential as tools of learning.

I will mention just a few of my ideas that emerged. Through happenstance, therapies with a number of patients were interrupted for a period of time because of outer circumstances. When these patients resumed therapy, many showed considerable improvement. I remember thinking that, if I had seen these patients throughout this time, I would have attributed the improvement to therapy. I thus learned to view life and its opportunities as important collaborators in doing therapy. This idea really echoes Alexander’s emphasis on the organism’s generative powers.

From relatively early on, I thought of myself as doing psychodynamic psychotherapy informed by my psychoanalytic training rather than conducting psychoanalysis. I varied frequency and, with a good sense of the past, focused on the difficulties in the present. I saw therapy as a collaborative enterprise. I used the couch only sporadically to encourage free associations that might give clues to meaning. I loved working with dreams, as they invariably made for a creative hour of surprises. I did not make interpretations in the sense of my knowing the meaning of the patients’ productions. I would just offer my take, my associations, to the mutual enterprise of trying to gain understanding. My suggestions though might stimulate the patient’s association. The patient may comment: “What occurred to me while you were talking was…” and these comments were always relevant. I favored active inquiry, as there was so much that we did not know, so much that the patients do not tell us, but which might help our understanding. They do not tell us not because of repression or conflict, but because it is just part of their lives, or exists as unformulated knowledge.

I am mentioning my own development to emphasize the creative, stimulating potential of this spirit of free inquiry essential to the Academy, and that still exists to this day.

Much has changed in the dynamics of psychoanalysis’ status and place in our society. In 1956 we urgently needed a platform free of ideological thinking and politics, devoted to the exchange of ideas and communication and breaching the existing isolation to the behavioral sciences. Today psychoanalysis has merged with psychodynamic psychotherapy and faces a totally different challenge. Psychiatry has embraced the blossoming drug industry, and insurance companies have dropped their support for extensive psychotherapy. But worst of all the teaching of psychodynamics in psychiatric training centers has become almost obsolete. So the urgent challenge which faces the Academy now is to uphold the torch of the existence of psychodynamic thinking, functioning, therapy and to provide mentorship to psychiatric residents and interested psychiatrists.

This shift in circumstances and need has given new vitality to the second important mission of the Academy: the importance of active liaison and collaboration with other organizations and societies in the field. Initially, our most important liaison was with the American Psychiatric Association to assure that we were acknowledged as representing psychoanalysis as well as the American Psychoanalytic Association. Gradually our liaison activities expanded. But now it has become a most important function of our organization. Our Newsletter reports on our collaboration with organizations in China and Italy For twelve years we have held joint meetings in Italy with the psychoanalytic organization referred to as OPIFER. In an innovative way members have supported a project of group teaching psychodynamic therapy to Chinese students via Skype. Most important, we have joined with another group to form the Consortium for Psychoanalytic Research located in Washington, D.C., which meets in February. This, Gerald Perman sees as an extension of the Academy and has rightly called this meeting our de facto winter meeting. Dr. Lefer and Dr. Mary Ann Cohen have
formed the active Society for Liaison Psychiatry. The Teichner Donation has been used to provide training in psychodynamic psychiatry to psychiatric residency training programs that are underserved in their area. The role of mentorship is being expanded in many ways.

It is a miracle how the Academy has retained its creative spirit, its vitality, and its flexibility for 58 years. This miracle it owes to the incredible wisdom of its constitution. Its draftees knew not only how to formulate its aim of intra-and inter-disciplinary open-minded curiosity and exploration, but also how to protect it from the dangers of power hungry politics by stating that the Academy will not license, supervise, certify or accredit training programs or institutes, and by insisting on a brief term for the office of the presidency. They, the draftees and founding members; all had suffered from manifestations of power politics and were aware of the organizational activities which were most apt to stimulate its flourishing. Thus while the dominant activity of the Academy has varied, its fundamental spirit and aims are as alive as ever and full of ever-regenerating vitality.

Our present program illustrates our spirit of inquiry. How can we overcome what appear to be obstacles to treatment? Resistance to treatment does not reflect upon the patient, but only on our improving our repertoire of treatment. Once we have found a new source for effectiveness, we stop seeing the patient as resisting. Having been given the privilege of becoming honorary Program Chairperson, I can attest to the vital creative enthusiasm of the program committee that heralds an exciting meeting. My thanks and regard to all past and present members who have sustained this wonderful organization.

---

The Academy’s 56th Annual Meeting in Philadelphia Offers a Rich a Exciting Program

by Eugenio M. Rothe, M.D.
Academy Chair of Programs

Philadelphia will host this year’s Annual Meeting that will take place from May 3-5, 2012. The chosen location will be at the Loews Philadelphia Hotel at 1200 Market Street with easy access to many of the city’s main attractions.

In what has now become a tradition and a statement about our strong ties with the APA, the Opening Speaker will be APA President John Oldham M.D., who will inform us about “Personality Disorders and DSM-5.” Thanks to the efforts of co-chairs Eugene Della Badia, D.O. and Kimberly Best, M.D., the meeting will highlight a Plenary Session with Henri Prens M.D., a child survivor of the holocaust and Professor of Psychiatry at Jefferson Medical College, who will present autobiographical material and discuss the topic of “Resiliency.” The Keynote Address will be delivered by Salman Akhtar M.D., also a Professor at Jefferson, who will present on “Psychoanalytic Perspectives on Human Goodness: Theory and Technique.”

The Friday program will begin with two concurrent panels: the first will be chaired by Andres Pumariega M.D., Chairman of Psychiatry at the Cooper Medical School in Camden, N.J. and will focus on “Psychotherapy Approaches with Children and Families of Underprivileged and Culturally Diverse Backgrounds.” The concurrent panel “New Frontiers in Psychodynamic Psychiatry,” will be chaired by Gail Berry M.D. with Gerald P. Perman M.D. as discussant. This will be a rich and diverse collection of presentations covering applied psychodynamics, politics and neuroscience.

Friday’s noon workshops will consist of César Alfonso, M.D., and Silvia Olarte, M.D.’s “The Psychiatrist as Internist of the Mind,” concurrently with Crittenden Brookes, M.D., Ph.D., and Clay Whitehead, M.D.’s ongoing and exciting discussion group, “Theoretical Models of Psychotherapy.” The afternoon will offer a series of very exciting consecutive presentations, all in the same room, in order to allow the members to interact as a group and be able to attend all the presentations without having to make difficult choices. The session will start out with Erminia Scarcella, M.D.’s “The Red Book of C.G. Jung,” and Sheila Hafer-Gray, M.D. as discussant, followed by Samuel Slipp, M.D. who will present on “How Freud’s Fight Against Anti-semitism Split the Psychoanalytic Movement.” Later, Myron Glucksman, M.D. and Milton Kramer, M.D. will present on “Initial and Manifest Dream Reports of Patients in Psychodymanically-Oriented Psychotherapy,” ending with Greg Mahr, M.D. of Michigan, who will present on “The Overdiagnosis of Bipolar Disorder: Countertransference Aspects.”

The Saturday morning program will begin with two concurrent panels. One will focus on the “The Interface between Psychodynamics and Biologic Psychiatry,” including topics such as evidence-based findings on adherence to treatment, splitting treatment with psychologists and social workers, and the use of MRI’s and genetic testing in psychodynamic psychiatry. The other panel will focus on “Child and Adolescent Psychiatry” and it will cover such topics as, psychodynamic reactions to foster care, psychotherapy with persons who are adopted, childhood precursors to personality disorders and an international perspective on attachment. The noon program will present attendees with two consecutive and very difficult choices. The first two workshops will focus on “Neurodynamics and Psychodynamics of Narrative,” by Richard Brockman, M.D. and “Transcultural and Psychodynamic Psychiatry in the Era of Globalization” chaired by César Alfonso, M.D. and Anthony Bullon, M.D. These are followed by another very difficult choice for the attendees: “Narratives and Brain Processing” with Andrei Novac, M.D. and Barton Blinder M.D. of Newport Beach, CA concurrently with a workshop titled: “Interfacing
The Academy held its Thirteenth Joint Meeting with OPIFER (Organizzazione di Psicoanalisti Italiani-Federazione e Registro) in Rome, November 12-13, 2011. The theme of the meeting was “Psychoanalytic Training Today: In the Footsteps of Silvano Arieti, Honoring the Memory of Jules Bemporad.”

Dr. Bemporad was a respected and inspiring Past President of the Academy as well as a Past Editor of its Journal who passed away in June 2011 after a long illness. At the meeting, Dr. Marco Bacciagaluppi, a founder and Past President of OPIFER and an Academy Fellow, spoke movingly about Dr. Bemporad who had also played an instrumental role in helping to establish the liaison with OPIFER and the yearly joint meetings in Italy. (This speech is listed on page ##.)

The American Keynote Speaker was Dr. John T. Walkup, Vice Chair, Department of Psychiatry and Director, Division of Child and Adolescent Psychiatry at New York-Presbyterian/Weill Cornell Medical Center. He spoke on “Challenges of Child and Adolescent Psychiatry at New York-Presbyterian Hospital/Weill Cornell Medical Center.” Dr. Walkup described the vast amount of information and expertise the current psychiatric resident needs to master, the increased patient load and bureaucratic paper work the resident faces. Learning psychodynamic principles and treatment is time consuming work that must be carefully balanced with the other requirements of the training. Dr. Walkup has been encouraged by the high caliber of residents his program attracts and their ability to integrate psychodynamic theory and treatment into their therapeutic armamentarium.

Academy Fellow Dr. Erminia Scarcella presented an excellent paper on “Training in Jungian Analytic Psychology: A Quick Overview.” Dr. Scarcella reviewed the history of the development of Jungian training programs in the United States and other places in the world. She then focused on what current Jungian training involves in the USA.

Dr. James Eaton, also an Academy Fellow, spoke on “Using a Consultation-Liaison Service to Begin Teaching Principles of Psychodynamics and Countertransference.” His talk was a rich and thoughtful discussion of clinical work he had done as a resident on the Consultation-Liaison Service of a large city hospital. His consultation to the urology service involved not only helping the patient, but also helping the staff deal with a medical crisis and significant counter-transference issues.

There were also many interesting talks by our Italian colleagues. Of note, was the Italian Keynote presentation by Dr. Gianni Guasto, “Towards a Lay Psychoanalytic Training.” Dr. Guasto became an Academy Fellow after he attended the Twelfth Joint Meeting in Genoa and has also published in our Journal. The meeting venue was the Centro di Formazione “Polo Didattico” situated in the Piazza Oderico da Podenone and this meeting marked the first time that the Academy had held its Joint Meeting in Rome. We are grateful to OPIFER’s President, Dr. Pietro Andujar, and his able Meeting Planning Committee that contributed an enormous amount of work in arranging all of the meeting details, including the venue, the audiovisual equipment, and a delightful and gracious opening reception. The meeting was extremely collegial with both formal and informal opportunities to exchange thoughts and ideas.

Holding our Joint Meeting the weekend of November 12-13,
2011 in Rome was particularly auspicious. This was the weekend that Prime Minister Berlusconi resigned and we learned that Mario Monti would likely replace him. There was much celebration in appreciation of this event. As my taxi driver happily announced, “We are free!”

As a result of the Joint Meetings with OPIFER, more than 14 Italian psychiatrists have joined the Academy. These Italian members have included such prominent psychiatrists as Dr. Adolfo Pazzagli, the past Chair of the Psychiatry Department at the University of Florence, and Dr. Giovanni Corsini, the preeminent psychopharmacologist in Italy. Additionally, because of their participation in the Joint Meetings, at least five American psychiatrists became Academy members, including Drs. David Lopez, Sandra Park, Craig Katz, and Charles Nemeroff. Dr. Modasser Shah who enthusiastically attended the Rome meeting, has recently become an Academy member. Welcome Dr. Shah!

The Consortium for Psychoanalytic Research (CPRinc) held its 19th Annual Research Conference at the George Washington University Hospital in Washington, D.C. on Sunday, February 5, 2012. J. Christopher Fowler, Ph.D., Associate Director of Clinical Research at the Menninger Department of Psychiatry at the Baylor College of Medicine in Houston, TX presented “Blind Men, Elephants and Psychotherapy Effectiveness: Skewed Views of Treatment Realities & How to Fix Them.” The CPRinc is made up of 12 Baltimore-Washington area mental health organizations and its purpose is to build a bridge between clinicians and clinically relevant research. The Academy provides the CME credits for physicians attending this de facto winter Academy meeting.

Introduction

Bonnie Gallagher, M.S.W., L.I.C.S.W., President of the CPR, welcomed and introduced Dr. Fowler. Prior to the formal opening, participants had completed the study instruments, assisted by Dr. Fowler and CPRinc Trustees.

Grasping the Complexity of Co-Morbidity

The morning session began with Dr. Fowler orienting the audience to the complexity of the concept of co-morbidity and the search for underlying mechanisms to guide interventions to the study instruments. Dr. Fowler began his formal presentation with a discussion of the metaphor of blind men and elephants. He offered several caveats. Medication trials are often performed on patients with a single disorder and without comorbid disorders. This is often not the clinician’s experience with patients in the real world. When treatment brings insufficient relief, it is the medical profession’s responsibility to identify the barriers to effective treatment, to assess for early detection of prodromal TR markers, and to develop treatment augmentation strategies. Fowler cited three vanguard CBT controlled TR studies: (1) TR to medication among patients with schizophrenia; (2) TR with patients with recurrent depression; and (3) TR in patients with borderline personality disorder (BPD). All showed only modest success. This is similar to other medical conditions.

TR disorders are currently categorized in a unitary, “yes – no” manner in the DSM-IV, without taking into account severity of illness and functional impairment. There is no classification system or assessment method to identify individuals at risk for TR across diagnostic categories. Fowler wanted to provide evidence for a spectrum of TR psychiatric illness that cut across diagnostic categories as well as adding a new category. Cross cutting markers included: (1) multiple co-morbid diagnoses; (2) a history of failed partial responses to treatment; (3) interpersonal impairment; (4) role performance impairment; and (5) self-defeating and self-destructive behaviors. Having any or several of these markers makes for a poorer prognosis and moves beyond Freud’s idea of whether the patient has sufficient “motivation for change.”

State of the Art of Treatment

Under optimal conditions, random controlled trials and efficacy studies show inadequate treatment responses, 15% to 50% of the time for single disorders and more frequently for complex disorders. One study showed that 72% of psychiatric patients have co-morbidity. Problems abound in defining TR for any single disorder and this problem is not unique to psychiatry, e.g. TR epilepsy. In the STAR-D Study, no treatment outperformed any other among various medications and psychotherapies. One definition of TR: suboptimal improvement in target symptoms of less than 50% and failure to return to baseline despite adequate dose and duration of known effective treatment.

Treating single disorders minimizes complexity but can miss the existence of co-morbidity. Categorical diagnoses obscure severity and functional impairment. The DSM-V workgroup for personality disorders has proposed a dimension of severity. It has shown that co-morbid, multiple, and borderline personality disorders (BPD) increases the risk of poor outcome. Pre-treatment characteristics of patients with BPD that predict worse outcomes include: more severe psychopathology, greater functional impairment, interpersonal relationship instability and a history of childhood trauma.

Fowler cited numerous studies indicating possible pathogenic factors of TR that included: genetics (e.g. side effects of SSRIs and mood instability), temperament (ability to delay gratification), impaired relationship function, poor therapeutic alliance, and lack of expectation of cure (trust and positive expectancy). Placebos accounted for 75% of improvement of active drugs with only a two point improvement on a semi-structured interview in a second meta-analysis of many studies. This has drawn expectable fire from pharmaceutical companies. Also, the sicker the patient, the more the active medication is effective. Placebo is a misnomer since both placebos and opioid drugs activate the rostral anterior cingulate cortex (ACC) and pons. The ACC has also been shown to be the “seat of transference.”

Part of negative outcomes may be due to the nocebo response, i.e. 19% of patients receiving placebos reported side effects in
100 studies. The nocebo response is increased by a history of adverse reactions. Patients with Type A personality traits report side-effects after placebos three times as often as patients with Type B personality traits. The hypothalamic-pituitary-adrenal axis has been implicated in the nocebo response. They may involve opposite activation of the endogenous opioid system.

Improving trust in relationships improves depression outcomes according to a 1996 reanalysis of the NIMH Treatment of Depression Collaborative Research Program. The greatest improvement was found with therapists who facilitated a positive therapeutic relationship, focused on psychological rather than biological explanations, used psychotherapy without medications, and were not disappointed when treatment took longer.

**Personality and Symptom Change in TR Inpatients**

Fowler presented the results of a study with 77 inpatients who averaged 16 months of intensive residential treatment compared to outpatients in a university counseling center. Most residential patients had multiple Axis I and II diagnoses and about 50% had poly-substance abuse, had a recent serious suicide attempt, had two or more hospitalizations and exhibited self-destructive behavior. Fifty-eight percent of these patients were female and the average age was 29.4. At the end of treatment, about half showed a reduction in symptom severity and improved social functioning.

He tried to account for the differential treatment response between the residential inpatients and the college student out-patients using the Global Psychiatric Severity of Impairment (GPSI) Index and examined various factors across site differences. The GPSI robustly predicted treatment response for Axis V symptom severity and social functioning. He also looked at the DSM-IV GAF (Global Assessment of Functioning). Patients in both settings were responsive although the outpatient college students improved rapidly in 12 session treatments whereas inpatients with more severe, chronic and co-morbid illnesses in long-term residential treatment programs improved at a glacial pace requiring over 250 sessions at four times per week. The GPSI therefore can be useful when speaking with third party providers and making treatment recommendations.

**It Takes a Village: Practice Research Networks (PRNs) to Advance Research & Treatment**

Dr. Fowler’s second keynote presentation of the morning described how to use PRNs to advance treatment and research. PRNs are networks of healthcare professionals dedicated to perform systematic inquiries in the clinical setting. These are accepted as legitimate scientific approaches for which funding is often available. They are designed to complement traditional research and are more practice-relevant and generalizable to day-to-day practice. PRNs are needed to challenge common assumptions based on poorly generalizable RCT findings. The PRN process is as follows: identify a knowledge gap, systematically search for adequate answer, generate and clarify study question, design a study, collect data, analyze and interpret the results and implement the results in practice.

**The Research Exercise**

In the afternoon the findings of the research exercise performed by attendees prior to the conference were presented by Sheila Hafter Gray, M.D. Participants anonymously rated two of their patients, a treatment responsive patient and a treatment resistant patient, using DSM-IV Axes I, II and V diagnoses, the GPSI and the Defensive Functioning Scale (DSM). Hafter Gray introduced Tim Pineau, M.A., a doctoral candidate at the Catholic University of America, who presented their findings. They showed only results that were significant at the p = 0.01 level or better, i.e. with 99% confidence. The data indicated that treatment resistant patients had a greater number of DSM-IV diagnoses, greater severity of functional and interpersonal impairment, a greater number of psychiatric hospitalizations and used more immature, defense mechanisms than the responsive patients.

**Discussion and Closing**

Discussant Susan B. R. Gibbons, Ph.D. stressed the importance of staying in a “both and” regarding the concepts presented. A “fixed” understanding helps us feel secure whereas a “fluid” understanding allows the potential for change. The gap between practice and research should be a fluid gap. She quoted Guntrip: “theory is a good servant but a poor master.” Gibbons told us that the best treatment in the universe is also a good servant, but a poor master, since the patient is the master.

Gibbons quoted Freud: “Analysts cannot repudiate their descent from exact science and their community. Moved by an extreme distrust of the power of human wishes and of the temptations of the pleasure principle, they are ready for the sake of obtaining some fragment of objective certainty to sacrifice everything. The dazzling brilliance of a flawless theory and the exalted consciousness of having achieved a comprehensive view of the universe and the mental calm brought about by the possession of extensive grounds for expedient and ethical actions – they gave all that up. In place of these they are content with the fragmentary pieces of knowledge and with basic hypotheses lacking preciseness and ever open to revision instead of waiting for the moment when they can escape from constraint of the familiar laws of physics and chemistry. They hope for the emergence of more extensive and deeper-reaching natural laws to which they are ready to submit. Analysts are at bottom incorrigible mechanists and materialists even though they seek to avoid robbing the mind and the spirit of their still unrecognized scientific characteristics.” (Freud, 1941d [1921], p. 178-79)

The research culture has been distorted by a bias toward the fixed at the expense of the fluid. Learning to be a rigorous scientist has been like studying a river. Perhaps we have our scientific defenses because we need them. But we need to stay mindful that a river has not been captured by scientific understanding. The conference concluded with audience discussion and evaluations.

I am most grateful for the editorial assistance on this article provided by Sheila Hafter Gray, M.D. Please visit CPRinc at www.CPRincDC.org.
Along with KFC, McDonald’s and Starbucks, China is importing psychoanalysis. I recently went on a multi-week study tour with the China American Psychoanalytic Alliance (CAPA). I was a bit taken aback at first at the wholesale adoption of all things western in China. For example, take women’s fashion: Mao jackets have been replaced by form-fitting blouses, 3” heels on unbound feet, and colorful miniskirts. George Clooney, Leonardo DiCaprio, and Kate Winslet appear larger than life on billboards advertising luxury products they would never dare hawk at home. Cell phones are as prolific as they are on the streets of New York. The irony, of course, is that most of the products are made in China although originally designed for western tastes. Consumerism is rampant.

It is this consumerism, in part, that has provided an incentive for Chinese therapists to seek training from outside the country’s borders. More than ever before, with a rapidly rising middle class, the Chinese feel pressure to make money and to keep up with their neighbors. With this pressure has come an upsurge in mood disorders. The one child policy, initiated in 1978, has created generations prone to narcissism and overwhelming parental expectation. The legacy of trauma from the Cultural Revolution finds its way into every corner and generation of this country that has experienced more profound change in the last 30 years than the 2000 that proceeded.

Among young clinicians there is a great interest in psychoanalysis, particularly classical Freudian theory. While conversant in the psychoanalytic literature, they have little clinical experience or training in its practice. That is where CAPA steps in. Founded by Elise Synder, M.D. in 2002, CAPA’s mission is to provide training in psychoanalytic psychotherapy to mental health clinicians in China.

Classes, supervision and analyses are conducted via Skype and ooVoo (for classes only) by psychoanalysts around the world. Since all activities are conducted in English, participants must have a good command of the language. Skype is used because it is secure and confidential. As Elise Snyder says, it is also the communication tool of choice for the Mafia and top corporate CEOs.

Most of our contact has been with Chinese psychiatrists, psychologists and counselors, who had trained with CAPA. In their papers and case presentations they displayed clinical competence and an understanding of psychoanalytic process and theory. By contrast, I visited a mental health clinic that had no affiliation with CAPA. We communicated through a translator in front of a large audience of young clinicians. I would speak a few sentences in English, wait for the translator to say what I had said in Chinese, wait for her response in Chinese, and then for his translation back to me in English. We averaged about two minutes per exchange. This posed quite a challenge not just for the obvious reason of having to speak with so much delay between thoughts.

It was a challenge because the material presented was shocking. The therapist anxiously presented a case of a patient with a sexual perversion the revolting me and, by the look of the scrunched up faces of our audience members, revolted them too. She was determined to help this young man who, to my ears, sounded psychotic or psychopathic. Containing (over two languages) what I believed to be her dissociated disgust and fear of this man, I steadied myself with two slow sentences at a time. I suggested she set firmer conditions and boundaries of the treatment, including a psychiatric evaluation and establishing conditions of safety. She did not like what I had to say. She wanted my psychoanalytic musings on what caused him to do these things and how she could explain them to him. Internally, I questioned whether I was hitting a cultural divide, displaying cultural insensitivity. Yes, there is something in the Chinese character that feel duty bound to finish any job started. However, I think it was the universal state that new therapists feel: “I have to help everyone who comes through the door or I have failed."

A colleague who had done supervision with a non-CAPA trained therapist observed a similar phenomenon. There was an infatuation with meaning and symbolism that superceded steps of establishing the therapeutic alliance.

After 10 days of excellent Chinese food for breakfast, lunch and dinner, I had a hankering for the more mundane tastes of home. One afternoon I snuck off to a Pizza Hut in a Shanghai mall. Sitting under an enormous sign that boasted “Great Testing Food!”, I felt the conflicted. I wondered had we come to China to sell, along with the personal pan pizza in front of me, psychoanalysis – another “product” that arose out of a very different ethos.

Psychoanalysis aspires to help the patient find psychic freedom and choice, to find a balance between the pulls of inner and outer worlds. How would this process operate in a culture, accustomed to authoritarianism, conformity, and tightly constrained social norms? Yet I also had begun to see what Elise Snyder termed the Chinese therapists’ “hunger” and need for training. Some of my American colleagues had very emotional in-person meetings with supervisees or analysands they had known intimately via Skype for months or even years. The Chinese therapists appeared sincerely grateful for the experience of their training.

The rich exploration of the unconscious that psychoanalysis invites can tantalize the newcomer, especially if knowledge comes from a book. However, it is the interpersonal and the interactive engagement of the class, the analysis and the supervision (face to face; screen to screen) that infuses the theory with life and ultimately can be helpful to patients. My CAPA experience underscored the value of psychoanalytic training, no matter what the culture.

Sally Rudoy, LCSW is a psychoanalyst in private practice in Montclair, New Jersey. She is on the faculty and co-director of the curriculum of the Center for Psychotherapy and Psychoanalysis of New Jersey. She is also the editor of the on-line newsletter of the International Association of Relational Psychoanalysis and Psychotherapy. Her email address is sallyrudoy@gmail.com.
Jules was a dear friend of mine and a stimulating intellectual partner. In this short commemoration, I shall not attempt to speak of all his many achievements, but shall limit myself to some personal recollections. I shall mention two of his scientific contributions with which I was particularly involved.

I first met Jules in New York City in 1963, nearly fifty years ago. I went there as Clinical Fellow of New York Medical College to study with Silvano Arieti who was then Professor of Clinical Psychiatry at the College – a position which Jules himself would later occupy. Together with my wife I attended all the lectures of the first-year residency course, as well as many other lectures, and Jules was one of the first-year residents. When we first arrived we stayed at the Hotel Paris in the Bronx. Then we met Jules, who was very friendly, and suggested that we move to a residential hotel, the Greystone – no longer existing – on Broadway and 91st Street where his parents were also staying. This proved to be a very helpful suggestion. From there, every morning we used to take a very convenient cross-town bus on 96th Street to the Metropolitan Hospital where the lectures took place. Jules showed his brilliant intellect in his comments at the lectures, the case conferences and the Journal Club, conducted by Arieti. Like his cousin, Arieti, when he used to speak to us in Italian, Jules would display his beautiful Tuscan accent, which he had retained from his country of origin.

After we returned to Italy, I kept up a correspondence with Jules for many years, until shortly before his death this year. I cooperated in making him come to Milan as Visiting Professor to the University of Milan in 1965, and I went there as Clinical Fellow of the Department of Psychiatry where I had studied. After he published Severe and Mild Depression, his joint book with Arieti (Arieti, S. & Bemporad, J., 1978, Severe and Mild Depression. The Psychotherapeutic Approach. New York: Basic Books. Italian translation by M. Bacciagaluppi and M. Bacciagaluppi Mazza: La depressione grave e lieve. L’orientamento psicoterapeutico. Milano: Feltrinelli, 1981), my wife and I translated it into Italian. In this book, Silvano and Jules alternated chapters. In my opinion, among his many valuable contributions to this book, an important one is the second part of Chapter 16, where Jules compares anthropological data on two cultures, the Eskimos and the Hutterites. The Eskimos “believed in total sharing and equality” (p. 390). “The Eskimo baby was welcomed into the tribe as the return of a departed loved one. He was satisfied in every way, even being nursed on demand until four years of age” (ibid.).

The Hutterites, on the contrary, are “a highly puritanical and duty-oriented community which has been found to have an extremely high rate of depressive disorders.” (p. 391) Families have ten to twelve children. Jules suggests that the different incidence of depression in these two cultures is due to their different socio-economic basis, with the resulting differences in child-rearing patterns.

In 1980 he recommended I should read Humankind, by Peter Farb. I found this a very useful book, which called my attention to the importance of the agricultural revolution in our history.

When Jules was Editor of the Journal of the Academy, from 1992 to 2001, I published some papers of mine in the Academy Journal. In 1998 I was Guest Editor of a Special Section on “Contemporary Psychoanalysis in Italy.” In 1999 a Special Section on Arieti appeared, with contributions from both of us. In 2001 I was struck by a paper on “The Complexity of Evil”, which Jules published on the Journal of the Academy (Bemporad, J., 2001, The Complexity of Evil. Journal of the American Academy of Psychoanalysis, 29, 147-171). In this paper he reviews various studies of large-scale violence, ranging from Goldhagen’s discussion of anti-Semitism in Germany to Chang’s The Rape of Nanking. Jules finally uses Milgram’s famous experiment as a paradigm unifying these various examples. In Milgram’s study, as many will recall, experimental subjects were instructed to apply what they thought were painful stimuli to others, and to increase the stimuli, notwithstanding the simulation of pain on the part of the alleged victims. Jules believes that two main factors characterize the behavior of the subjects: (1) the dehumanization of the other, and (2) obedience to authority (Bemporad, 2001, p. 169). This paper stimulated me to write a paper of my own on violence, which was published three years later, also on the Journal of the Academy (which by this time had become the Academy of Psychoanalysis and Dynamic Psychiatry) (Bacciagaluppi, M., 2004, Violence: Innate or Acquired? A survey and some opinions. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 32(3), 469-481.).

Finally, since 1999, Jules cooperated with Joan Tolchin in organizing the yearly Joint Meetings between the Academy and OPIFER. This was for him a way of maintaining a link between his adoptive country and his country of origin. It is sad that he is not with us today, for the Thirteenth of these meetings, to which he contributed so much.
World War II began with the bombing of Pearl Harbor by the Japanese on December 7, 1941. I was attending Rutgers University when President Roosevelt’s voice came booming out over the loud speaker announcing the attack on our Navy as a day of infamy. Two years later I was inducted into the Army. In 1945, the war ended with the atomic bombing of Japan, and I was discharged. Having read Freud’s work in college, I thought it might be interesting to visit his home in Vienna. Thus I went to Vienna.

At that time, Vienna was divided into four zones, American, Russian, French, and English areas. From what I heard the Americans were most liberal to the Nazi collaborators and the Russians were the most severe. When I asked Viennese people about their experience during the war, they depicted themselves as victims of Germany. However, on looking at the newsreels of Hitler’s taking over Austria, it was just the opposite. Hitler was welcomed with great jubilation, like a conquering hero. He was the local boy, born in Austria, who had made good. The large crowd of people in Vienna exchanged Nazi salutes with Hitler in his car. There was great excitement as they shouted greetings. Also, during the war, Austrian soldiers fought alongside German soldiers against the allies - American, British, French, and Russians. Some of the earliest internment of Jews into concentration camps occurred in Austria. Austria was no victim, but a willing collaborator of the Nazis.

To find the address of where Freud lived, I called up city hall. I told them I was an American soldier and would they please give me Sigmund Freud’s address. They told me that they had never heard of Freud. I then called up the Psychoanalytic Society in Vienna, and they said he had lived at 19 Bergasse Street. I had hoped they might help me find it, but they did not offer to do so. I eventually found the building, which contained a furniture store on the first floor. But there was no indication that Freud had ever lived there, and someone was occupying his flat. I looked in the entrance and saw the small garden and staircase leading to the second floor. In order to feel a closer affinity to Freud, I went across the street to a small restaurant and ordered a meal. I assumed Freud must have eaten there, and I ordered a dish he might have liked. After finishing, I decided to venture forth in my quest.

I walked across the street to 19 Bergasse and an elderly lady was now sitting at the entrance on a wooden orange crate. I walked up to her and she looked up. In my best German, I asked her how long she had lived at this address. “Oh a long time,” she replied. Then I asked her if by chance she had known Herr Professor Dr. Sigmund Freud who had lived here. She looked up at me with a quizzical expression on her face and scratched her head. “No,” she said, “I never heard of him, but if you need a good doctor, there is Dr. Joe (Schmegge) down the street.” I chuckled to myself quietly.

The denial of Freud’s existence must have been due to the shame of how he was treated. Freud loved Vienna and did not want to leave, despite the Nazis taking over the country and being rabidly anti-Semitic. However his daughter, Anna, was called in by the Gestapo, and Freud feared he might never see her again. Jews were already being sent to concentration camps. In 1938, the analysts Marie Bonaparte and Ernest Jones as well as US Ambassador William Bullitt were then able to persuade Freud to leave. They paid a ransom to enable him and his immediate family to leave plus stole some of his property.

Before allowing him to leave, the Gestapo called in Freud and asked him to make a statement about how he had been treated. He said “I can recommend the Gestapo to everyone.” Despite his environment rendering him a helpless victim, he remained the individual conquistador through this sarcastic statement. Freud did not want to submit passively to his environment, to be unlike his father and also to be scientific. This was reflected in his theory that focused on the individual and not environmental interaction. He and his immediate family were able to leave Vienna and were settled in London England, in an apartment in Hampstead. However four of his sisters were sent to Terezin concentration camp where they died. Freud died in 1939 in London and Anna continued to live in the apartment, but never married.

Several years later, Austria recognized the existence of Freud and put up a plaque on the entrance to 19 Bergasse. Then years later, they must have evicted the people living in Freud’s apartment and turned it into a museum. In that way they could financially benefit from tourists who wanted to see where Freud had lived and wrote his famous works. Instead of Austria keeping this money, it should have been used to help holocaust victims. This would not undo the anti-Semitic cruelty toward Freud, the murder of his sisters and a great many Jews. But, it would show some remorse for past anti-Semitic brutality instead of benefiting financially for this traumatic period out of self-interest.

Samuel Slipp, M.D. is Past-President of the American Academy of Psychoanalysis and Dynamic Psychiatry. His email address is samslipp@aol.com.
The Usefulness of the Manifest Dream Report

by Milton Kramer, M.D. and Myron Gluckman, M.D.

Freud (1900, The Interpretation of Dreams, S.E. IV, V) considered the manifest dream report (MDR) similar to the envelope of a letter, with the latent meaning of the dream contained in the contents of the letter. In his Introductory Lectures on Psychoanalysis (1916, S.E. XV, P.120), he said: “We will describe what the dream actually tells us as the manifest dream-content, and the concealed material, which we hope to reach by pursuing the ideas that occur to the dreamer, as the latent dream-thoughts.”


The latter is a generic, phenomenological, non-psychoanalytic analysis of the manifest content. Kramer and colleagues (1964, Kramer, M, Whitman, R, Baldridge, R. and Lansky, L. Patterns of Dreaming: The Interrelation of the Dreams of the Night. J. Nervous and Mental Disease, 139: 426-439.) described how multiple MDRs of the night are linked together to achieve emotional problem solving. In addition, Kramer (1993, The Selective Mood Regulatory Function of Dreaming: An Update and Revision, in A. Moffitt, M. Kramer and R.Hoffmann (eds.) The Functions of Dreaming, State University of New York Press: Albany, New York) demonstrated that the change in mood from night to morning relates primarily to which individuals appear in the MDRs. Currently, the available evidence suggests that the manifest content alone may serve as a reliable indicator of the dreamer’s problems, conflicts and emotional state. Yet, studies evaluating the effectiveness and outcome of psychoanalytic treatment have paid little attention to dreaming, including manifest and latent content, except for anecdotal case reports (2000, Galatzer-Levy, R., Bachrach, H., Skolnikoff, A. and Waldron, S. Does Psychoanalysis Work? Yale University Press: New Haven.).

A non-clinical approach to using the MDR was that utilized by Hall and Van De Castle (1966, The Content Analysis of Dreams, Appleton-Century-Crofts: New York). They developed a reliable, valid system for quantifying MDR content. Their system revealed that manifest content differences corresponded to demographic variables as well as mental illnesses, including schizophrenia and depression (Kramer, M., and Roth, T., 1973, A Comparison of Dream Content in Laboratory Dream Reports of Schizophrenic and Depressive patient groups, Comprehensive Psychiatry, 14: 325-329). However, their protocol was developed for dreams of 100 words or more, and therefore excluded dream material consisting of fragments or brief MDRs. In addition, they did not use the MDR for evaluating the effectiveness of treatment.

Until recently, clinical observations utilizing the MDR in order to establish a relationship between changes in the manifest content and therapeutic progress have been anecdotal and lacked experimental validation Warner, (1987, Manifest Dream Analysis in Contemporary Practice, in M.L. Glucksman and S.L. Warner (eds.) Dreams in a New Perspective: The Royal Road Revisited, Human Sciences Press: New York) and Glucksman (1988, The Use of Successive Dreams to Facilitate and Document Change During Treatment, The Journal of the American Academy of Psychoanalysis, 16: 47-70). In view of this, we embarked on a series of studies aimed at examining the hypothesis that there is an association between clinical improvement, or lack of improvement, and changes in the MDR (Glucksman, M and Kramer, M, 2004, Using Dreams to Assess Clinical Change During Treatment. J. of the American Academy of Psychoanalysis and Dynamic Psychiatry, 32:345-358; Kramer, M and Glucksman, M 2006, Changes in Manifest Dream Affect During Psychoanalytic Treatment, J of The American Academy of Psychoanalysis and Dynamic Psychotherapy,34:249-260). We chose the MDR because we believed that manifest content could be reliably rated according to specific variables by independent observers. Nevertheless, we also believe that latent content is clinically relevant and indispensable in the therapeutic setting.

We began this effort by comparing an MDR from the initial phase of therapy to an MDR in the later phase of therapy. Our hypothesis was that there would be significant differences in the MDRs of those patients who either improved or did not change. One of us (MG) selected 12 of his patients who had terminated either psychoanalysis or psychoanalytically-oriented therapy, and divided them into two groups of six patients each. One group of six patients had demonstrated considerable improvement in therapy, and the other group had exhibited little or no improvement (according to MG). The manifest content of an early as well as later MDR of each patient was extracted from MG’s therapy notes. Each pair of MDRs was typed on a separate piece of paper, randomly numbered with no identifying information, and presented to MK (who had no clinical knowledge of the patients). His task was to place each patient in either an improved or unimproved group according to his assessment of the 12 MDR pairs. MK placed all MDR pairs correctly into the improved or unimproved groups. This was a highly significant result (p <.001). During a course on understanding dreams, MK presented the same data to six psychiatric residents, two of whom placed all 12 MDR pairs correctly, and two who placed 10 pairs correctly. On the basis of this observation, it seems that the ability to judge MDRs may be a teachable skill.

The following examples of MDRs from patients in the improved and unimproved groups are illustrative:

1. Improved patient:

   Early MDR: “I returned to teaching after a nervous breakdown. Another female teacher said: “You just made it back
in time or you would have been fired. A choir director was trying to get me to sing alone. We were in an old Victorian house, and I saw a panther. I was frightened.”

Later MDR: “I was at a beach resort where I won a beauty contest. I looked for my husband to tell him. I felt no urgency in finding him, and savored the experience.”

2. Unimproved patient:
Early MDR: “I was with a group of college friends talking about having kids. I stayed out of the conversation, and someone asked why I was staying out of the discussion. I told them about the conflict between my husband and myself. I felt badly about telling them.”

Later MDR: “I was on a sailboat with a man. He fell asleep. I tried to wake him up, but he wouldn’t get up. I was totally on my own to sail the boat.”

The improved patient entered treatment with anxiety symptoms, phobias, feelings of inadequacy and dependency on others. Her mother was controlling and devalued her. The unimproved patient came to treatment because she wanted to get pregnant, but her passive-aggressive husband was opposed to it.

The results of the previous study allowed us to distinguish significant improvement from little or no improvement in a small group of patients. Subsequently, we attempted to correlate changes in the MDR with a rank ordered degree of clinical improvement in the same 12 patients. The treating clinician (MG) rank ordered the degree of clinical improvement in the 12 patients, and provided MK with the first and last MDR of treatment in a randomized order, for the same 12 patients. MK’s task was to rank order the MDR pairings according to his judgment of clinical improvement reflected by them. The correlation between MG’s clinical rankings of the 12 patients and MK’s MDR pair rankings was significant at almost the .05 level of probability ($r=.45, p=.069$). This result was very encouraging, and led us to believe that the MDR has the potential of being utilized as a measure of therapeutic outcome. In the future, we hope to refine the criteria for rating MDRs in order to reliably measure clinical progress.


However, it has been reported that in spontaneous and sleep laboratory dream reports, affect is not always present (Kramer,M. Winget, C. and Whitman, R. 1971, A City Dreams: A Survey Approach to Normative Dream Content, American Journal of Psychiatry 127:1350-1356; Strauch, I. and Meier, B. 1996, In Search of Dreams. State University of New York Press, Albany, New York). This observation raises a question as to whether the dream is primarily affect driven or narrative driven. In order to further explore the role of affect in dreams, we examined the frequency and valence of affect in MDRs over the course of treatment. One of us (MG) selected the first and last MDR from 24 of his patients who had either completed, or were well along, in psychoanalytic treatment. This group included 14 women and 10 men, all of whom had shown considerable improvement. Both of us independently rated the MDRs for the presence or absence of affect, as well as the valence (positive or negative) of affect. MK had no clinical information about the patients, and the MDRs contained no identifying information regarding the identity, gender or diagnosis of the patient.

We agreed on either the presence or absence of affect in 94% of the MDRs, and on the valence (positive or negative) of affect in 100% of the MDRs. An example of the presence, absence, and valence of affect in an MDR pair may be helpful:
1. First MDR: “I look in the mirror. I have a man’s beard. My mother is also looking in the mirror.” (No affect in the MDR).
2. Last MDR: “I was snow-boarding alone. It was peaceful and I enjoyed myself.” (Affect present and positive).

In view of the fact that both MG and MK had a significantly high level of agreement on the presence, absence and valence of affect, we chose to report MKs observations since he was the least biased observer, having had no contact with the patients. MK found that affect was present in 58% of MDRs, and the valence of affect was more likely to be negative than positive. If associations were included with MDRs, 98% of MDRs contained affect. Initial MDRs had significantly more negative (77%) than positive (19%) affect; however, final MDRs had significantly more positive (53%) than negative (47%) affect. In essence, there was a significant change from negative to positive affect in the MDRs over the course of treatment. The most likely explanation for this shift in affect valence from the first to the last MDR is that it reflects clinical improvement in response to treatment.

The following is an illustration of the shift in affect valence from the first to last MDRs of treatment:
1. First MDR: “[s] I was in a dark and dingy bar with a date. A man was shot. The purpose of the bar was to shoot people. There was an odd assortment of characters, and the police were paid off by management. I sat with my date trying to figure out how to get out. There was a baby crawling on the floor with a bag full of coins. A man threatened to shoot it. My date bought me a $2000 box of “oldie but goodie” records. I was mad at him.”
2. Last MDR: “I was at the movies sitting next to a man I don’t know well. We were attracted to each other. I wondered whether he was going to make love to me.” The patient entered treatment with a history of conflicted and failed relationships with men. At the end of therapy, she was planning to marry a man with whom she had formed a stable, committed relationship.


In order to methodically test this hypothesis, we collected the initial MDRs from 63 patients (33 women and 30 men) who were either currently in, or had previously completed psychoanalytically oriented therapy with MG. We rated the initial MDRs for the presence and valence of affect, major psychodynamic theme, presence and type of transference, and gender of patient. We found affect in 44% of the MDRs and agreed in our ratings of affect in 88% of the initial MDRs, and observed that 32% contained negative affect while only 11% had positive affect. This finding was consistent with our previous observation that initial dreams contain significantly more negative than positive affect. When associations were included, negative affect occurred in 75% of initial MDRs.

There was a significant level of agreement between us (87%) on the major psychodynamic themes of the initial MDRs. In addition, MG (the treating clinician) observed that the major psychodynamic theme was predictive of the core psychodynamic issues that emerged during the course of treatment in 94% of the patients.

An example of the major psychodynamic theme of an initial MDR and the core psychodynamics that emerged during treatment is the following:

“I was playing bridge with my wife and we were in a bidding sequence. I knew I was in a bad situation and was afraid I’d make a mistake with a bad result. I would be a failure and everyone would see it.”

Both MG and MK agreed that that the major psychodynamic theme of this MDR involved a sense of inadequacy, fear of exposure, failure and humiliation. The patient, a married male, was perfectionistic, compulsive, and highly competitive. His mother was extremely critical, and his wife complained of his controlling behavior. He was deeply fearful of rejection, criticism and failure. His early transference was one of distrust and wariness. After several years of therapy, he became more trusting of the therapist, less defensive, and increasingly open with his feelings. Transference was evident in 44% of the initial MDRs, and predominantly negative (61%). However, neither the presence nor type of transference in the initial MDR correlated with clinical progress.

Previous studies have demonstrated male/female differences in manifest content (Hall, C., and Van De Castle, R., 1966, The Content Analysis of Dreams, Appleton-Century-Crofts: New York. Winget, C., and Kramer, M., 1979, Dimensions of Dreams, University Presses of Florida: Gainesville). Women are more likely to have dreams of friendly social interactions, emotions, and family references. Men have dreams with more aggression, hostility, competitiveness and sexuality. MK, who had no knowledge of the sexual identity of the patients in this study, correctly judged the gender of 62% of the MDRs without any other identifying information. His observations support the previous reports of systematic differences in the MDRs of males and females.

We also categorized the MDRs according to psychodynamic themes, including those concerned with relational issues, psychological or physical injury, self-identity, problem-solving, sexuality and loss. Relational and Injury themes were predominant, but clinical progress was not associated with any particular theme category.

We believe that these studies systematically demonstrate the clinical usefulness of MDRs in psychoanalytic therapy. Nevertheless, we recognize that latent content is essential in order to fully understand dreams as they occur during therapy. Our studies repeatedly emphasize the centrality of affect in the formation and content of dreams. Equally important, affect and the valence of affect constitute a reliable guide in regard to clinical improvement. Moreover, the major psychodynamic themes of initial MDRs are highly predictive of the core psychodynamics that emerge during treatment. However, no particular psychodynamic theme category (relational, injury, etc.) is predictive of clinical progress. The presence and type of transference in initial MDRs also does not appear to influence the course of treatment. In summary, we have found the initial MDR to have significant clinical and predictive value in psychoanalysis and psychoanalytically-oriented therapy. Moreover, the MDR can be used as a reliable instrument for evaluating clinical progress in treatment.

Dr. Kramer is Emeritus Professor of Psychiatry, University of Cincinnati, Cincinnati, Ohio (milton1929@yahoo.com). Dr. Glucksman is Clinical Professor of Psychiatry, New York Medical College, Valhalla, New York glucksmanmd@optonline.net).
Trauma in the Life of “Shakespeare”
and its Impact on his Works

by Richard M. Waugaman, M.D.

What do we know about traumatic events in the life of William Shakespeare, and how they might have influenced his literary works? Much attention has focused on the death of his son Hamnet, and the possible influence this may have had on his play of a similar title. Increasingly, there is also interest in the possibility that he was secretly Catholic at a time when English Catholics were sometimes executed, and that this in turn may have influenced some of his plays. However, the overwhelming scholarly consensus is - as James Shapiro articulates in his 2010 book Contested Will - that Shakespeare’s life experiences bear only a faint connection with his writings. In fact, he is usually cited as the prime exemplar of the writer whose native genius overshadows the role of life experiences in shaping his imaginative creations.

I will explore a different hypothesis. I believe we have been barking up the wrong authorship tree for 400 years. When I read in the New York Times in 2002 that Freud may have been correct about Shakespeare’s identity as Edward de Vere, Earl of Oxford (1550-1604), I became an amateur Shakespeare scholar. My research has convinced me Freud was in fact correct in thinking de Vere used Shakespeare as his front man and pseudonym. Further, there is evidence that Shakespeare was also de Vere’s stage name. An Oxfordian psychoanalyst, I now identify myself as an Oxfordian.

My Oxfordian perspective allowed me to discover the largest hitherto unknown literary source for Shakespeare. This is the 1569 Whole Book of Psalms, translated by Sternhold and Hopkins. Its influence on Shakespeare’s works is greater than that all other psalm translations. Allusions to the Whole Book of Psalms provide the keys that unlock many enigmas in the interpretation of Shakespeare’s works. Lady Macbeth’s “Out damned spot” speech implicitly asks us to measure her words against religious definitions of a true state of contrition, since she is alluding to the chief penitential psalm, Psalm 51. Sonnet 21, “So is it not with me as with that Muse,” replies to Psalm 8, and thus competes with King David, the traditional author of the Psalms. Shakespeare’s history plays are replete with psalm allusions that suggest a providential interpretation of English history. Psalm 137, that recalls the Israelites’ Babylonian exile, is a leitmotif in Richard II, making its several exiled characters more sympathetic. Characteristic allusions to Psalm 103 in Edward III help establish the canonicity of this disputed play, while helping those who recognize these allusions to peer beneath the surface of the text to an ironic level of meaning. I have made most of my discoveries in psalms that de Vere marked in his copy, now at the Folger Shakespeare Library, and available on-line.

We do not often think of violence as constituting a trauma for the perpetrator. However, research with Vietnam veterans revealed a 100% incidence of PTSD in only one cohort: those soldiers who had committed atrocities against the enemy (David Spiegel, personal communication, 1987). So I would propose that one of many overlooked links between Shakespeare’s works and trauma in the life of its author was the fact de Vere killed a servant in his guardian Burghley’s household when de Vere was 17. Later, he boasted that he could murder the courtier poet Philip Sidney and get away with it.

There are numerous connections between de Vere’s 35 annotations in the Apocryphal Wisdom of Solomon and Sonnet 30. That sonnet begins, “When to the sessions of sweet silent thought/ I summon up remembrance of things past.” That last phrase, used to translate Proust’s A La Recherche du Temps Perdu, is known to come from Wisdom 11:10. Wisdom repeatedly shows how the unrighteous will be punished. Commentators on this sonnet have only looked at allusions to the poet’s grief over his past losses. But “grieve” at the time could also mean to inflict emotional or bodily harm. The only three words de Vere underlined in Wisdom are “sin,” “sinneth,” and “sinned.” In three chapters, he only underlined the verse number of one verse, and each time the verse included the word “sin.” I would conclude that de Vere’s special interest in references to sin in Wisdom helps answer the question of the nature of the “things past” that are being remembered in Sonnet 30. De Vere’s biblical sources for Sonnet 30 allow him to allude indirectly to his past sins - including murder - without the humiliation of acknowledging them explicitly.

De Vere’s authorship of Shakespeare’s works would overturn the prevailing assumption that this author’s life experiences have little relevance to his writings. On the contrary, links with de Vere’s life appear nearly everywhere one looks in the works of Shakespeare. Freud pursued a few connections between traumatic events in de Vere’s life and parallels in the works of Shakespeare. He retracted his previous surmise on the impact of the death of Hamnet, and instead connected Hamlet with the death of de Vere’s father when he was 12, and what Freud believed to be his mother’s hasty remarriage afterwards. James Shapiro, in Contested Will, cynically and tendentiously reduces Freud’s acceptance of the abundant evidence for de Vere’s authorship to nothing more than an allegedly self-serving wish on Freud’s part to evade an inconsistency with his oedipal theory of Hamlet. There is an important trauma that Freud omitted. Just after his father died, de Vere was sued by his older half-sister. She tried to establish that he was illegitimate, so she would inherit their father’s vast wealth. De Vere’s insight into the psychology of bastards such as Edmund in King Lear may be one result.

In a 1934 letter, Freud linked King Lear’s having only one unmarried daughter (out of three) in the play - unlike in the play’s source - with de Vere having one unmarried daughter (out of three) when he wrote it. Freud added, “if Shakespeare was Lord Oxford the figure of the father who gave all he had to his children must have had a special compensatory attraction, since…de Vere was the exact opposite, an inadequate father who never did his duty by his children.”

In fact, de Vere lived apart from his first wife for several years, publicly humiliating her, by claiming that her first child was not his. De Vere may have been projectively identifying into his child his earlier experience of being accused by his sister of being illegitimate. There is suggestive evidence that he was later plagued by remorse over what he now realized were his unjust
accusations, in his astute portrayal of pathological jealousy in plays such as _Othello_ and _The Winter's Tale_.

Freud perceived that people still cling to the traditional author, because relinquishing him is unbearably traumatic for us - it forces us to face deeply unsavory truths about a real author who was, as Freud said, much less “perfect” than his works, but was instead complex as are his literary creations. Freud believed that the traditional author offers the advantage of being such a blank slate that we can imagine him to be as perfect as we wish.

In 1932, Freud wrote of de Vere’s proposed authorship of Shakespeare’s Sonnets, “In the light of that conception the Sonnets become much more understandable… there are no doubts any longer about [their] serious nature and their value as self-confessions.” The blatant bisexuality of Shakespeare’s Sonnets has been strikingly ignored, covered up, or rationalized away by the vast majority of Shakespeare scholars. Homophobic reactions to the Sonnets in past centuries continue to resonate with many contemporary scholars and other readers of Shakespeare. To read the Sonnets as autobiography confronts the objective reader with disconcerting evidence of the poet’s bisexuality, and of de Vere’s affair with the 23 years younger Earl of Southampton, who was first proposed as the Fair Youth of the first 126 sonnets in 1817. But he was quickly dismissed by scholars who said it was unthinkable that a commoner from Stratford would have addressed an Earl so familiarly, most notoriously in the reference to the Youth’s penis in Sonnet 20.

Mathew speculated in 1922 that Southampton wanted “to hide a scandalous meaning” of homosexuality in the Sonnets as originally published. Robert Giroux thought Southampton suppressed the 1609 Sonnets out of concern for his reputation, if a wider public learned of his affair with the author (Mathew, Frank (1922) An Image of Shakespeare London: J. Cape). Southampton may have also influenced the editors of Shakespeare’s 1623 First Folio to omit de Vere’s name, and instead to promulgate the myth that Shakespeare of Stratford was the author. Helen Vendler, one of our most brilliant Sonnet commentators, bypasses bisexuality and all other autobiographical implications with her evasive theory that the speaker of the Sonnets is merely a “fictive self” who does not speak for Shakespeare. The intense admiration people feel toward Shakespeare makes them uneasy with the possibility that he was bisexual. (Even today, bisexuals face discrimination from both heterosexuals and homosexuals.) One solution to this cognitive dissonance for the past four centuries has been denial or avoidance of Shakespeare’s bisexuality, and of his actual identity.

To my knowledge, I am only the second analyst besides Bronson Feldman to have endorsed in the psychoanalytic literature Freud’s hypothesis about Shakespeare’s identity. Feldman had a Ph.D. in English, and published several papers on Shakespeare in the 1950’s. From personal experience, I would surmise that other analysts have attempted to publish Oxfordian articles, only to have their submissions rejected by editors who have rigid preconceptions about this topic.

In thirty publications on Shakespeare, I have explored some of the sources of Shakespeare’s works in traumatic events in de Vere’s life. For example, I commented that “de Vere wrote _The Tempest_ when he was beset with loss—he had lost Queen Elizabeth, he was struggling to relinquish his youngest daughter to marriage, and he was contemplating his own impending death,” which took place in June of 1604.

After his father’s death when he was 12, Queen Elizabeth assigned Lord Burghley as de Vere’s guardian. De Vere was financially exploited by the Queen and by his guardian and future father-in-law, Burghley. Recent research has revealed that the financial exploitation of de Vere was even worse than we knew. Thus, it no longer appears that de Vere’s financial irresponsibility was the primary cause of his severe economic decline. He had every reason to feel deeply betrayed by powerful people who stole much of his wealth.

The Stratfordian Patrick Murphy interprets Shakespeare’s long poem _Venus and Adonis_ as a veiled critique of the corrupt Elizabethan wardship system, and of de Vere’s victimization by that system. When he turned 21, Burghley had de Vere marry Burghley’s daughter Anne, then 15. Four years later, de Vere was abroad for several months. When he learned Anne was pregnant, Murphy speculates that de Vere may have suspected that his wife had been impregnated through incest with her father. Fifteen years later, Burghley ordered his subsequent ward, the Earl of Southampton, to marry Anne’s daughter. Murphy infers that the author of _Venus and Adonis_ was hinting through this poem that Southampton could use suspected incest as legal grounds for defying Burghley’s order to marry Anne’s daughter, and thus avoid the 5,000 pound fine Burghley forced him to pay.

In reaction against the past excesses of reductionistic psychoanalytic approaches, literary theory often minimizes the significance of an understanding of the psychology, pivotal experiences, and traumatic events in the life of the author. For several years, the predominant view has been that studies of the text itself should be paramount, and it is often not considered legitimate or relevant to introduce data, much less psychological speculations, about the influence of the author’s psychology on their literary creations. Psychoanalysts have often lacked the confidence to challenge this misconception, despite how much violence it does to our cumulative clinical experience about the overdetermined nature of all human endeavors. Just as Freud’s translator James Strachey persuaded Freud to censor in print his belief in de Vere as Shakespeare to avoid antagonizing the English, psychoanalysts still allow themselves to be silenced into accepting the deeply flawed traditional Shakespeare authorship legend, to avoid antagonizing the English professors.

Richard M. Waugaman, M.D. is Training and Supervising Analyst Emeritus, Washington Psychoanalytic Institute, Clinical Professor of Psychiatry, Georgetown University School of Medicine and author of 100 publications. His Shakespeare website is www.oxfreudian.com and his email is rwmd@comcast.net.
These notes are an invitation to arrive at a coherent autobiographical narrative based on self-analysis, in addition to conscious memories, as is usual in traditional autobiography. By examining traumatic experience, in addition to positive experience, we may better assess our strong points.

Antecedents
I have recognized four cultural identities in myself. Two come from my parents. My father was a Milanese engineer, with a family tradition of secularism and Socialism. He completed Classical High School in Torre Pellice, the capital of the Waldensians (the Italian Protestants). My mother had an American WASP mother of Scotch-Irish descent and a British father, and was a Protestant. When I was born my parents agreed on speaking English at home in order to make me learn the language. English is thus my mother tongue (with a British accent). I was baptized in the Anglican Church of Milan.

On the Italian side, my grandfather owned a small publishing house that published books of philosophy. My paternal great-uncle, Francesco Ferrari, was an M.D. who practiced hypnotic psychotherapy in Milan prior to World War One, following his teacher, Auguste Forel, who was the predecessor of Bleuler as Director of the Burghölzi in Zürich. He was the author of many scientific papers and books, but when he died he was a forgotten figure because of the prevalence in Italy of Freudian psychoanalysis. I believe I was influenced by his example in the choice of a profession.

My parents got married with a civil wedding at the end of 1930 and left immediately for Zürich, Switzerland, where my father, who had just taken his degree, had found a job as a workman. There, unlike his fellow students, he learned to handle tools.

Infancy
I was born in Bozen, South Tyrol, on October 22, 1932, and for several years I was taken to South Tyrol every summer for the holidays. South Tyrol had been part of Austria until 1918. When the Italians took over and the Fascists took power, a forced Italianization of South Tyrol took place. The German place names, and even German surnames, were Italianized. My parents were anti-Fascists and firmly on the side of the local German-speaking population. I thus acquired a third, South Tyrolean, and therefore Austro-Hungarian identity.

I was born in Bozen because my father, back from Zürich, had found a job in an American-owned telephone company, and had been entrusted with transforming all the Italian telephone exchanges from manual to automatic. He thus worked his way from South Tyrol, the most Northern part of Italy, to its Southern tip, taking my mother and me with him, as well as a South Tyrolean nanny, Regina (with a hard “g”) by name. Of course I don’t remember anything of that trip, but I know my mother breast-fed me.

Back in Milan after one year, my mother had a “nervous breakdown.” I believe this was an attack of depression. My parents, after one year in Zürich and another year travelling through Italy, were used to being independent of their families of origin. Their return to Milan and to vicinity to their families made them suffer, and me with them.

At the family level the relevant author here is Murray Bowen, according to whom the emergence of emotional illness in a family member has its origin in the difficulty previous family members have had in separating from the core family.

Childhood
In 1938 I enrolled in the Swiss School of Milan, where my parents sent me in order to avoid the Italian schools, that were militarized by the Fascist government. From the start I was taught in both Italian and German. That school, and later events, created in me a fourth, Swiss identity. My third and fourth identities converged in German language and culture, typical of the three German-speaking countries: Germany, Austria (with South Tyrol) and German Switzerland. I obviously refer to the civilized great German tradition, as distinct from what was then Nazi Germany.

In that same period I endured multiple losses. In 1939 my paternal grandfather died. In 1940 also my great-uncle died, and my English grandfather and two aunts had to escape to England when Italy entered the war on the German side. I thus lost many affectionate parental figures. Here, of course, the relevant author is John Bowlby, with Loss, the third volume of his trilogy.

The Resistance
In September 1943, after Italy signed an armistice with the Allies, the Germans occupied Northern Italy. A resistance movement was set up against them, in which my father actively took part. This situation strengthened the relationship between my parents, and I saw my father as a protector against predators. My mother and I eventually had to seek refuge in Switzerland by escaping through the mountains, and later we were joined by my father. There was a strong contrast between Italy, on the one hand, caught in a lost war, occupied by the ruthless Germans aided by their Fascist henchmen, with blackout and insufficient rations, and Switzerland, on the other hand, lit up at night, with sufficient rations, an oasis of peace and democracy in Nazi-occupied Europe. In that country our small family was once more united. All this strengthened my fourth, Swiss identity.

High School
After the war I attended an Italian Classical High School, where I learned Latin and Greek. During my first year, in 1948-49, I won a scholarship for the New York Herald Tribune World Youth Forum, in which, together with a girl, I represented Italy. For three months we attended High Schools throughout the United States. We were also received by President Truman at the White House. That was my first trip to America, and my first major move out of my family of origin.

University
After High School I enrolled in the Faculty of Medicine of Milan University in 1950. I met three fellow students with whom I established a firm friendship. We used to attend the University Film Club together and read Eliot’s Waste Land in English. That was another move out of my family through peer relationships.

Postgraduate training in Genetics and Evolutionary Theory
After graduation from Medical School I won a scholarship for a two-year course in Genetics and Radiobiology at the University of Pavia. The Institute where I worked had extensive
contacts with America. One of the teachers, Cavalli-Sforza, eventually moved to the United States. There I acquired a firm grounding in evolutionary theory, which I later encountered in Bowlby’s attachment theory.

Postgraduate training in Psychiatry and Sociology

After attending the School of Specialization in Psychiatry of Milan University I won a scholarship at New York Medical College, where I studied for one year, in 1963-64, with Silvano Arieti and many other fine teachers, among whom Paul Dince and Irving Bieber. Before leaving Italy I married a fellow resident and travelled with her to America. Together we attended as many lectures as we could. We thus thoroughly assimilated the interpersonal-cultural school, originally founded by Sullivan, Fromm and others in 1943. I also took an evening course in Sociology at the New School for Social Research, where Fromm and, before him, Ferenczi, had lectured. My later reading of Fromm confirmed my interest in the social sciences. In other words, I made good use of my stay in America. Back in Italy, my wife and I translated most of Arieti’s books into Italian.

This was another, and final, move away from my family of origin, through a pair relationship. I believe I thus followed the

Finding the Real Enemy in the War on Drugs: Disorders of American Character

by Peter Alan Olsson, M.D.

There are dangerous drug wars south of our US border. We are desperately building fences and patrolling our borders to prevent drugs and aliens from entering America. But seldom do we examine why we Americans are such a receptive, exploding market for cocaine, heroin, methamphetamine and cannabis. American children become aware of their parents’ substance abuse early in their lives. American kids get significant amounts of drugs from their own parents’ medicine cabinets. Many TV commercials cleverly tout chemical solutions to all medical problems and somatic complaints. In one recent ad, a cold beer was preferred to a cute girlfriend.

After over forty years of clinical work in medicine, psychiatry, and psychoanalysis, I have come to a painful conclusion: one major cause of our drug abuse epidemic is the slow, steady erosion of our American Character. To paraphrase Pogo, “We have found our enemy in the war on drugs, and it is US.” Is there a cure? There is, but do we have the courage and will to claim it? Our weakness of character is compensated for at every level of society by the use of substances of abuse. And, we are in denial about this reality!

What is Character? How does it relate to Personality and Personality Disorder? Is “good character” important in an ordinary individual, in their political representatives, or in a president? Disorders of character are both chickens and eggs. Character disorders provide a ready soil for criminality, irresponsible sex, defective parenting, unhappy marriages and substance abuse. And, drug abuse provides a psychological wasteland and motivational milieu for massive problems related to drug dealing and trafficking.

American celebrities are our heroes, antiheroes, role models, and even our modern Gods. They spice-up the humdrum lives of many TV-overdosed Americans. Celebrities act out our collective unconscious proclivity to reject virtue, wisdom, sobriety and moral integrity. Substance abuse, cynicism, self-absorption, hedonism, and materialism are last-ditch defenses against despair, existential depression, fear and loneliness. Some young Americans think agnosticism is merely inevitable and cool. They are shallow because their parents and teachers have grown theologically ignorant and politically correct in the domain of spirituality.

Celebrityism and drug abuse are symptoms of a disorder of the American Character. Many Americans seem to believe that it is abnormal, dumb or naive to be truthful, kind, merciful, patient, humble, forgiving, sober, virtuous and accepting of God’s love. For many Americans, our celebrities provide vicarious thrills and stimulation to assuage our mundane, materialistic, boring, rebellious and stimulation-seeking lives. We seem fascinated with our favorite celebrities’ drunken escapades, their drying-out, and their rehab efforts as well as their smarmy, self-promoting comebacks. Many of our role models seem to seek excitement and happiness via the “outside-in” of drugs and exciting uncommitted or extramarital sex. Even flowery TV ads extol the Prozac, Paxil and Zoloft solutions to depression. Viagra and Cialis are promoted via bucolic TV scenes without any mention of prior psychological or couples evaluation or psychotherapy efforts.

There are no ads that recommend inner psychotherapeutic exploration of our vulnerabilities and strengths. Insight, mindfulness, meditation and accurate empathy towards self and others takes time, effort and yes, quite often, money. However, several years in psychotherapy at two sessions per week costs no more than the payments on a good car. And, it is like compounding
interest in a reliable inner money market or savings account. The gradual strengthening of character during an effective psychotherapeutic relationship can prevent future substance abuse or communication problems in a marriage or a job. The talking cure’s benefit from “inside-out” can change a life and often can last a lifetime.

Our weaknesses and defects in character lead to and perpetuate our dependence on substances of abuse. Our American weakness of character result in denial about the millions and millions of dollars our American dependency on cannabis, narcotics, stimulants and other substances of abuse costs our country. But there are ways for us to strengthen our national character from the inside out.

Do we only build higher and higher fences on our borders? The drug smugglers only build their skills at clever deception in order to serve their drug-seeking American customers on the other side of the wall. Many Americans use and abuse the “medical marijuana cause” as a rationalization for promotion of the destructive marijuana industry and its gateway to other drug addictions. For folks with significant mental illness, marijuana is highly destructive to treatment efforts. Marijuana’s LALA land derails thought processes, waters down long-term motivation and career planning. Pot softens the edges of character.

In terms of good character or total lack of it, what images come to mind at the mere mention of O.J. Simpson, Scott Peterson, Drew Peterson, Ben Rothlesberger and Michael Vick? How are we all affected by predatory pedophilic kidnappers, serial killers and murderers who get endless news coverage? What is the impact of so many philandering movie stars and politicians on America’s character? How about our prevaricating sport star “heroes” such as steroid gobbling Mark McGuire, Sammy Sosa, Barry Bonds, Roger Clemens and gambling-addicted guru stars Michael Jordan, Charles Barkley and Pete Rose? Or, finally, Tiger Woods? Could Tiger Woods really resolve his “sex addiction” in time to play in the Masters after a brief stay at an expensive rehab spa? How could he significantly resolve in a few months a personality disorder that would usually take 3 therapy sessions per week over three to five years? We all know he could afford that treatment.

TV coverage of serial killers and psychopathic predators like Joren Vander Sloot saturate prime time. “Criminal Minds,” serial killer shows, and “CSIs” dominate prime time as well. Many sincere and devout Americans decry these perverse programs’ content. The fact is that the TV ratings indicate that we Americans love our addiction to exciting film violence, lurid sex, irresponsible sex, and substances of abuse. “Hallmark Hall of Fame” wholesome TV movies fight an uphill battle. As Marshall McLuhan observed many years ago: “The Media is the Message.”

Then there are the TV images of college students on Spring Break showing drunken scenes on Florida beaches. What would America be like if they were helping out at nursing homes, hospitals or community clean-up projects or other service programs? Or even working at jobs to help pay for their education?

National Character

If there is such an entity as National Character, how does the behavior and character of a celebrity, leader or president interrelate with National Character formation? It is clear to me that we Americans have a disorder of National Character! We are mesmerized and seduced by the charm of “Characters” we call celebrities. Our presidents have become primarily celebrities and secondarily leaders.

Personality and Character Disorder: National Character and Its Disorder

For psychologists and psychiatrists, personality is the relatively persistent totality or complex array of behavioral and emotional characteristics that distinguishes an individual over time. Character is a core sector of personality. Good character implies adequate intelligence, a good sense of humor/playfulness, personal integrity, ethical consistency, social adaptability, and flexibility during adversity. It has survival value.

Historians and social psychologists sometimes write about National Character in reference to some persistently describable generalities about distinctive character traits of ethnic, social or even national groups.

Do we American parents “swaddle” our kids with TV images? Does our society and our National Character pay the price of our TV addiction, our obsession with excitement, the pornography of cinematic violence, and irresponsible, hedonistic sex portrayed on TV? The answer is a resounding YES!

Causes of Character Disorder

Some personality traits are influenced by genes and inherited. However, “Nurture” issues arise from the fact that character and character disorder are formed over many years of personality development in the context of family and social life in a community. Parental attitudes, parenting style, and values (or lack of them), are clearly significant shaping factors in personality formation. The quality of emotional, empathic, and nurturing connection between the child and caretakers, weave their effects into the developing personality over many years. The child unconsciously identifies with many parental traits or rebels against them, as a separate individual identity forms. Many American parents abuse substances and the kids notice! Many contemporary kids obtain drugs of abuse from their own parents’ supplies of prescription narcotics or tranquilizers.

Our many presidents’ wars on drugs have been sadly unsuccessful. Their failure is because the emphasis has been on tough law enforcement, interdiction and incarceration. We Americans need more opportunities for participation in psychotherapy or activities that foster empathy, humility, solitude, helpful introspection, sacred music, and worship.

In-depth psychotherapy treatment, especially the individual and group therapy of character and personality disorders has been shallow and too brief because of financial considerations. Treatment of substance abuse involves more than sobriety education and maintenance. It must involve several times per week intensive individual, group and family/ couples psychotherapy over several years! These sessions approach, confront, and seek to actively change the symptoms and behaviors of character disorder.

The Character Domain and Our American Drug Abuse Epidemic

In my work with persons with character disorders, I often have noticed the frequent and obvious association of serious character defects with substances of abuse. Rather than looking inward for strength and meaning under stress, Americans seem to be conditioned to seek some external substance to ingest to take away pain or even normal sadness or anxiety. TV ads in particular, imply that social and sexual fun naturally emerges during alcohol use. Ads for sleeping pills, antidepressants and...
anti-SD chemicals like Viagra barrage TV viewers. Managed care and health insurance companies prefer less costly chemical solutions to anxiety and depression. Seeing a therapist 2-3 times per week for a year or two has become a rarity; even though it has been shown that psychotherapy alone can do as well as Prozac.

Advocacy for “medical marijuana” has become a cause celeb for the naïve. The subtle dangers of pot get glossed over. Pot and cigarettes are often the entry point to harder drugs for our kids. Decriminalizing cannabis and other substances of abuse is no answer any more than prohibition was an answer to alcoholism. Addressing what it takes to strengthen American Character is crucial. President Obama’s new plan named after Senator Teddy Kennedy can provide a vehicle for strengthening Americans’ character via experiences of tangible service to others. In-depth drug prevention education involves on-the-job volunteer participation at drug abuse treatment programs. Drug abuse prevention involves creative ways of engaging young people in service to their community. Effective psychotherapy combined with sobriety maintenance and enlightened law enforcement needs to be in place. At the core of successful drug rehabilitation is in-depth psychotherapy. To paraphrase and expand on Socrates, “The unexamined substance-dulled life is not worth living.”

Peter Olsson, M.D. is an assistant professor of psychiatry at Dartmouth Medical School and an adjunct professor of clinical psychiatry at Baylor College of Medicine. He is partially retired with a small private practice. His email address is polsson@ne.rr.com.

Medieval Chronicles I
by Richard D. Chessick, M.D., Ph.D.

The following document describing the hot and bitter dispute among distinguished medical practitioners during the era of the Merovingian empire (circa 550-754 C.E.) was brought to my attention by a fellow medieval fossil and I have taken advantage of the existence of the Academy Forum to share it with you. The Merovingians, as you know, were conspicuous during the early middle ages for their continual civil warfare among branches of the dynastic family. These wars were notorious, pitting various family members against each other and resulting in continuous blood and slaughter of brothers against brothers, fathers against sons, cousins against cousins, and so on. The document was written by a monk from the monastery of St. Denis. At that time it was a small and rather obscure monastery, but later it evolved into an abbey due to its growing political and theological influence. The first monarch of France to be buried at St. Denis, a fascinating place to visit, is Dagobert (628-638 C.E.), who is considered to be its founder. I am presenting the carefully written manuscript here in annotated form in order to assist in clarification and understanding of this interesting historical medical controversy.

* * *

Esteemed Brothers, I Angelus, a poor scribe and son of our Father, Benedict, have been directed by my fellow brothers who follow the revered path of the Apostle Luke [physicians], to write down the confusion that emerged in the long practiced cure of bloodletting to assist the many patients who daily come to our doors. I write what has been told to me by these Esteemed Brothers [the majority of physicians at that time were members of religious communities] in the hope that a common method of curing the sick may be observed by all. May the Lord Jesus guide my hand as I report these concerns.

It is claimed that there were at least two surgeons who accompanied the Trojan army to the siege of Troy, one of whom was named Podalarius, who was cast by a tempest, it is said, on his return journey after the war, onto the shore of Caria. When it was discovered that he was a physician he was brought to Dametus, the king at that time, whose daughter had allegedly fallen from the top of her house after inadvertently coming across the king in sexual congress with two of his mistresses. She was lying insensible and motionless and was supposed to have been dead. However this skillful surgeon bled her from both arms and had the happiness of restoring her life. [This early example of the practice of bleeding may or may not be authentic but it is the first recorded description of that renowned medical procedure, which then persisted through the time of Hippocrates up to very recent years, and actually now has been revived in certain medical conditions. For about twenty-five hundred years this procedure was standard treatment by the medical profession.]

We learn from the ancient authorities that bloodletting was based on a system of medicine in which blood and other body fluids were considered to be “humors,” the proper balance of which maintained mental and physical health. Chemical imbalance of these humors led to all sorts of physical and mental illnesses, as has always been believed. The great ancient physician Galen taught us that the four humors, blood, phlegm, black bile, and yellow bile, relating to the four Greek classical elements of air, water, earth, and fire required careful balance in the human organism, and that blood was the most important humor and the one in need of constant control by removal of excess blood.

So of course the practice of bleeding was one of the most common treatments by physicians of our time also, but during our time, in the Merovingian dynasty, various evolutions of it took place which I have been assigned to chronicle. The majority of the physicians of the Merovingian dynasty were convinced from their experience that bleeding usually works and that in addition the salutary mental effects of bleeding were much better than no treatment at all. Many patients were bled in those days and it was common knowledge that they often recovered sooner or later from whatever illness they had.

Most unfortunately, however, there occurred a sudden upsurge of criticism of this procedure, allegedly attributed to a Jewish physician whose name is unknown. He demanded that very strict rituals should take place during the bleeding procedure involving the positioning of the patient, the silence of the physician, and the instructions to the patient. He probably stole this from the Talmud, which already in the sixth century A.D.
The second school, which by this time had formed an organization of its own, followed the instructions of the putatively Jewish genius and carried out the bleeding procedure using certain strict rituals that he had prescribed, insisting that they were practicing "science," that they frequently called "our science." By this they meant that Aristotle, whom we are now beginning to consider "The Master of Those Who Know," would highly approve of what they were doing. But they emphasized paying attention to the causes of the illness as best they could and developed rituals to try to unearth these causes, which often were quite hidden both to the patient and the doctor. This effort was necessitated because certain rituals were to be applied or not applied depending on the particular causes of the patient's illness.

The third school of bleeding procedures loosened and changed and emended the various rituals which had been required by "the professor" to take place during the bleeding procedure. As a result of their many anecdotal reports there was a sudden upsurge and excitement about the potential of bleeding patients who had undiagnosable, strange, and previously untreatable conditions by using various new rituals, and the explosion of great interest in attempting to find congenial physicians who would follow their assortment of special rituals. The emended rituals that were followed differed depending on the charisma of the advocate. Each advocate attracted disciples and claimed that his (or her[!]) emendation from the strict rituals of the second school was an indubitable improvement.

But the schism among the practitioners caused a problem. The group that followed the strict rituals was gradually overshadowed by the rebellious group, who in turn were riding off madly in all directions, each in their own style to order, ease, and revise in a variety of ways the techniques that were originally prescribed by "the professor." Because there was so much controversy, as was typical in our Merovingian times, both of these new schools, the second and third described above, began to lose favor and lose patients, and doctors who followed them began to starve. Patients, confused over all the controversy and urged on by the manufacturers of equipment for simply bleeding them, returned to the physicians who practiced in the classical manner. Patients of the latter group of physicians also enjoyed the bonus of saving time and money because the classical bleeding procedure was shorter and cheaper and required no nosy prying by the doctor into personal matters.

This critical problem of the members of the two new schools, how to avoid starving, was resolved by the doctors in different ways. Some of the members of the group that followed "the professor's" strict rituals began to question whether it was necessary for someone to be a physician in order to bleed a patient and therefore they began to incorporate physician assistants and even non-medical and lay persons including women(!) into their group and train them how to bleed a patient using the strict rituals prescribed. [Eventually in more modern times barbers were assigned to carry out the bleeding treatments, accounting for the red stripes on today's barber poles.] The more rebellious group, on the other hand, had a strong personal investment in remaining exclusively a group of physicians and therefore they refused to employ this solution. But this forced them to water down their technique and bring it closer and closer to the original physicians who had been bleeding patients for two thousand years without any concern for rituals or even for the differences between one patient and another.

Eventually the strict ritual group evolved into a kind of cult which carried out non-evidence based, non-medical procedures; they began to have their own meetings and removed themselves more or less from those of the physicians. They soon started quarrelling among themselves regarding which set of strict rituals should be observed, those of "the professor" or of some of his allegedly devoted followers. Finally they ceased attending routine physicians' meetings entirely and developed meticulously hand-written manuscripts constituting journals and textbooks of their own.

On the other hand, the more rebellious group, who were trying all kinds of changes to the strict rituals and could not even find agreement among themselves, began to gradually become absorbed into the original group of physicians who were bleeding patients in a non-ritual way prescribed for thousands of years; they took a lancet or leeches and simply bled the patient without comment. The rebellious group came to be regarded as a small side group of theirs and, although they were tolerated by the large original group, they received very little attention. Their various suggestions and rituals were not taught and their bleeding procedures as physicians, with their innumerable variations on the original strict rituals, became increasingly

[24]

---


He wrote this about 180 A.D. as he waged his life fighting the northern “barbarians,” some tribes of whom later founded our current Merovingian civilization through their victories over the other tribes and eventually over the Romans themselves.

The second school, which by this time had formed an organization of its own, followed the instructions of the putatively Jewish genius and carried out the bleeding procedure using certain strict rituals that he had prescribed, insisting that they were practicing “science,” that they frequently called “our science.” By this they meant that Aristotle, whom we are now beginning to consider “The Master of Those Who Know,” would highly approve of what they were doing. But they emphasized paying attention to the causes of the illness as best they could and developed rituals to try to unearth these causes, which often were quite hidden both to the patient and the doctor. This effort was necessitated because certain rituals were to be applied or not applied depending on the particular causes of the patient’s illness.

The third school of bleeding procedures loosened and changed and emended the various rituals which had been required by “the professor” to take place during the bleeding procedure. As a result of their many anecdotal reports there was a sudden upsurge and excitement about the potential of bleeding patients who had undiagnosable, strange, and previously untreatable conditions by using various new rituals, and the explosion of great interest in attempting to find congenial physicians who would follow their assortment of special rituals. The emended rituals that were followed differed depending on the charisma of the advocate. Each advocate attracted disciples and claimed that his (or her[!]) emendation from the strict rituals of the second school was an indubitable improvement.

But the schism among the practitioners caused a problem. The group that followed the strict rituals was gradually overshadowed by the rebellious group, who in turn were riding off madly in all directions, each in their own style to order, ease, and revise in a variety of ways the techniques that were originally prescribed by “the professor.” Because there was so much controversy, as was typical in our Merovingian times, both of these new schools, the second and third described above, began to lose favor and lose patients, and doctors who followed them began to starve. Patients, confused over all the controversy and urged on by the manufacturers of equipment for simply bleeding them, returned to the physicians who practiced in the classical manner. Patients of the latter group of physicians also enjoyed the bonus of saving time and money because the classical bleeding procedure was shorter and cheaper and required no nosy prying by the doctor into personal matters.

This critical problem of the members of the two new schools, how to avoid starving, was resolved by the doctors in different ways. Some of the members of the group that followed “the professor’s” strict rituals began to question whether it was necessary for someone to be a physician in order to bleed a patient and therefore they began to incorporate physician assistants and even non-medical and lay persons including women(!) into their group and train them how to bleed a patient using the strict rituals prescribed. [Eventually in more modern times barbers were assigned to carry out the bleeding treatments, accounting for the red stripes on today’s barber poles.] The more rebellious group, on the other hand, had a strong personal investment in remaining exclusively a group of physicians and therefore they refused to employ this solution. But this forced them to water down their technique and bring it closer and closer to the original physicians who had been bleeding patients for two thousand years without any concern for rituals or even for the differences between one patient and another.

Eventually the strict ritual group evolved into a kind of cult which carried out non-evidence based, non-medical procedures; they began to have their own meetings and removed themselves more or less from those of the physicians. They soon started quarrelling among themselves regarding which set of strict rituals should be observed, those of “the professor” or of some of his allegedly devoted followers. Finally they ceased attending routine physicians’ meetings entirely and developed meticulously hand-written manuscripts constituting journals and textbooks of their own.

On the other hand, the more rebellious group, who were trying all kinds of changes to the strict rituals and could not even find agreement among themselves, began to gradually become absorbed into the original group of physicians who were bleeding patients in a non-ritual way prescribed for thousands of years; they took a lancet or leeches and simply bled the patient without comment. The rebellious group came to be regarded as a small side group of theirs and, although they were tolerated by the large original group, they received very little attention. Their various suggestions and rituals were not taught and their bleeding procedures as physicians, with their innumerable variations on the original strict rituals, became increasingly
irrelevant to the mainstream practice of physicians who were using bleeding procedures. Gradually these practitioners became incorporated into the long standing organizations of traditional physicians. So eventually the distinction between no rituals at all and the need for rituals as part of a bleeding procedure of any kind became disregarded by the vast majority of general physicians, who only tolerated this gradually shrinking rebel group of doctors for the sake of wanting to appear as giving lip service to something that at one point had been so exciting and seemed so revolutionary an improvement in the practice of medicine.

As these ideas died out there was also a gradual evolution in the strict ritual group that moved it farther and father away from the medical field, and that group became a kind of repository for the treatment of patients for whom ordinary bleeding did not seem to have an effect. Hostile critics called these patients "the worried well." But that group was never able to convince ordinary doctors that their strict ritual procedure of bleeding was any better than non-ritual bleeding used by the general physicians, and their members were treated with scorn and ridicule. As a result this cult became smaller and smaller and attracted more and more characters who seemed to have less and less of a concept of what they were doing. They seemed to be confused about how it was different or the same from what the general physicians were doing, and what relationship their current procedures had to the practices of the original founder of the strict bleeding technique. They even no longer read the meticulously prepared manuscripts of their "Jewish genius" in their training and education, and began to regard him as a fossil and out of date with modern thought. Those who insisted on basing their work on what they had learned by going back to the original manuscripts written by "the professor" were considered eccentric, and ignored. All of this has faded out now, near the end of the Merovingian dynasty, and is only recorded in these chronicles as a part of church history assigned by Esteemed Brothers to be written by this humble monk. Sic transit gloria mundi.

* * *

The honorable readers of the Academy Forum I am sure will be delighted to know that the bleeding procedures that are used today, carried out by the use of phlebotomy or even in some places still the application of leeches to the patient, is becoming more common and there is a good chance it may revive. Also, as we in the field of psychiatry approach the birth of DSM V we can feel secure that our psychiatry rests on the firm biological basis that was established for it by neurologists in the 19th century and has finally come around to reviving the classifications and pharmacologic practices that were extant at that time. There has even been some improvement since then, in that these pharmacologic procedures have now been liberally applied to children, sometimes even to two year olds.

It is very befuddling to the average practitioner to understand why their parents and other disturbed persons would object to such advances in medical practice and even picket our medical meetings.

I have brought your attention to the controversy that went on in the Merovingian era to reassure you how basic medical and psychiatric practice have continued unchanged in the mainstream since the fall of Troy in spite of temporary intruders like "the professor." I have found it helpful and I sleep better knowing that the procedures from the time of Hippocrates which are used today have the authority of thousands of years of announced success, even though the concept of experimental demonstration has not been always bothered with. It is comforting to know that we are practicing biological psychiatry in a tradition of chemical imbalance that is parallel to and based on a classical practice from twenty-five hundred years ago. With the exception of a few obviously eccentric Greek intuitive geniuses who recommended that psychiatric patients should go to the temple at Asclepius at Epidaurus in the north-eastern Peloponnese and dream there in order to have their dreams read by the priests at the temple, most practices such as bleeding were carried out without any interest or exploration of how the patient got sick or why they were sick or even why they preferred to remain sick. These matters were usually attributed to the will of the gods.

The process of bleeding, just like the process of prescribing drugs, is very short, and a trained nurse practitioner can bleed several patients either at once or sequentially in a very reasonable amount of time, guaranteeing for herself and for the corporation of doctors that employ her, currently known by the curious epithet as “mental health providers” and no longer as “Esteemed Brothers,” a suitable income from a plethora of patients who are convinced by classical authorities that they have a chemical imbalance. As the eminent physician W. Michell Clarke writes about the history of bleeding patients in the British Medical Journal of July 17, 1875:

We cannot yet say, in many cases, here is such and such a group of symptoms; they indicate a definite derangement, which can be met with mathematical precision by such and such remedies; in some cases, we do almost attain to this accuracy, and it is highly desirable that the numbers should be increased; but in the meantime, in the majority, we take a safer course in following the path that the stored up information that has been gathered in the past leads us.

(p.69)

How fortunate we are that only about 135 years later DSM V will have finally solved this problem for the diseases that are addressed by psychiatry!

Clarke also points out that, “Most of the older of us will have met with instances in which permanent injury has been done to the individual…I have heard many stories of the way in which the patients at the infirmary and other places used to be bled all around by the students, and that in the most lavish manner.” He could not know that bleeding would be back in practice today but he thought that the reason it was given up was, “I think we should be inclined to say that it was the excess of the last generation that caused the utter collapse of the practice” (p.63).

Plus ça change, plus c’est la même chose.
Descent into Darkness, The Psychodynamics of Mental Illness: An Introduction and Illustration in the Form of a Novel,
by Richard D. Chessick, M.D., Ph.D., Xlibris.com, 237 pp. Available on Amazon.com and BarnesandNobles.com in ebook format @ $7.99. Reviewed by Joseph R. Silvio, M.D.

Dr. Richard Chessick, one of the Academy’s most distinguished senior members, has taken a bold step into new territory with Descent into Darkness, a work not only innovative in style but also in format. In creating what he calls a didactic novel, Dr. Chessick has attempted to both illustrate and teach psychoanalytic theory and technique through a fictional plot that demonstrates neurotic and character pathology through the conflicts and behaviors of its various personalities, while offering theoretical understanding through a series of lectures or discussions provided by the same. And to remain solidly in the forefront of modern technology, he is publishing the work in e-book format exclusively, which means it must be read on an electronic device. As with all new prototypes, it has its advantages and disadvantages.

First, let me say that this is not a book for the casual reader. The author tries to address what he perceives as serious threats in contemporary culture and society not just to the future of psychoanalysis and psychodynamic psychotherapy, but to the basic foundations of what make us human and to our survival as a species. This involves extensive reviews of history and philosophy from ancient to modern, interspersed with descriptions of psychoanalytic schools from Freud to the post modern. Needless to say, it is not an easy stroll.

In brief, the fictional plot involves the adventures of a group on a tour to visit several centers of ancient civilizations in Turkey and learn from their historical developments principles of psychic development and psychopathological formations. The study tour was organized by Martin, the novel’s protagonist and Dr. Chessick’s avatar, as an attempt to extricate himself from a state of loneliness and anxiety following the death of his wife and the development of potentially life threatening cardiac problems which he thinks of as psychosomatic. Martin’s hidden motivation for this venture is to seduce his former patient J. whom he has invited to participate because he believes that only through their physical and emotional uniting will he be revitalized. He also hopes to inspire in others a commitment to the humanistic foundations of psychoanalytic and psychodynamic treatments to counter the dehumanizing movements of contemporary society, biological psychiatry, and anti-Freudian psychoanalytic therapies.

The study group is composed of rather stereotypic characters who behave in expected ways that illustrate their character types. J. is the ideal patient with whom every therapist would fall in love. She is beautiful, intelligent, sensitive, and moral, and while she falls in love with her analyst, she maintains and respects the boundaries of the therapeutic relationship. Her husband Henry, on the other hand, is an academic philosopher who holds psychotherapy in contempt and views J. as a narcissistic ornament for self aggrandizement while he repeatedly pursues his sexual appetites outside their marriage. Richard is the epitome of a grandiose, obsessional training analyst of dogmatic ideology who holds all those outside his circle with contempt, and his wife Pearl is the timid, yet intelligent and insightful analyst eclipsed in her husband’s shadow. Claire is the gorgeous, young, highly intelligent psychiatric resident committed to psychoanalytic/psychodynamic approaches, while her husband Edward is an older businessman scornful of psychoanalysis as unscientific and ineffective. Sarah and Gertrude are a lesbian couple from Oregon, Sarah being a brilliant but cold academic professor of literature and Gertrude being an intersubjective psychoanalyst with little use for Freudian ideas. George and Marsha are two mature and modest psychoanalysts who have shared a long and loving relationship and seem genuinely non-judgmental and open to discussions of differing psychoanalytic and philosophical points of view. Ali is the movie-star handsome foreign psychiatry resident hungering for psychodynamic training after exclusive exposure to biological psychiatric teaching. Sema is a young and lovely Turkish tour guide who dresses and wants to appear very Western, but who is also inculcated with the principles of her traditional Muslim upbringing.

As the group travels from one city to another, libidinal and aggressive drives break out in many forms of harmful and irresponsible behavior, for which no one seems to be willing to take ownership or responsibility. Richard tries to rape Claire and blames his behavior on Martin for a poorly planned and organized tour. When he leaves the group, Gertrude seduces his wife Pearl into a lesbian relationship and abandons Sarah, her longtime partner. Henry tries to seduce Sema but is caught in the act by J., who acknowledges to Martin that Henry has been unfaithful on a number of occasions. Edward leaves the tour in a fury after drinking too much and verbally assaulting Martin for a useless tour of irrelevant cities and a series of boring philosophical and analytic lectures. Claire then takes up with Ali, and both beautiful young residents abandon psychiatry to find success together in other professional and business ventures. All the while, Martin tries to convince J. to become his lover, despite her steadfast refusal to violate her marriage vows and the boundaries of the therapeutic relationship.

Interspersed amidst all this unbridled drive expression are long discussions and lectures on ancient history, western philosophy, and psychoanalytic theories and practice. The overarching theme is the decline of contemporary society and culture from humanistic to materialistic, from shared dependency to selfish greed, from ego reality to id satisfaction and a corresponding decline of psychiatry from humanistic psychotherapy to biological reductionism, and of contemporary psychoanalytic/psychodynamic theory and practice from a focus on drives and their unconscious effects on neurotic and character pathology to postmodern ideas of intersubjectivity and co-created transferences that rob the individual of those unique unconscious forces and core fantasies that make him/her most human. The various discussions are impressively detailed and scholarly, very educational, and often thought provoking. The depth and breadth of Dr. Chessick’s knowledge about the fields of ancient
history, philosophy, and psychoanalysis/psychodynamics is truly extraordinary, and his ability to synthesize and convey it in clear and concise prose is also exceptional. The book is perhaps best appreciated if one reads it like the tour it describes - one chapter/city at a time - for time is needed to absorb and reflect on the many ideas encountered.

The Jewish World of Sigmund Freud: Essays on Cultural Roots and the Problem of Religious Identity
Reviewed by Samuel Slipp, M.D.

The Jewish World of Sigmund Freud: Essays on Cultural Roots and the Problem of Religious Identity, edited by Arnold D. Richards, is a comprehensive review of how the Austrian culture affected Freud personally, his theory, and his therapy. The authors are mostly members of the American Psychoanalytic Association as well as historians and German scholars. This is fascinating, since the contentious split in the psychoanalytic movement occurred precisely because the American Psychoanalytic embraced Freud’s individualistic libido theory and demeaned the American Academy of Psychoanalysis members for recognizing interpersonal and cultural dynamics. However, the libido theory could not be denoted and scientifically verified. Several years ago, Marvin Margolis, the President of the American Psychoanalytic Association apologized to the Academy for their error, and this book is an example of their new direction from ideology to science.

The back cover of the book and the initial chapter by Jill Salberg, Hidden in Plain Sight: Freud’s Jewish Identity Revisited, state that not enough has been written about Freud’s Jewishness. But this was true only of the Orthodox Freudians. Members of the Academy, historians, and others have since written extensively on this topic. I myself have written a number of books addressing this area (Object Relations: A Dynamic Bridge Between Individual and Family Treatment 1984, Jason Aronson, NY, The Freudian Mystique: Freud, Women, and Feminism 1993, NYU Press, Healing the Gender Wars 1996, Jason Aronson, Northvale, NJ and London). Salberg reviews anti-Semitism after the European Enlightenment, the Dreyfus affair in France and Karl Lueger in Vienna. Freud’s mother, Amelia, is described as narcissistic and tyrannical. Since she could not live vicariously through her failed husband for status, she attempted to live through her golden Sigi. Salberg mentions Freud did not attend her funeral, but sent Anna. I found H. T. Hardin’s (On the Vicissitudes of Freud’s Early Mothering: Alienation from his Biological Mother, Psychoanalytic Quarterly 1988, 57:72-85) insight significant. Hardin related Freud’s sending a surrogate to the funeral, because his mother used a surrogate nanny to raise him in early childhood. Salberg ends up saying his repression of femininity, Jewishness, passivity and religion clashed with his idealization of masculinity, activity, science, and atheism which became embedded in his theory.

I note Freud’s ambivalence about religion is also related to his religious Catholic nanny who was convicted of theft. Freud was disappointed in his father’s passivity to anti-Semitism and fought against being like him, by identifying as a conquistador.

The chapter by Marsha L. Rozenblit deals with assimilation and secularization of Jews who were allowed to live in Vienna from the Hapsburg Empire after the 1848 revolution. Jews were mostly poor and blamed for the ills in the world. After the election of the anti-Semitic Lueger as mayor of Vienna the rights of Jews were limited, which included Freud’s professional growth. Jews saw themselves politically as Austrian, culturally as German, and theoretically as Jewish.

The chapter by Richard H. Armstrong discusses Freud’s gymnasium education in Vienna, which included Jewish history and religion. Education enabled him to move up from the lower middle class of merchants and shop keepers. He had an honorary membership in the Zionist Kadima society, which provided him with self respect. The number of Jews in medical school rose to 55% in 1880’s since medicine offered more opportunity. Armstrong notes Freud identified with Hannibal, who opposed Rome, after the Vatican forced Emperor Franz Joseph to confirm the anti-Semitic Karl Lueger as mayor. I note that Freud was not aware that the Hasmonian Jews at that time were on the side of Rome against Hannibal of Carthage.

The chapter by Leo A. Lensing is entitled The Neue Freie Press Neurosis: Freud, Karl Kraus, and the Newspaper as Daily Devotional. It deals with the newspaper writer Karl Kraus who was an opponent of psychoanalysis. Fritz Wittels wrote about the writer’s Oedipal complex, but Freud had been friendly with Kraus and was disappointed in the lost relationship with him.

The brilliant Sander L. Gilman, a historian, was given a topic, Sigmund Freud and Electrotherapy. This wastes a golden opportunity, since it does not tap his erudition. I attended a seminar by Dr. Gilman at Cornell on turn of the century Vienna, and his scholarship was brilliant. Gilman here points out that Freud’s patients were mostly Jewish women and electrotherapy was used by neurologists. However Freud was one of the first to note its limitations.

Gilman’s book, Jewish Self Hatred and the Hidden Language of the Jews, 1986, would have been more applicable here. He describes Herzl’s 1899 book The Jewish State, 1898, describing anti-Semitism. Theodore Lessing and later Kurt Lewin noted the demeaning of Jews was not due to inbreeding but had its origin in cultural conditioning. Some Jews wished to distance their identity from a devalued group by identifying with the aggressor. After the Israeli victories in the 1967 and 1983 wars, people were proud of their Jewish heritage. Clearly Freud was conflicted about his Jewish identity. He was proud of it, yet he associated it with passivity and femininity.

The next chapter is by the outstanding psychoanalyst Harold P. Blum, whom I was fortunate to get to know personally. His topic is Anti-Semitism in the Freud Case Histories. He explores Anna O, Dora, Little Hans, the Rat-Man, and the Wolf-Man. He notes that unanalyzed conflicts and ambivalence about Jewish identity are evident in Freud, in his patients, as well as in their treatment. Anti-Semitism changed from Jews being seen as infidels to a despised race, who were deformed, effeminate, and had long hooked noses. When Freud escaped to England in 1938 he expressed his ambivalence by joining the B’nai B’rith, but he also blamed the character of Jews for contributing to anti-Semitism. Blum notes that a transference-countertransference collusion may provide a barrier to analytic recognition of bias. Freud also did not comment on the anti-Semitism in the delusion of the Schreber case. This chapter alone is worth reading the book.
The chapter by Eliza Slavet on Freud’s Theory of Jewishness: For Better and for Worse briefly discusses Moses and Monotheism. She states Moses and not God created the Jews. Freud said the Jews killed Moses, like all others described in Totem and Taboo. Freud held that Jews biologically were a race held together by a tradition of intellectual ideals and practice. When I read Yerushalmi (Freud’s Moses: Judaism Terminable and Interminable 1988 p. 26-27), he notes that Freud was “captivated” and influenced by Ernst Sellin’s book, which stated Jews killed Christ, and also killed Moses.

The chapter by Ethan Kleinberg is entitled Freud and Levinas: Talmud and Psychoanalysts Before the Letter. In Moses and Monotheism Freud turns the oppressive Egyptians into the savior and the oppressed Jews into the oppressors. Levinas also looked to Moses, who he accepted as divinely establishing universal law. Levinas was a Lithuanian Jewish-French philosopher who identified ritual, the study of the Talmud and religious Jewish thought as essential for Jewish identity. This was opposite to Freud who identified with atheism, assimilation, science, and secular Jewish thought. Freud used Lamarkian theory, in which memory traces were passed down to create a Jewish identity. Yet Freud’s use of Lamarck’s theory and his ideas about Moses are not scientific. Kleinberg states both Freud and Levinas created a school of thought, with disciples, doctrines, acolytes and heretics, like conflicting religions.

The chapter by Abigha Gillman is entitled Freud’s Moses and Viennese Jewish Modernism. She mentions the rapid and profound changes in art, music, literature, philosophy, and politics occurring in Vienna that accompanied Freud’s developing his theories as consistent with this change. She discusses Moses and Monotheism, with circumcision being of Egyptian origin. Freud’s image of Moses, the founder of Judaism, is the most provocative work he produced and was criticized by others.

Mary Bergstein’s chapter is Freud’s Michelangelo: The Sculptural Mediations of a Hellentzed Jew. The statue of Moses created similar ambivalent wishes and fears in Freud concerning his father. She states that Michelangelo’s slave represented a personification of his father in his unconscious mind. She states Freud had a classical education and enjoyed visiting Rome and Pompeii. I wrote that after Emperor Franz Joseph was forced by Rome to ratify the election of Karl Lueger, Freud took a trip that traced the path of Hannibal, who attempted to conquer Rome. Interestingly Michelangelo secretly was part of an underground group opposed to the Vatican’s selling indulgences.

The chapter by Florence Dunn Friedman on Freud, Moses, and Akhenaten discusses Freud’s theory that the Pharaoh Akhenaten originated monotheism and not Moses. Freud also blames Moses for making the Jewish people feel superior, chosen by God. But I understand that the Jews were not superior but given more responsibility to heal the world, tikkun olam. She wrote that Freud blamed the victim. Freud however identified with Moses, who opposed authority for freedom. I note that Freud ignored the fact that Akhenaten narcissistically drew power to himself and worshipped the mute sun disc. After this pharaoh’s rule, he was declared a heretic and his son, Tutenkhaten, changed his name to Tutenkhamon, who ruled shortly. He was followed by Ramses II, the Pharaoh of the Exodus. The God of Moses was invisible and spoke, while Moses was reluctant.

Frank Mecklenburg’s chapter Sigmund Freud in Exile: The End of an Illusion, considers that Moses and Monotheism attacks all religions as an illusion. Freud saw himself as the new Moses that introduced the unreligion of science and rationality. Freud’s time in Britain was troubled, even though he was surrounded by many of his possessions. He learned that his work was being burned in Germany and of the mass killing of Jews by the Nazis. He was terminally ill and in pain and felt hopeless. He committed suicide on September 23, 1939, which was the day of Yom Kippur. Why this day? Was it a final slap at religion or a recognition of his Jewish roots?

The chapter by Benigna Gerisch is on Leaving This World with Decency: Psychoanalytical Considerations on Suicide in the Life and Work of Sigmund Freud. Suicide is discussed in Freud’s meetings and work, as in Mourning and Melancholia, and the death instinct. In England he suffered severe pain from his cancer and asked Dr. Max Schur to help him die in dignity. As a stoic he kept control of his life to the end.

The final chapter by Steven Beller is entitled Freud's Jewish World: A Historical Perspective. This is a comprehensive wrap up about Kraus, Lueger, the Logical Positivists, Hertzl, Akhnaten, Moses Maimonides, etc. Freud was part of the Jewish intellectual heritage that believed in universal human values for individuals. The belief in an abstract non-corporeal God facilitated abstract thinking in Jews. Beller states Freud was adversarial, patriarchal and authoritarian about his psychoanalysis, since he alone discovered the secret of the human psyche. However Beller considers Object Relations Theory, developed in England, based on relationships, as closer to Jewish thought.

My summary: But why did such a genius as Freud focus solely on the individual in his work? One factor was that he joined his mentor Brucke in the Logical Positivist society that emphasized empirical Newtonian mechanics. Freud then developed the libido theory. I speculate that what is even more important was the anti-Semitism of 19th Century Europe. People mostly were seen collectively in stereotypes and not as unique individuals. For example women were seen as compliant ornaments that were baby machines. Jews were demeaned because they were blamed for the death of Jesus and for being avaricious, since Judas supposedly betrayed Jesus for money. The Nazis further dehumanized Jews. Freud suffered because he was seen collectively as a Jew despite his genius. Freud’s academic career was blocked by anti-Semitic laws, and when he proclaimed his theory of hysteria, he was labeled a Jewish pornographer. He feared psychoanalysis would be dismissed as a Jewish psychology. By focusing on the individual and not the collective identity, Freud wanted to create a universal psychology that was applicable to all individuals. He called religious rituals an obsession neurosis, instead of noting that when people sing, eat, or move in synchrony it fosters group solidarity. In response to anti-Semitism, the psychoanalytic movement split. Freud focused on the individual and was blind to relationships. The British Object Relations Analysts, Horney, Sullivan and others in the American Academy of Psychoanalysis and Dynamic Psychiatry also included interpersonal relations and the culture.

Anti-Semitism also influenced his last book, Moses and Monotheism. In 1934, Freud wrote the original version of this book as a historical novel. This was when Hitler rose to power. In 1938, after he was rescued from the Nazis by Marie
Bonaparte, Ernest Jones and Ambassador Bullitt, he finished writing Moses and Monotheism. As mentioned, he describes Moses as an Egyptian; that monotheism was created by the Pharaoh Akhnaton. As mentioned, Freud’s idea that Moses was killed by the Jews was probably derived from Sellin’s book, which extended seeing Jews as killing Jesus to Moses. It was also similar to Freud’s ideas of the universal killing of the father in Totem and Taboo, which is rejected by biblical scholars, anthropologists, and historians. I speculate that in tribute to being rescued by three Christians, he made Moses, the rescuer, non-Jewish. Yerushalmi mentions that the ideas in Moses and Monotheism attempts to repair Freud’s self esteem, which had been damaged as a Jew by his relation with his submissive father and by being demeaned by anti-Semitism. Here again Freud probably attempted to fight against seeing himself degraded collectively as a Jew, and to identify himself as a strong masculine individual, a conquistador.


It has been fifty years since I first met James Kirsch. Memories of him frame important parts of my own entry into the analytic world and my evolution as a psychiatrist and psychoanalyst. We continually forget or misplace our experiences, periodically retrieving and retranslating them like lost shards of time. Each shard is unique and reminds us of the rich dimensions of who we were and who we are, our continuity in time, and ultimately our own mortality. The profound issues and contexts embedded in the Jung-Kirsch Letters: The Correspondence of C.G. Jung and James Kirsch evoke strong emotional connections and the engaging dimensionality provides a rich reward for the reader.

James Kirsch’s son, Tom, and I became friends when we were psychiatric residents at Stanford in the early sixties. When I met James in 1962, I was struck by his ebullient personality, intellectual passion, and Old World scholarship. It seemed that there was little that he hadn’t read! Until then I had been a bit disappointed in the somewhat parochial views of the psychiatrists and psychoanalysts whom I had encountered. James was an exuberant man who renewed my interest in the broader dimensions of the field. Knowing him encouraged my explorations of the analytic world and stimulated me to begin a personal analysis with a Jungian.

The letters between Carl Jung and James Kirsch immerse the reader in the lived history of psychoanalysis. These letters are a rich set of artifacts, important facets of the narrative of psychoanalysis - some that have “disappeared” from consciousness. Others may yet be seen “through a glass, darkly,” and still others remain embraced as living mementos. This important volume evokes the play of memories and forgettings, with all their disturbing and enlightening aspects. The accompanying photographs are often poignant, bringing back lost people and times, their fates awaiting them that we, the onlookers, know as they did not. The process of reading the letters provokes us to wonder: why we cling avidly to some things and “forget” the others? Such historical treasures represent an archeology of the past, but also the present: the past as the “remembered present” (Edelman, G., Wider Than the Sky, 2004, p. 55). In these letters one re-experiences the present in the somewhat melancholy light of dreams lived and dreams aborted, fallacies still dominant but possibilities silently lurking, with glimpses of a psychoanalysis that might have been but is yet to be.

The correspondence begins when James Kirsch is a young psychiatrist, a graduate of the University of Heidelberg, practicing in Berlin and supporting his wife and young family. He undertakes a Freudian analysis, but becomes dissatisfied after two years. Reading Jung’s volume, Psychological Types, motivates him to enter analysis with Toni Sussman, a lay analyst in Berlin. In November 1928, he writes Jung with a request for appointments in Zürich and Jung agrees to meet with him the following May. This initiates a series of sixty analytical hours, which at that time was considered a lengthy analysis.

The period covered in the letters is 1928-1960, ending shortly before Jung’s death in 1961. These were momentous times in the history of the world and in the history of psychoanalysis. James’s initial encounters with Jung begin in troubled pre-war WWII Berlin (1928-1932). Thereafter, due to the rise of Nazism and his family’s Jewish identity, James and his family moved to Tel Aviv (1933-1934) and then to London (1935-1938). The final period circulates around Los Angeles, where the Kirsch’s settle and become central figures in the establishment and culture of the C. G. Jung Institute of Los Angeles.

The early letters portray a James Kirsch who clearly admires Jung as a revered elder and teacher, often using terms that are exaggeratedly honorific. In response, Jung seems to take quite a shine to the bright and engaging younger man. He even shares his Red Book, the intimate journal of writings and paintings that he had transcribed during a deep personal crisis around 1914.

Kirsch struggles mightily with the vicissitudes of being a pioneer in analytic practice, especially in relationships with his female patients, and he often turns to his mentor for help. In one clinical emergency he even tries to call Jung by telephone while he is away on vacation. The consultative responses are invariably kind and helpful in tone. Such examples provide insight into how Jung viewed the analytic process. For instance, with regard to the treatment of a patient whom we might call borderline today, he advises in 1929 (Letters, p. 5):

The picture is really unsatisfactory and seriously dissociated. In such cases it is...advisable not to analyze too actively [and] let the transference calmly run its course and listen sympathetically. Evidently the patient needs you as a father, which is how you have to present yourself - properly as a father, with admonition, scolding, caring, fatherliness, etc. Not a technical attitude at all, but an essentially human one. The patient needs you to [do] so [in order for her to]…unify her dissociated personality in your consistency, calm and security. For now, you must just stand by, without too many therapeutic intentions. The patient will surely take from you what she needs. Without rectifying her relationship with her father, she also cannot bring her love problem into order. She must first achieve peace with her father, that is, in a human trust relationship.

In another exchange in 1934 (Ibid, p. 63), Jung comments on the intersubjective field:
With regard to your patient, it’s quite correct to say that her dreams have been induced by you…This is the meaning of transference…As soon as certain patients start treatment with me, the type of their dreams changes. In the deepest sense, all of us do not dream out of ourselves but out of that which exists between myself and the other.

From another, more unfortunate perspective, even in the early part of his career, Kirsch begins to express harsh assessments of fellow Jungians who seek to find common ground with people such as Freud and Adler and their adherents (Ibid, p. 24 & n. 96). This is one harbinger of the chronic strife and intolerance that has plagued the analytic world from its beginnings.

When Hitler took power in January 1933, James made plans to leave Germany. I recall a lengthy discussion with him about that time and his frustration that he couldn’t convince others of the dangers for Jews. In July, after a brief stay in Ascona, Switzerland, he and his wife Eva and their two children left for Palestine (before it was Israel). Hilde Silber, a widow with two children who was his patient, accompanied him. They lived in Tel Aviv for 18 months. Although he was a staunch Zionist, the family “experienced the early Zionists as more fanatical than they were comfortable with” (Ibid, p. xiv).

During this time, in perhaps the most engaging dimension of the Letters, Kirsch and Jung conducted a remarkable correspondence regarding the rumors that Jung was anti-Semitic or even a Nazi. In this rich and intense exchange, often more like a confrontation, Jung goes to great lengths to explain some of his actions, and his thinking about Jews, Judaism, and Jewish mysticism.

The exchange began in May 1934, when James—now in Tel Aviv—questioned Jung about his earlier standoffishness when they were in Ascona (Switzerland) on the way to Palestine. He apparently wondered whether that had been a sign of Jung’s emerging anti-Semitism. Jung reassured him that he had intended to be somewhat aloof because, “All your libido was required to realize the change, undoubtedly enormous, which Palestine represents for you…it moved me to show the utmost restraint.” Kirsch responded that he still found his attitude towards him “incomprehensible” and asked why, if Jung’s attitude was so conscious, they had not had any discussion about it. He also quoted “remarks which did not present you as a friend of the Jews,” and said that as a result Jung’s books had been placed on the boycott list in Palestine (Ibid, p. 39 ff.).

More specifically James asked Jung about an interview on Radio Berlin, where he had spoken of the “youthfulness of the German nation” as the chief way that “distinguished [them] from other European nations,” and lauded “the assurance of German youth in pursuit of their goal,” with their “daring and drive and sense of adventure.” Some people also thought that part of Jung’s remarks were admiring of Hitler. Kirsch pointed out that, in his opinion, the Nazi leaders were actually “abusing the young and misrepresenting their goals” (Ibid, p. 42).

Kirsch took strong exception to another statement by Jung in an essay published in 1934 asserting that, “The Jew is a relative nomad who has never and, as far as one can see, will never create his own form of culture” (Ibid, n. 38). James says that Jung must be referring to the “Galut” Jew, a term that refers to an exile, implying banishment, as opposed to voluntary emigration (Ibid, n. 39). Although it is not discussed in the text, it seems to me that this aspect of Jung’s views could have been taken to imply something close to the Nazi idea of Jews as “parasitic.” This was, in turn, related to the rationalization for their elimination so that the “pure” or “natural” German could “fully emerge.” In psychoanalytic terms, to eliminate the Jews would allow for a return to a fantasied purity: the seamless self-identity of a utopian world in which one was free to destroy what threatened the claustral intimacy of a narcissistic illusion (Santner, E., Stranded Objects: Mourning, Memory and Film in Postwar Germany, 1990, pp. 5-6).

In the face of Kirsch’s learned arguments, Jung somewhat stubbornly replied that his “…view is based on (1) historical facts, and (2) the additional fact that specific cultural contribution of the Jew evolves most clearly within a host culture.” However, he concedes that Palestine may become an exception because it might give Jews grounding in their own earth (Letters, p. 45).

James continued to take strong exception to Jung’s portrayal of Jewish history as nomadic, and said that it is only since the French Revolution and the pressure for assimilation during the Enlightenment that Jung’s evaluation might have some merit (Ibid, p. 52). Overall, he strongly asserted his own views of history and religion, and seemed in this area more knowledgeable than Jung.

To my reading, although he came across as attentive and respectful, Jung didn’t always engage with the specifics of Kirsch’s scholarly reflections on Jewish thought and history. However, in his later (1936) essay, Wotan, Jung described the German youth movement in much darker terms than before (Ibid, p. 42, n. 36).

During the 1934 exchange with Kirsch, he goes on to carefully discuss a very important happening regarding the rumors of his anti-Semitism. This has to do with his replacing Ernst Kretschmer as president of the Medical Society for Psychotherapy (AAGP), an important organization centered in Germany. Kretschmer had resigned his post in protest in April 1933, after trying in vain to prevent the forced removal of German-Jewish psychiatrists from the organization’s leadership (Ibid, p. 44, n. 48). A story circulated that Kretschmer had been removed because he was Jewish, although he was indeed not Jewish, and had resigned (Ibid, p. 308, n. 5).

The fact was that the general secretary of the organization begged Jung to take over the presidency to save the organization (Ibid, n. 49). His solution to the problem was to make it international (IAAGP), rather than German (AAGP), and thus to allow membership either through national sections or directly through the international society. That way Jews could remain individual members of the IAAGP. As a Swiss, Jung was in a better position to accomplish this than Kretschmer might have been.

However, the solution did not work on many levels. Jung apparently underestimated the pressures of the times, “in numbers, finances, manipulation, and will to power - that persistently worked to undermine the neutrality of the IAAGP and to make it conform, or at least appear to conform, with Nazi principles” (Ibid, p. 309). The edition of the organization’s quarterly journal in December 1933 was a public relations disaster for Jung. Dr. M. H. Göring’s official manifestation of Nazi loyalty appeared in that issue in juxtaposition with an essay by Jung. Göring was a fervent Nazi, and the cousin of Hitler’s close confidant, Marshall Herman Göring. This association tarred Jung’s name as Editor. It never became clear how this
incident happened. Jung protested to several people, but the damage to his reputation was dramatic (Ibid).

The rumors about these happenings persisted for many years, and may still persist among some of the older generation of psychoanalysts. In my reading of the situation, Jung was guilty mainly of naïveté, and of underestimating the power of the unconscious historical forces at work both in the world and within himself. However, I did wonder why he didn’t resign his post until 1940.

Was Jung anti-Semitic? My own opinion is a definite “no.” His judgments may have sometimes been a bit slow regarding the dangers of Nazism, and he may have retained some Swiss-cultural stereotypes of Jews and Jewish history, but he was respectful and responded wholeheartedly to James Kirsch’s questioning. His thinking about Judaism was complex, unlike the simplistic attitudes of true anti-Semites. Jung was not perfect, but indeed all too human. We tend to project godlike expectations upon our analytical forebears, and they all have feet of clay. I personally prefer the human Jung who did his best and had human flaws.

He later apologized for passages in his work that might have had the potential to do harm (Ibid, p. xxxii). Also, after the war, he extensively discussed his past views of Nazism in an Epilogue to Essays on Contemporary Events (CW 10, pp.227-243). It is important to note that the Nazis proscribed his own books. For those who are unconvincing or curious, and especially for those who value history, experiencing the exchanges in these letters, firsthand, is invaluable.

From Palestine, the Kirsches moved to London in 1935, where Eva and James divorced and James married Hilde Silber. Jung approved Hilde as a lay analyst while they were in London. Thomas Kirsch was born in 1936. Because of the threat of a German invasion of England, the Kirsch family emigrated to the United States in October 1940.

After some initial difficulties with the immigration process, the Kirsches settled in Los Angeles. The correspondence with Jung did not pick up again until 1945. These communications dealt with the establishment of the Los Angeles institute and with discussion of theoretical issues such as synchronicity and the Jewish/Christian interplay.

In addition, Kirsch frequently sought Jung’s perspective about his interpersonal conflicts in Los Angeles and his continuing problems with the “anima” - the Jungian term for the soul of a man that is often experienced in projection on women. It is clear that James was still struggling with boundary issues. He was also hypersensitive to interlopers who might seem to have stolen the limelight. Jung was especially critical of Kirsch’s treatment of his Zürich colleague, Jolande Jacobi, during her stay in Los Angeles (Ibid, p. 196).

Discussions of the “right kind of analysis” and similar things persisted over the years, in Los Angeles as in the wider analytic world. Unfortunately, we now know how destructive such attitudes within and between institutes can be. When one believes in foundational principles that can be known, rather than valuing the search and the questions for their own sake, one is always on dangerous ground. This is a lesson yet to be learned, both in the world of psychoanalysis and the larger world. In works such as these letters one can see the sad emergence of such attitudes and their destructiveness.

James continued to teach and inspire many people for the rest of his life. He gave weekly seminars on Jung and related matters until 1988, a year prior to his death, and he continued to see patients until near the end. His hearing declined markedly over time, and he had a custom sound system built for use with his analysands and others. I asked a couple of his patients about this system after he died and they reported no flagging in his “enhanced” hearing or in his general capacities. One of my last memories of James was seeing him at a meeting, when he greeted me exuberantly and wanted to show off the new, portable sound system of which he was very proud!

The Jung-Kirsch Letters are well worth reading. For me, it was an experience of nachträglichkeit, a transformation of the past that is in the present. The book has a deeply thoughtful Preface by Tom Kirsch, and an excellent Foreword by the editor, Ann Lammers. The footnoting is very clear and helpful. The translations by Lammers and Ursula Egli flow well and capture the spirit of the original German. All in all, this is a scholarly work that is also alive and engaging. I highly recommend it to all interested readers, but most particularly to psychotherapists, psychoanalysts, and those interested in the history of depth psychology.

Dreams from My Father: A Story of Race and Inheritance
By Barack Obama, New York: Three Rivers Press, 2004
Reviewed by Joan Tolchin, M.D.

While reading Dreams from My Father: A Story of Race and Inheritance, as a child and adolescent psychiatrist, I was struck by the many and severe traumas that President Obama experienced during his growing up. The traumatic nature of his experiences was not emphasized by the author, but his vivid writing style made them poignantly real for the reader.

The book, in fact, begins with a rather later instance of such trauma. When Obama was 21, he unexpectedly learned that his father, whom he last saw at ten years old, was killed in an auto accident in Africa. The author writes: “At the time of his death, my father remained a mystery to me, both more and less than a man. He had left Hawaii back in 1963, when I was only two years old, so that as a child I knew him only through the stories that my mother and grandparents told.” (p.5)

It is not clear from the book when his mother Ann and her parents (the author’s beloved grandparents) learned that Barack Obama Sr. had a wife in Africa and two small children when he married Ann and conceived Barak, Jr.

When Obama’s father does come to Hawaii for a one month visit, Barak is ten. The author describes his father as distant and critical: “...Barry, you do not work as hard as you should,” he scolds the boy. (p.68) The reader is painfully aware of the child’s disappointment and loss.

Although Obama describes his mother with great love and affection, “the kindest, most generous spirit I have ever known” (xii), she can be strikingly ineffective when the child is in need. They have just arrived in Indonesia to live with Lolo, Ann’s second husband. Ann is 24 years old and Barak is six years old. Lolo insists that “The boy should know where his dinner is spurring, it’s thrown in the air, hits the ground running until the headless bird collapses.
Back to Life: Getting Past Your Past with Resilience, Strength, and Optimism
By Alicia Salzer, M.D., Harper Collins Publishers, NY 2011
pp. 278
Reviewed by JoAnn Elizabeth Leavey, Ed.D. (Psychology)

Alicia Salzer, in Back to Life, suggests an intimate relationship with the reader as she speaks in plain language and shares her views on psychological trauma based on her clinical and volunteer experiences. Salzer’s approach includes making basic cognitive behavioral therapy (CBT) techniques and existential concepts accessible to the lay public. She provides CBT exercises and strategies to assist the reader in understanding the first steps in how to change their automatic thinking patterns.

Salzer refers to trauma as “experiencing any event or situation that fundamentally shakes our understanding of the world and our place in it.” She asserts that trauma healing should be future oriented and not focused on the past. She believes that the retelling of the trauma puts the patient at risk of retraumatization. She explains that a trauma can rob one of a sense of hope and safety in the world. She takes us through a journey of understanding in which “what was” is not as important as “what is.”

According to her method, the healing journey begins by focusing on significant strengths to assist the reader in regaining a sense of self through understanding their core values by naming these strengths. She does this through exercises that help the person identify core strengths such as bravery, courage and forgiveness. By focusing on these strengths, Salzer maintains that the reader will avoid ruminating and reliving her trauma and will avoid reexperiencing the trauma’s negative impacts. She believes that if one can use these strategies, the sense of victimization will be reduced and empowerment will be increased. Otherwise the person may be at risk for “permatrauma” in which the trauma is continually relived and reexperienced through a “trauma lens” resulting in a state of fight/flight, anxiety and fear.

Salzer tells us that victims of trauma need to find meaning in, and make sense of, their worlds. She sees trauma as a potential “inoculation” for future traumas that can allow victims to gain hope and become stronger because of the trauma. However, if their thinking is not changed, victims may risk entering into a state of “permatrauma” by personalizing, generalizing and catastrophizing. Salzer also points out that a person’s social circumstances can support permatrauma through the media, justice system, and family and friends by shaming and blaming the victim. Victims can be made to feel as though the trauma is their fault, that they don’t have the skills to get over it, and/or that they are taking too long to get over it.

Salzer uses many common metaphors to describe her concepts such as comparing trauma to a dent in a car, seeing the glass as half empty rather than half full, making a mountain out of a mole hill, and so on. At times her use of such metaphors seems superficial and risks trivializing the trauma experience itself. She seems to suggest that if the reader merely follows the chapters step by step, they will be free of “permatrauma” by the time they have finished the book. Though some of her strategies may seem helpful, or suggest common sense, in reality, it may take years of practice before someone can change their automatic thought processes.

From the beginning of the book, Salzer uses the pronouns “us”
and “we” when referring to trauma, hinting at self-knowledge. However one is never sure whether she herself has experienced a traumatic event or if she is referring to vicarious trauma through her work and volunteer experiences. Later in the book she refers to certain experiences such as when a patient crashes her hand in a New York City psychiatric ER and Salzer alludes to some of the side effects of the event such as feeling shaken and becoming jumpy at work, but she does not fully take us through her own journey using her own healing steps and methods. She may have thus lost an opportunity to anchor her methodology and experiential credibility. Salzer does however use many clinical examples to make her thought processes accessible to the reader.

Back to Life at first glance seems to reflect a new way to gain coping skills and hope; however, she neglects tackling the possibility that these steps might not work. She does not address options to address the situation if the reader has difficulty finding new ways of thinking, being, and finding social and cultural supports to establish a future orientation. It would be prudent to caution readers to find additional supports beside this book to assist them in their journey to help avoid retraumatizing the trauma experience itself if the goals are not achieved by the end of each chapter.

Salzer makes an attempt to provide the general population with hope and answers about how to get “past your past” as she declares having found a new and different approach to dealing with trauma. To be sure, there are some useful elements that will help the reader gain insight and create cognitive strategies for coping. She encourages the reader to compose a list of needs and to learn to ask what he needs from his support networks. However the book seems rather one dimensional in its approach and relies heavily on basic existentialism and CBT techniques without suggesting ways to access formal therapeutic support. Back to Life often seems recipe-like and superficial, instead of exploratory and suggestive. Therefore readers of Back to Life may once again become unable to get “past their past” and risk exactly what the book is trying to avoid, retraumatization.

A Movie Review of Anonymous
Richard M. Waugaman, M.D.
www.oxfreudian.com

Roland Emmerich’s new film, Anonymous, is inspired by a theory that gripped Sigmund Freud during the last dozen years of his life - that “William Shakespeare” was the pseudonym and front man of Edward de Vere, Earl of Oxford (1550-1604). Freud was the first prominent person to endorse this unorthodox theory. And Emmerich is the first director to make a major film about it. For that, psychoanalysts are in his debt. As a profession, we have mostly trashed Freud for his heretical opinion about who Shakespeare was. No matter how much prestige Freud once had for analysts, that was no match for analysts’ hunger for popular acceptance, which may be one reason they did not dare challenge the Shakespeare “experts.”

Some of the acrimonious reviews of Anonymous prove Freud’s observation that we know so little about the traditional author that we can imagine he was every bit as great as his works are. Our idealizing transference toward the Bard collapses, though, once we look at de Vere up close.

Anonymous chooses one among many possible narratives about de Vere’s choice of Shakespeare of Stratford to serve as his front man. Further, it depicts the theory that the offspring of de Vere’s possible affair with Queen Elizabeth was the Earl of Southampton. This was the Earl to whom Shakespeare’s two long poems of 1593 and 1594 were dedicated. Further, many of us believe that Sonnets 1-126, the so-called “Fair Youth” sonnets, address Southampton.

But this is precisely where any consensus disintegrates. Some of us believe the bisexual de Vere had an affair with Southampton. Others—possibly because of their discomfort with de Vere having been bisexual—instead claim that Southampton was de Vere’s son by Queen Elizabeth. They can then explain the unusual warmth of these sonnets as reflecting paternal love. Incest is a theme in the film. The allusions to incest in the plays might reflect de Vere’s quasi-incestuous relationship with his first wife—they grew up as virtual step-siblings.

Confused? I’m not surprised. Anyway, don’t you have to be a snob and a conspiracy theorist to doubt that Shakespeare wrote Shakespeare? Well, Elizabethan authorship was a bit more complicated than it is today. Most plays were published without the author’s name. Literary anonymity and pseudonymity were common before the 20th century.

Rhys Ifans departs from his past film roles to become the older Edward de Vere. He brings to life de Vere’s passion for writing, his awareness that “All art is political,” his reckless impulsivity, and his resigned awareness that he would not receive credit for his politically polemical works. Ben Jonson plays an intriguing if invented role in the film. His admiration for de Vere’s literary genius stirs deep envy in him. Here, the screenwriter John Orloff was making his homage to Amadeus, which was a major inspiration for him.

When his wife Anne pleads with de Vere to stop writing plays, he replies, “The voices! I can’t stop them. They come to me. I would go mad if I didn’t write down what the voices say!” This is an intriguing surmise about de Vere’s creative process, as though his Muse speaks to him aloud. In fact, I suspect that some form of unusual awareness and tolerance of multiple self states plays a crucial role for some literary geniuses such as de Vere. Part of Shakespeare’s magic is that he evokes specific self states in us. Great authors tap into several of their own respective self states when they write. Writing under pseudonyms may loosen the grip of the author’s central self state, and activate a wider range of ego states. Psychoanalysts are in a unique position to elucidate the psychology of literary anonymity and pseudonymity. The evidence suggests that keeping one’s authorship secret helps promote what Keats called Shakespeare’s “negative capability”—keeping his own identity in the background as he created hundreds of utterly convincing characters.

In a sense, Edward de Vere’s most magical character of all was his pseudonym and front man, “William Shakespeare.” With some likely assistance from the man from Stratford, this character lives on for most people more vividly than does de Vere himself.

Why did de Vere have to conceal his authorship? For many reasons. Nobility did not write for the common theater. They rarely published poems under their own name during their lifetime. And the plays of Shakespeare spoof many powerful court figures, and comment on various court intrigues. Attributing the plays’ authorship to a commoner helped conceal some of their provocative critiques.

Even so, the Elizabethan theater audience as depicted in the film recognized the character Richard III as a spoof of de Vere’s hunch-
backed brother-in-law, Robert Cecil. And they also recognized Polonius in *Hamlet* as a disguised portrayal of de Vere’s father-in-law. Some Shakespeare scholars still admit the latter is correct, though others have backed off from this identification, since it strengthens the case for de Vere’s authorship.

Anonymous is introduced by Derek Jacobi, who also provides the epilogue. This was an inspired choice, since Jacobi is a highly respected Shakespearean actor who happens to believe de Vere wrote the canon. He is thus an apt intermediary to introduce the film’s audience to its controversial and theatrical subject. Other great Shakespearean actors who have rejected the traditional author include Mark Rylance, Kenneth Branagh, and John Gielgud.

You may have read some of the vitriolic attacks on Anonymous by Columbia University’s James Shapiro and others. This fierce backlash intrigues me. The academic Shakespeare establishment usually treats the authorship question as taboo. In other words, many Shakespeare organizations and publications will not even discuss it. One English professor told me it would be “academic suicide” for a graduate student to research de Vere’s possible authorship.

So it’s my hunch that if these bright scholars are going to enforce their taboo, they have to convince themselves that it is entirely justified—that all challenges to the traditional author are, as they claim, based on ignorance or mental aberrations, ranging from snobbism all the way to psychosis. This makes it unlikely they can evaluate contradictory evidence objectively. Both Emmerich and Orloff admit their film takes poetic license in order to provoke and entertain. But the Stratfordians are not amused. Their over-reaction to the film has been Inquisition-like in its tone. We instinctively sympathize with the underdog, all things being equal. The Shakespeare establishment may have made things worse for themselves by forgetting this is just a film.

Although Anonymous is bringing fresh attention to the issue, the authorship debate is longstanding. In my view, Oxfordians try repeatedly to introduce new evidence into the discussion. Traditional Shakespeareans don’t even admit their theory is a hypothesis—they claim absolute certainty.

So, instead of arguing *ad rem*, about the issue itself, they keep reverting to arguing *ad hominem*, with personal attacks on us authorship “heretics.” We’re accused of being like Holocaust deniers; being anti-Semitic: being like the bhirers who deny that Obama is a U.S. citizen; being like people who claim we never landed on the moon, or who claim the U.S. organized the 9/11 attacks. Seriously. Do you detect a whiff of desperation in such despicable accusations?

Many of the reviews of Anonymous have panned the film because its premise is so controversial. A common theme in these critical reviews is the assumption that the Shakespeare scholars must be correct, and there is “no evidence whatsoever” that Shakespeare did not write Shakespeare. Certain premises are repeatedly asserted to be irrefutable refutations that de Vere could be the author.

You’ve probably heard that many plays of Shakespeare are known with certainty to have been written after 1604, the year that de Vere died. Unfortunately, the facts are a bit more complicated. As some Shakespeare scholars admit, we simply do not know with certainty when any of the plays were written. The conventional dating of the plays is based on Shakespeare of Stratford having died in 1616. So it was assumed he wrote roughly two plays per year, and these assumptions played a crucial role in the conjectured dating of when the plays were written.

What about the possibility that de Vere left some unfinished manuscripts at his death, and playwrights such as Fletcher finished them? Since the late plays do show evidence of collaboration, I find this narrative more plausible than the orthodox speculation that Shakespeare “apprenticed himself” to other playwrights when he began writing Romances such as *The Tempest*.

Yet another irony is that Stratfordians claim that Shakespeare didn’t need an advanced education, or travel to Italy, or training in the in-law, or first-hand experience at court, or of falconry, in order to write his plays. According to them, everything he needed to know could have been learned at the tavern, or by talking to travelers, or browsing at bookstores. With one huge exception: knowledge of the world of theater. For some reason, this is placed in an entirely different category from other fields of knowledge. Many people pin their orthodox beliefs on their certainty that the plays had to be written by an actor, and by someone intimately familiar with the world of the theater. They seem blissfully unaware that de Vere sponsored theatrical troupes most of his life; that he hired playwrights such as John Lyly as his literary secretaries; that he was known as the best playwright for “comedies and interludes” in the Elizabethan era; and that he probably acted at court. For whatever reason, evidence that “Shakespeare acted” ceases after the year of de Vere’s death.

I have noticed an intriguing pattern in orthodox attacks on de Vere and his supporters. Again and again, they launch attacks about issues where they are actually themselves most vulnerable. They thus seem desperate to distract us from the weakness of their own case. I would suggest that Shakespeare of Stratford was born 14 years too late to have been the author, since many plays of Shakespeare rewrote earlier plays that were written when Shakespeare of Stratford was only a boy. Because of circular reasoning, Shakespeare scholars assume these anonymous earlier plays had to be written by playwrights other than Shakespeare. They accuse Oxfordians of being too wedded to their theory.

We all need to be cautious to avoid cherry-picking evidence that confirms our preconceptions. When I am told that Oxfordians are simply unable to admit they’re wrong, I point out that most Oxfordians started as a Stratfordian, until they looked into the matter more deeply. So it doesn’t look as though we’re the ones incapable of admitting we’re wrong. Oxfordians are told we do not know how to evaluate the historical evidence. In reality, all the recent evidence about the ubiquity of anonymity and pseudonymity in Elizabethan authorship is mostly getting ignored by the Shakespeare specialists.

If we want a strictly accurate film about de Vere, Emmerich has failed us. When I am told that Oxfordians are simply unable to admit they’re wrong, I point out that most Oxfordians started as a Stratfordian, until they looked into the matter more deeply. So it doesn’t look as though we’re the ones incapable of admitting we’re wrong. Oxfordians are told we do not know how to evaluate the historical evidence. In reality, all the recent evidence about the ubiquity of anonymity and pseudonymity in Elizabethan authorship is mostly getting ignored by the Shakespeare specialists.

What impact has Anonymous had? Prior to this film, countless people had not realized there was any question at all about Shakespeare’s identity. Six weeks after the film opened, of 108,000 people responding to a survey, only 52% supported the traditional author, and a full 48% supported de Vere. Freud would have been thrilled.
A Movie Review of *The Help*
By Cassandra Klyman, M.D.

“The Help” is the movie adaptation of Kathryn Stockett’s blockbuster novel directed by her friend Tate Taylor. It takes place at the beginning of the Civil Rights era. Though set in Jackson, Mississippi—where I have never been—it was not so different from my Detroit experience in the 60’s. “Schvatsas’ was the Yiddish word used among Jewish employers to describe many beloved African-American domestics behind their back and in front of them; in all households, regardless of age, she was called “the girl.”

Minivans or station wagons would bring these women from the inner city to the northwest suburbs where they would be paid meager weekly wages with no benefits. Extra pay for overnight baby-sitting or for helping with entertaining was an unpredictable largesse. We hired a succession of maids with the names Sadie, Mamie, Pearl and Angel over a period of 30 years. We gave them cars, vacations, medical care and legal advice. We never sat down at the table with them. They loved our sons and were loved by them in return. And when Mamie died we attended her funeral and donated a large sum to her Church in her memory - which was what she wanted.

Besides child-care, these women, clean, laundered, chau-ffeured and served for myself and other young married women who were going to school, in training or working as well and who wanted a more luxurious suburban-matron life. Grandmothers did not feel they were handing down these maids to their daughters - we felt we were insuring them steady and welcome employment in familiar and increasing technologically advanced households where, as they aged, they had to work less laboriously.

I cringe now at the reason for my unwillingness to consider live-in help when the boys were little and I still had to take call at the hospital. My small home had only one full bath, and while I could share toilets, I felt I could not share a bathtub with my help. This issue becomes both poignant and bitter in the movie as the “help” have to go out in the rain to relieve themselves, toilet paper sheets are marked so as to catch any infringement, and finally, in a “separate but equal” arrangement, a rough wooden-partitioned commode is built in the basement. In the film, with an ironic twist, this issue builds to an unforgettable tragi-comic moment in the film.

I had to meet African-American individuals more informed and educated than myself before I could reverse my own unacknowledged personal prejudices. On the outside we were ACLU members and wanted our sons to grow up in an integrated neighborhood so as to be prepared for the world into which they would become men. Until mid-elementary school their best friends were African-American and Asian boys. They had sleep-overs, played in the tree-houses and built castles in our sand-box.

In 1967 the Detroit riots erupted and we were close enough to the inner city to the northwest suburbs where they would be paid meager weekly wages with no benefits. Extra pay for overnight baby-sitting or for helping with entertaining was an unpredictable largesse. We hired a succession of maids with the names Sadie, Mamie, Pearl and Angel over a period of 30 years. We gave them cars, vacations, medical care and legal advice. We never sat down at the table with them. They loved our sons and were loved by them in return. And when Mamie died we attended her funeral and donated a large sum to her Church in her memory - which was what she wanted.

In 1967 the Detroit riots erupted and we were close enough to have the smoke come in through the windows. We had misplaced our hopes for the city in Mayor Coleman Young, repeated more recently with Kwame Kilpatrick. But when we were called “honkies” at the PTA meetings, when I was the only white face in the grocery check-out counter and when a colleague’s wife was mugged on the sidewalk, when I used the criterion of language. And in the film-story, the interviewer’s first question is, “what did it feel like to take care of someone else’s child while yours was at home taken care of by someone else?” There is no answer from Abilene or from the many women in the audience. Some of us have enough love and energy for people in and out of our own home. In “The Help” three out of four maids’ children and charges did well. Whether we’re maids or medical doctors, these seem to be accurate odds in how our modern day children turn out.

But it remains a haunting question. How do you feel when someone else is involved in raising your child? Has it not been usually the case that it takes a “village” to raise a child? Fathers are never asked that question. I suppose the issue is whether it is “involved in raising” or “turned over to raise.” For the former I used to use the criterion of language. And in the film-story, however much the children may love and have been influenced and comforted by their nannies, their mother’s love and approval was paramount.

Raising children is not the primary aim for the lives of the majority of young women I know. It is no longer a racial issue but a gender and societal one. When it is not an economic issue that takes a woman out of her home during her reproductive years it is the pull of personhood, of self-actualization and choice on a larger scale. Defining oneself as a mother is rarely sufficient. Maybe it never was - as in many happy homes being wife, daughter, activist vied for first place. In the 70’s and 80’s my friends and I would joke that we wished we had a “wife” to help us with our multi-tasking. Perhaps the best part of “The Help” is the take-away message that we “sisters” have to stick together.

Some black-activist women have complained that “The Help” did not include enough of the Civil Rights movement nor of the sexual abuse that was so rampant in the South. But the film did direct attention to the “back of the bus” issues as evident in the early speeches of Martin Luther King, the death of Medgar Evers and the seminal TV clip of John and Robert Kennedy. Within the narrative of the film we see the role of passive-aggression/resistance in one failed attempt and one that hilariously triumphed - the foiled theft of a ring when a loan via advanced wages was refused, and the gift of an excremental pie when another maid was summarily fired.

White woman’s second class status was also presented. “They might be kind, they might be smart” but they were not considered important unless they were following strict conventions - they had to be pretty and ask permission before they took any initiative outside the kitchen. Exceptions within the film were when they had a strong institution behind them like the D.A.R. or were mentored by a strong, out-spoken female “bitchy” editor. Ultimately however it was a mother’s permission and pride that could set the white girl free to not need or submit to a man. Later we see that a black maid can suffer under black male domination - so perhaps gender discrimination is primary!

The film reminds us that there is domination and subordination in every aspect of our civilized society to curb upward mobility of every sort. It is not just skin color - it is family and city of birth, white’s have their white trash, mother’s have disdain for their plain-faced or fat daughters. Ambition is called “selfish.” Putting on a wig or hairpiece or today’s Victoria’s Secret push-up bra is meant to direct attention onto a body part and not the mind behind the mascara. Women often get some power only in the guise of submission and sexual receptiveness.

A well-noted theme in the film is the relationship between the “help” and the children they raise. The interviewer’s first question is, “what did it feel like to take care of someone else’s child while yours was at home taken care of by someone else?” There is no answer from Abilene or from the many women in the audience. Some of us have enough love and energy for people in and out of our own home. In “The Help” three out of four maids’ children and charges did well. Whether we’re maids or medical doctors, these seem to be accurate odds in how our modern day children turn out.

So with much unhappiness we sold our home for less than we had paid at purchase and moved 12 miles north. We bought Mamie a car and I taught her how to drive because there was no reliable bus service. She and her husband did not want to live with us in our new lily-white neighborhood.

For the former I used to use the criterion of language. And in the film-story, however much the children may love and have been influenced and comforted by their nannies, their mother’s love and approval was paramount.

Raising children is not the primary aim for the lives of the majority of young women I know. It is no longer a racial issue but a gender and societal one. When it is not an economic issue that takes a woman out of her home during her reproductive years it is the pull of personhood, of self-actualization and choice on a larger scale. Defining oneself as a mother is rarely sufficient. Maybe it never was - as in many happy homes being wife, daughter, activist vied for first place. In the 70’s and 80’s my friends and I would joke that we wished we had a “wife” to help us with our multi-tasking. Perhaps the best part of “The Help” is the take-away message that we “sisters” have to stick together.
New Member Profiles – Accepted

The Membership Committee is pleased to welcome the following who are new members to the Academy.

Medical Student

Veronique Haymon  Kenner, LA
Sponsors: Helen Ulrich, M.D. and Gerald P. Perman, M.D.

Ms. Veronique Haymon received her B.S. in Psychology and Biology from U. of New Orleans in 2007. She anticipates graduating from LSU Health Science Center, School of Medicine in NO in May 2012. She won four scholastic honors in college. She worked at a student run homeless clinic from 2009 to the present. She has volunteered at a camp for physically and mentally challenged individuals in 2008 and 2009 and, for seven years, has served on an advisory board that organizes and funds a Halloween parade in neighborhoods with hazardous trick-or-treating. She belongs to the Louisiana State Medical Association, the AMA, the American College of Physicians and the Sexual Medicine Society of North America.

Jea-Hyoun Kim  Brooklyn, NY
Sponsors: Scott Schwartz, M.D. and Joseph Merlino, M.D., M.P.A.

Ms. Kim graduated from Stamford University in 2004 and is expected to graduate from SUNY Downstate in May 2012. She has been involved in seven community service projects over the past 10 years and participated in several published research projects while in medical school.

Lucy L. Magcalas  Brooklyn, NY
Sponsors: Scott Schwartz, M.D. and Gerald P. Perman, M.D.

Ms. Lucy L. Magcalas is a third year medical student at St. Georges University School of Medicine in Granada, West Indies. She expects to graduate in May 2012. She graduated Magna Cum Laude from Boston U in Neuroscience and Neuropsychology in 2004 and she completed her master’s degree in Public Health with a concentration in Health Law, Bioethics and Human Rights also from Boston U in 2006. She has worked in the U.S. and in Paris in neuroradiology as it relates to autism and antibiotic resistance, and with emotionally challenged children and adolescents. She has also engaged in volunteer work for the Grenadian Mental Health Hospital and produced an award-winning short medical drama “Skin and Bones.” She has been a “Big Sister” for the past five years. She is proficient in French and enjoys filmmaking, fencing and writing.

Psychiatric Associate

Amaury Delgado Hernandez, M.D.  Exeter, Great Britain
Sponsors: César Alfonso, M.D. and Gerald P. Perman, M.D.

Dr. Amaury Delgado Hernandez is a psychiatric resident-equivalent of British and Cuban citizenship in the United Kingdom. In January 10, 2010 he was admitted to the Royal College of Psychiatrists (MRCPsych). He went to pre-university in Cuba at the Raul Diaz Arguelles pre-university in Havana from 1885-1988. He attended the Enrique Cabrera Faculty of Medicine in Havana from 1989-1995. He relocated from Cuba to England in 1996. He worked in a variety of health care settings until May 2003 when he passed part 1 of the required PLAB exam in England. He passed part 2 in July 2004. Since then, he has had a variety of training experiences in General Adult, Geriatric, Child and Adolescent, Substance Abuse, Eating Disorder and Community psychiatry. He listed 17 educational experiences in psychodynamic and psychoanalytic psychotherapy from 2006 until the present. His special interests include borderline pathology and eating disorders. His application included four letters of recommendation from supervisors.

Jason Grove, M.D.  Richmond, VA
Sponsors: Cesar Alfonso, M.D., Gerald P. Perman, M.D.

Dr. Jason Grove is a fourth year psychiatric resident who received his BS degree in biophysics from the U of MD in College Park, MD in 1997, his BS in Nursing from Columbia Union College in Takoma Park, MD in 2003, his D.O. from the Virginia College of Osteopathic Medicine in Blacksburg, VA and he will be completing his psychiatric residency in June 2011 from the Medical College of VA. He has worked as a research assistant, RN and house staff psychiatrist. He belongs to the APA, the American Psychoanalytic Association and the Psychiatric Society of Virginia. He is considering pursuing advance psychodynamic psychotherapy or psychoanalytic training.

Carolina Jimenez-Madiedo, M.D.  Brooklyn, NY
Sponsors: Scott C. Schwartz, M.D. and Gerald P. Perman, M.D.

Dr. Carolina Jimenez-Madiedo received her MD from the Universidad National de Colombia in Botota, Colombia in 2005 and has been in residency training at SUNY Downstate Medical Center/Kings County Hospital Center in Brooklyn since July 1, 2008. She is a Clinical Assistant Instructor, PGY3. She received an honors award in medical school and from the Geriatric Mental Health Foundation in 2011. She is a member of several psychiatric professional associations and has taken over a dozen brief medical and psychiatric courses outside of medical school. She has presented over a half dozen posters on schizophrenia, religion and geriatric psychiatry.

Megan Maraumoto, M.D.  Honolulu, HI
Sponsors: Cesar Alfonso, M.D., Christopher Perry, M.D.

Dr. Maraumoto attended college at Brown University and transferred to the University of HI where she completed college and medical school. She completed her residency and Child and Adolescent Fellowship at the U of HI Affiliated Hospitals Psychiatry Residency Program. She has received numerous awards and honors including an APA Minority Fellowship and the American College of Psychiatrists Laughlin Fellowship. Dr. Maraumoto practices as a child psychiatrist in Honolulu. She teaches in several capacities and has three separated clinical faculty appointments. She has been active in multiple psychiatric professional organizations over her career.
Clayton Morris, M.D.  Oklahoma City, OK
Sponsors: Mariam Cohen, M.D. and Gerald Perman, M.D.

Dr. Morris graduated the University of OK in 2000, attended Uni. of OK College of Medicine, and completed his psychiatric residency at Uni. of OK Health Sciences Center in 2008. He participated in the Psychoanalytic Psychotherapy Program at the Oklahoma Society for Psychoanalytic Studies in 2009-2010. He is in the private practice of psychotherapy and medication management and provides admission and call coverage at Red Rock Behavioral Services. He served as Associate Faculty and Course Director for Human Behavior the Uni. of OK Health Sciences Center in 2008-9.

Hari Nair, M.D.  Coral Gables, FL
Sponsors: Mary Ann Cohen, M.D. (awaiting letter) and Dr. Kimberly Best, M.D.

Dr. Nair graduated from Jefferson Medical College in Philadelphia and is an intern at the University of Miami/Jackson Memorial Hospital Psychiatry Residency. He is Clinical Event Coordinator for the Jefferson Psychiatry Society, is a member of the APA, and has volunteered and mentored at Jeff-Hope for Kids for children in homeless shelters since 2006. He has been President of the Jefferson Student Blood Drive team since 2006. He is choreographer and singer with the Jeff SAMOSA to increase awareness of South Asian culture. He plays hockey, basketball and tennis and enjoys socializing with friends.

Oluwabusi Oluwabusi, M.D.  Philadelphia, PA
Sponsors: Kimberly Best, M.D., Craig Lichtman, M.D.

Dr. Olumide Oluwabusi is currently chief resident at the Drexel University College of Medicine in Child and Adolescent Psychiatry. He is involved in training medical students and psychiatric residents. He was fully trained and qualified in Europe (Ireland and England) after completion of the Membership Royal College of Psychiatrist (MRCPsych), London. He was a medical officer in Nigeria from 1999 through 2001, and held multiple psychiatric positions in Ireland from 2002 – 2007. He then trained in four years of psychodynamic psychotherapy (two child/adolescent and two adult) at the Psychoanalytical Center of Philadelphia. He belongs to seven psychiatric organizations and has lectured on numerous psychiatric topics.

Kiyoko Rachel Ogoke, M.D.  Bronx, NY
Sponsors: Scott Schwartz, M.D., Gerald P. Perman, M.D.

Dr. Kiyoko graduated from the Kyoto School of Medicine in 2006 and is a 4th year psychiatric resident at SUNY Downstate Medical Center. She interned at Tufts Baystate Medical Center in MA. She did a Fellowship in Psychoanalysis with the Institute for Psychoanalytic Education affiliated with the NYU School of Medicine from September 2009 through June 2010. She belongs to the APA and to APsyA. She is fluent in Japanese.

Andrei Osipov, M.D.  New York, NY
Sponsors: Gerald P. Perman, M.D. and Cesar Alfonso, M.D.

Dr. Osipov was born and raised in Russia and entered the Russian Army at age 14. He received a BS equivalence in 1984 and majored in mathematics and computer science. He completed medical school in Moscow graduating summa cum laude in 1991. He did a psychiatry residency in the Long Island Jewish Health System between 2003 and 2007 after several years of corporate IT work. He is board certified in Psychiatry and Addiction Medicine. Earlier in his career he had a special interest in the developmental course of schizophrenia. Dr. Osipov’s wife is Cristina Waniek, a psychoanalyst and member of the Academy.

Dr. Osipov is Medical Director of Success Counseling Services and Fidelis Care, both in Manhattan. He has a staff of five with two addiction psychiatrists and they work with recently-released prisoners often with substance abuse and comorbid psychiatric problems. This is mostly paid for by New York State Medicaid. He finds this population of patients challenging, interesting, and similar to emergency room patients he worked with in the past. In particular, he is interested in patients with sociopathic personalities whether they are in the prison system or not. Dr. Osipov has closely followed his wife’s career and they are philosophically “bound at the hip.” He would like to have more exposure to psychoanalytic and psychodynamic colleagues to help him with the clinical work he is doing. He also has a small private practice and is in the process of opening up an office that he will be sharing with his wife.

Nausika Prifti, D.O.  Philadelphia, PA
Sponsors: Kimberly Best, M.D., Eugene Della Badia, D.O.

Dr. Nausika Prifti is a PGY-2 resident in the Department of Psychiatry at Albert Einstein Medical Center in Philadelphia, PA. She emigrated to the U.S. from Albania as a young adult and graduated from the Philadelphia College of Osteopathic Medicine in 2009. She plays piano and composes music and has an interest in the overlap between psychiatry and music. She was nominated for outstanding intern in her class and, according to Dr. Best, who knows her well, she builds good relationships with patients. Dr. Della Badia notes that Dr. Prifti plans to train in psychoanalysis or psychodynamic psychotherapy after graduation.

Anjela Rahimova, M.D.  Roanoke, VA
Sponsors: Cesar Alfonso, M.D., Gerald P. Perman, M.D.

Dr. Anjela Rahimova is a first year Child and Adolescent Psychiatry fellow at the Carilion Program in rural Virginia where she also completed a residency in psychiatry. She found the Academy while surfing on line. She is an experienced physician from Uzbekistan. She learned basic principles of psychoanalysis and psychodynamic psychotherapy during her residency training in VA and had long-term treatment cases supervised. She will need to seek employment in an underserved area when she completes her fellowship in 2013 in order to maintain her Visa. She eventually hopes to become a permanent resident in the U.S. because of the greater opportunities to practice psychiatry compared to her country of origin. She plans to attend the CPR meeting in February in D.C. and the annual meeting in Philadelphia. She has met with her sponsors, Drs. Alfonso and Perman, over Skype and both are enthusiastic about supporting her application to join the Academy.
Modasar Shah, M.D.  
Joplin, MO  
Sponsors: Joan Tolchin, M.D. and Gerald P. Perman, M.D.

Dr. Shah graduated Tokyo Medical and Dental School in 1968 and did his residency training at the Missouri Institute of Psychiatry graduating in 1977 and is Board Certified in Psychiatry and Neurology. He works full-time at the Ozark Community Health Center where he practices supportive psychotherapy and medication management. He is interested in psychodynamic psychiatry as expressed in his letter of introduction and as evidenced by his attendance at the OPIFER meeting in Rome in November 2011.

Shaneel Shah, M.D.  
Brooklyn, NY  
Sponsors: Scott C. Schwartz, M.D. and Joseph P. Merlino, M.D., M.P.A.

Dr. Shah received his M.D. from the Government Medical College in Surat, India. He obtained an master’s degree in Public Health from the University Michigan, Ann Arbor 2008-09, and has been in the Michigan Psychoanalytic Society Fellowship, NYU Psychoanalytic Society Weekly Seminars (2009), the William Alanson White Institute Intensive Psychoanalytic Psychotherapy Program (2011-12), and will complete his psychiatric residency training at Downstate Medical Center in Brooklyn in 2013. He has given many medical and psychiatric presentations. He has several hobbies and is fluent in Hindi and Gujarati in addition to English.

Zhenyu Shi, M.D., Ph.D.  
Shanghai, China  
Sponsors: Elise Synder, M.D. and César Alfonso, M.D.

Dr. Shi received his undergraduate degree from Tianjin Medical University and his Ph.D. (statistics, cognitive neuroscience, psychotherapy and molecular genetics) from Tonjii University. He attended Kunming Medical College receiving a master in psychiatry in 2005. He completed his psychiatric residency from Shanghai Mental Health Center in 2011. He was an attending psychiatrist at the Shanghai Mental Health Center for two years. He was a research fellow at Harvard University in 2008-09 in Bio-behavioral Family Studies in the Department of Psychiatry. He has had extensive experience teaching and practicing psychiatry in China. He has a dozen publications and has participated in numerous additional training experiences including the two year CAPA program.

Deepan Singh, M.D.  
Arverne, NY  
Sponsors: Scott C. Schwartz, M.D., Joseph Merlino, M.D.

Dr. Deepan Singh received his MBBS from Sikkim Manipal Institute of Medical Sciences, Sikkim, India, his Sub-internship, Internship and Residency Training in Psychiatry at SUNY Downstate Medical Center beginning in October 2008. He expects to complete residency training in 2013. He plans to begin Adult Psychodynamic Psychotherapy training at the Institute for Psychoanalytic Education affiliated with the NYU School of Medicine in September 2011. He has volunteered at the Infant and Child Learning Center in Brooklyn, NY since May 2009. He has supervised medical students, psychiatry and neurology residents and a psychology intern over the past two years. He received a Fellowship in Psychoanalysis from the Psychoanalytic Association Associated with New York University from September 2010 until the present. He is a member of six psychiatric/psychoanalytic organizations.

Rangsun Sitthichai, M.D.  
Bangkok, Thailand  
Sponsors: César Alfonso, M.D. and Silvia Olarte, M.D.

Dr. Sitthichai graduated Suankularb Wittayalai College in Thailand in 1993, received his M.D. from Chulalongkorn Uni. Medical School in Thailand in 1999, completed a psychiatric residency at St. Louis Uni. Medical School in 2009, and completed his Child and Adolescent fellowship at Children’s Hospital Boston/Harvard Medical School in 2011. He has worked with mentally handicap and autistic children and has participated in several psychoanalytic and other seminars. He has received several awards and belongs to a number of psychiatric organizations.

Marna R. Sternbach, M.D.  
Philadelphia, PA  
Sponsors: Melissa Crookshank, M.D., Donna J. Cotzen, M.D.

Dr. Marna Sternbach graduated from Radcliffe College in 1971, Tufts School of Medicine in 1975, completed her psychiatry residency from Thomas Jefferson Medical College in PA, her family practice residency at Albert Einstein College of Medicine in 1978, and Fellowship in Academic Family Medicine in 1989. She has worked in a number of family practice settings and is currently a staff psychiatrist with Temple U Tuttleman Counseling Center. She is currently doing a fellowship at the Psychoanalytic Center of Philadelphia and attends monthly case conferences with the psychoanalytic candidates.

Jamuna Theventhiran, M.D.  
New York, NY  
Sponsors: Scott C. Schwartz, M.D., Joseph Merlino, M.D.

Dr. Jamuna Theventhiran graduated Barnard College, Columbia U with a BA in Psychology in 2002, St. George’s University Medical School in the Caribbean in 2008, completed two years of residency training in Psychiatry at St. Vincent’s Catholic Medical Center in NYC from 2008-2010, and is completing her residency training at SUNY Downstate Medical Center from 2010 until the present. She volunteered for three months in 2002 at The Special Needs Clinic of Columbia Presbyterian and has volunteered at the International Medical Health Organization from 2005 until the present that works to develop health care infrastructure in underserved areas around the world. She speaks Tamil fluently and enjoys tennis, yoga and reading.

Gregory Thorkelson, M.D.  
Akron, OH  
Sponsors: Cesar Alfonso, M.D., Xavier Jimenez, M.D.

Dr. Gregory Thorkelson is a third year psychiatric resident at Temple University in Philadelphia who received his BS in Finance with a minor in Violin performance from Miami U in Ohio in 2003, his EMT certification from the Cleveland Clinic in 2006, and his M.D. from Ross U in the Dominican Republic in 2008. He has worked briefly at a state mental hospital and the Cook County Correctional Facility in Chicago.
He did a one-year fellowship at the Psychoanalytic Center of Philadelphia. He has received several awards and honors and has given a half dozen psychiatric presentations over the past two years on the human lifecycle, non-psychiatric countertransference, Dextromethorphan-induced psychosis and ADHD co-morbidities. He has also given of time in charity healthcare in India and the West Indies. His sponsorship letter from Dr. Jimenez describes a deeply committed psychiatric physician with a broad range of humanistic interests.

Wendi M. Waits, M.D.  Kailua, HI
Sponsors: Christopher Perry, M.D., Cesar Alfonso, M.D.

Dr. Waits graduated college from Westpoint and medical school from USUHS. She completed her residency (and served as chief resident) at the National Capital Area Consortium, and finished her Child and Adolescent Psychiatry Fellowship at the Tripler Army Medical Center in 2005. She practices in HI and serves as Chief of Inpatient Psychiatry at Tripler and is Chief of Behavioral Health Services at the Schofield Barracks in Honolulu, HI. She has received numerous military decorations and teaching awards including Faculty of the Year Award at Tripler and is an APA Fellow. She has been deployed in Iraq in 2006 and in Afghanistan in 2010.

Deval Zaveri, M.D.  Bridgewater, CT
Sponsors: Scott Schwartz, M.D., Lada Alexeenko, M.D.

Dr. Zaveri is a 4th year psychiatric resident at SUNY Downstate Medical Center and expects to graduate on June 30, 2012. She received her undergraduate degree (M.B.B.S., Bachelor of Medicine and Surgery) from the Nashik University in Mumbai, India in 2007. She is a member of the APA, the NY State Psychiatric Association, the Brooklyn Psychiatric Association, and the Indo-American Psychiatric Association. She has participated in a half dozen community psychiatric events, been an author on two peer-reviewed psychiatric articles, and given 13 presentations on general psychiatric topics. She has been in twice weekly psychotherapy supervision with Scott Schwartz, M.D. for eight months and Dr. Schwartz believes that she would be an asset to the Academy.

Psychiatric Member

Peter G. Collori, M.D.  Honolulu, HI
Sponsors: Scott Schwartz, M.D., Eugene Della Badia, M.D.

Dr. Peter G. Collori is a psychiatrist in private practice with interests in psychodynamic psychotherapy, psychopharmacology and their integration. He teaches residents to apply mindfulness to the integration of psychotherapy and psychopharmacology across inpatient and outpatient settings. He is Assistant Clinical Professor at the U of HI at Manoa and on the Adjunct Clinical Faculty at Argosy U in Honolulu. He received his BA from Southern Illinois U, his M.D. from Loyola U in Chicago, and trained in psychiatry at HI Residency Programs in Honolulu completing his residency in 2006. He has given several Grand Rounds and other presentations, engaged in research activities, and should be encouraged to participate in future Academy meetings and in other capacities.

Garrett Marie Deckel, M.D., Ph.D.  New York, NY
Sponsors: Cesar Alfonso, M.D. and Gerald P. Perman, M.D.

Dr. Deckel graduated Barnard College in 1988, received her Ph.D. in philosophy from Princeton University in 1998, her M.D. from the University of PA in 2004, and completed her psychiatric residency at Mount Sinai Medical Center in 2008. She completed one year of psychodynamic psychotherapy training at Columbia before switching to psychoanalytic training at the Columbia Center for Psychoanalytic Training where she is a first year candidate. She has had over six years of personal psychoanalysis as well as hours of supervision.

Dr. Deckel worked in a mental health center and a VA Medical Center before beginning her private practice 3 ½ years ago. She had also worked as the assistant to the CEO of a NY investment bank. She is trained in CBT and has received several academic awards prior to entering medical school.

Douglas G. Foster, M.D.  Leesburg, VA
Sponsors: Gerald P. Perman, M.D. and César Alfonso, M.D.

Dr. Douglas G. Foster is a 56 year old married psychiatrist who has been in full-time private psychiatric practice for 23 years. He attended Berklee College of Music from 1972-1974 before attending the George Washington University from 1976-1979. He attended the George Washington University Medical School for two years and completed his medical school education at the University of Connecticut. He completed his residency training in psychiatry at the George Washington University Medical Center in Washington, D.C. in 1988. He primarily does psychoanalytically-oriented psychotherapy. He served as Director of Inpatient Services (the psychiatric unit) of Loudon Hospital Center in Loudon County, VA from 1988-1992. In addition to his Board Certification in Psychiatry in 1993, he received Master Psychopharmacology Certification in 2010. He received an ethical reprimand for a brief email communication with the husband of a patient in an effort to be helpful to his patient. His patient complained about this breach of confidentiality and reported him to the local regulatory body. I knew Dr. Foster early in my practice when he was a G.W. resident and I was a member of the Clinical (voluntary) Faculty. I remember him to have been friendly, bright and a competent young trainee. I enjoyed reconnecting with him recently at a psychotherapy training event at which I encouraged him to join the Academy. I fully support his membership in the Academy.
in 1989, completed residency training in psychiatry at the George Washington University Medical School in 1992 and completed a Fellowship in Child and Adolescent Psychiatry at Children’s National Medical Center in Washington, D.C. in 1994. He completed psychoanalytic training in 2006 with the Washington Psychoanalytic Institute in D.C. He is an Assistant Clinical Professor at G.W. and is on the teaching faculty of the Washington Psychoanalytic Institute in their Intensive Psychotherapy Program. He is in full-time private practice of child, adolescent and adult psychiatry.

Dr. Houston belongs to multiple psychiatric and psychoanalytic societies and his committee activities are too extensive to list. He has been an examiner for the Child and Adolescent Oral Boards since 2004. He was President of the Washington Psychiatric Society in 2007-8 and has served in many other elected positions within organized psychiatry and psychoanalysis. He had won multiple awards and honors.

Sponsors: Roy Greinker, Jr., M.D., Clay Whitehead, M.D.

Dr. Eugene D. Mindel received his BS with honors from the U. of MD in 1956, his MD from the George Washington U. School of Medicine in 1960, and completed his internship and residency at the Michael Reese Hospital in Chicago in 1964. He had 600 hours of supervision and 300 hours of psychoanalysis. He completed a fellowship in Child and Adolescent Psychiatry in 1968 and, in 1970, began a second psychoanalysis for 650 hours. He has attended multiple APA workshops on a number of topics. He was in active duty in the Navy from 1964-66. He has received several outstanding teaching awards and for helping deaf children and adults in 1987. He has about a dozen publications on psychiatry and the deaf. He has had numerous academic appointments and consultancies over the years. He has worked at a high level of a number of HMOs in Illinois. In 1997 he relocated to NC where he continues to work with inpatients and outpatients.

Scott Shapiro, M.D.  Jersey City, NJ
Sponsors: Scott Palyo, M.D, Daniel Bauman, M.D., Mary Ann Cohen, M.D., Cesar Alfonso, M.D.

Dr. Scott Shapiro received his BA Cum Laude from U PA in 1993, graduated from UNC School of Medicine in 1996, completed his psychiatry residency training from Massachusetts General/Harvard in 2002 and his Fellowship in CL from Mass General/Harvard in 2002. He is Board Certified in Psychiatry and Neurology and in Psychosomatic Medicine. He is founder and Executive President of Milestones NYC that provides pro bono mental healthcare to underserved New Yorkers. He directed HIV Psychiatry at St. Vincent’s Catholic Medical Center and New York Medical College from 2002-11. He directed HIV Psychiatry at Mount Sinai Hospital from 2010-2011 and is Director of Advance Behavioral Psychiatry and works at the Hallowell Center in NY, NY. He has published and presented mostly on HIV psychiatry.

M. Jody Whitehouse, M.D.  Philadelphia, PA
Sponsors: Melissa Crookshank, M.D., Arnold Feldman, M.D., Gene Della Badia, D.O.

Dr. M. Jody Whitehouse received her BA from U PA in Philadelphia with a 4.0 average in her major, psychology. She completed the Combined Accelerated Psychiatric Program at the U of MD in Baltimore, MD and graduated the U MD School of Medicine in 1983. She did post-graduate training in couples and family therapy at the U of PA in Philadelphia, PA 1990-92. She studied forensic psychiatry for a year under Robert Sadoff, M.D. at U PA in Philadelphia, PA 1996-97. Dr. Whitehouse had Intensive Short-Term Dynamic Psychotherapy training followed by Advanced Training in 2011. This consisted of 324 hours over three years. She was in two years of psychoanalysis. She is in private practice and has been a Clinical Associate Professor in Psychiatry at the Pennsylvania Hospital since 2008. Dr. Whitehouse is qualified in forensic psychiatry.

Litao Wang, M.D.  Shandong Province, China
Sponsors: Michael Blumenfield, M.D. and Cesar Alfonso, M.D.

Dr. Wang graduated from medical school in China in 1989 and completed his psychiatric training in China in 1997. He has worked as an attending psychiatrist for over a decade and has taken additional training in psychotherapy. In November 2007- October 2008 he was a visiting scholar in the Department of Psychiatry at Donau Hospital in Vienna, Austria where he took additional courses. He also studied Lacanian psychoanalysis in China for two years. He has been supervised by Michael Blumenfield, M.D. through CAPA who described him as insightful, sensitive and with a good understanding of psychodynamic principles. He is fluent in English and undergoing a personal psychoanalysis through CAPA. He shows leadership qualities and Dr. Blumenfield recommended him for Psychiatric Fellow rather than Member for which he applied.

Psychiatric Fellow

E. James Lieberman, M.D.  Potomac, MD
Sponsors: Gerald P. Perman, M.D. and Ann Louise Silver, M.D.

Dr. Lieberman is a retired, highly-esteemed psychiatrist in the Washington D.C. area and a recognized scholar of Otto Rank. He is Clinical Professor Emeritus with the George Washington University Medical Center in Washington, D.C. He trained at Massachusetts Mental health Center (1959-61) and had an analysis with Herbert Harris, M.D., whom he later learned had been analyzed by Beata Rank, Otto’s widow and a lay analyst. He received supervision from Freud’s granddaughter, Sophie Loewenstein, and got to know Rank’s daughter, psychologist Helene Rank Veltfort (1919-1999), and he remains in touch with one of her daughters, author Ruhama Veltfort. Dr. Lieberman was a colleague of Academy members Paul Chodoff, Harold Lief and Judd Marmor.

Dr. Lieberman had a varied and interesting career including positions with the Peace Corps and committee work with the American Psychoanalytic Association and the APA. He has written numerous book chapters, articles and book reviews. In the past, Dr. Lieberman was an active member of the American Public Health Association and the American Association for Marriage and Family Therapy, and he now is looking “to affiliate with psychiatrists who value psychotherapy as much or more than pharmacy.” He has published a book on the Freud-Rank
letters. Dr. Lieberman plays cello in a string quartet as a hobby and gives pro bono performances to nursing homes and other local venues.

Deborah S. Rose, M.D.  Palo Alto, CA
Sponsors: Joan Tolchin, M.D. and Matthew Tolchin, M.D.

Dr. Deborah S. Rose graduated the U. of Chicago School of Medicine with honors in 1967 and trained in psychiatry at Stanford University Medical Center and the University of Cincinnati Medical Center finishing in 1972. She has had a lengthy career in private practice doing psychodynamic psychotherapy mostly with patients with PTSD. She is now an Emeritus Adjunct Assistant Professor of Psychiatry at Stanford University School of Medicine. Dr. Rose has supervised residents, taught classes in PTSD and teaches medical student psychiatric interviewing. She volunteers providing free psychotherapy to trainees and their families. She wrote a lead article on PTSD in the green journal, has written a book chapter on PTSD in an APPI book, and has been a consultant to the Women’s Trauma Recovery Unit at the National Center for PTSD. She has multiple publications, seminars and lectures in the area of trauma and PTSD.

---

Become an Academy Sponsor!

Every day holds the potential for another individual to become a member of the American Academy of Psychoanalysis and Dynamic Psychiatry and they need your support!

Voting members of the Academy are eligible to sponsor applicants. If you are a Psychiatric Member, Psychiatric Fellow, or Psychoanalytic Fellow of the Academy, you are eligible to become a sponsor.

According to the AAPDP Constitution & Bylaws, each applicant requires two voting members of the Academy to act as their sponsor. A written letter or email is requested by each sponsor to be sent to the Academy Office which details personal knowledge of the applicant. Your statement assists the Membership Committee in their deliberations for the applicant.

Thanks to those listed above, the AAPDP’s ranks are over 600 strong and these numbers continues to grow. In many cases, applicants contact the office without knowing Academy members and they need sponsors. Won’t you consider becoming a sponsor and assisting the Academy’s continued growth?

What you can do:

- Promote membership in the AAPDP to colleagues and friends in your area
- Email your professional listserv’s with information on the Academy
- Direct interested individuals to www.AAPDP.org
- Contact the Academy Office and volunteer to sponsor applicants in need
Psychodynamics in Contemporary Psychiatry: Mutual Influences

In recent years with the explosion of information in the neurosciences, contemporary psychiatry has made tremendous advances, which has led to a better understanding of mental illness. This biological focus, however, has caused a shifting of attention away from psychological intervention and replaced it with the idea that biological treatment is sufficient to treat mental illness. This reductionism has caused a split between biologic psychiatrists and psychodynamic psychiatrists. This split hurts our patients and leads to less than optimal care.

If we look at the data, current research has shown that psychological interventions can have a marked measurable effect on the brain and can alter the responses of the brain to biochemical factors. We have seen how psychological interventions can improve the outcome of many physical problems. Much of this research is very exciting and underscores the synergistic effect of biology and psychology in our work with patients.

As psychodynamic psychiatrists we can make a unique contribution to psychiatry. Through psychodynamic understanding of our patients we can deal with transference and countertransference problems. We can use our skills to unearth unconscious conflicts that many times sabotage psychiatric treatment. We can teach residents and young psychiatrists to develop an understanding of their patients that will help them build therapeutic relationships that lead to better outcomes. We are challenged do this in a context backed by good clinical research and evidence based treatment.
MEETING REGISTRATION FORM  
American Academy of Psychoanalysis and Dynamic Psychiatry  
56th Annual Meeting  
Loews Philadelphia Hotel  
Philadelphia, PA  
May 3-5, 2012  

Advance registration is recommended. Badges will be held at the AAPDP Registration Desk at the hotel.  

If you are not an AAPDP member, please tell us how you heard of this meeting:  
☐ Referred by a Member  ☐ Ad  ☐ Website  ☐ Mail  ☐ Other  

Please type or print clearly:  
Name & Degree ____________________________________________  
Address __________________________________________________  
City, State, Zip ____________________________________________  
Phone _______________________________ Fax ____________________  
E-Mail _____________________________________________________  
Professional Specialty ____________________________________  

* Guests requiring Continuing Medical Education credits should register as non-member professionals.  

<table>
<thead>
<tr>
<th></th>
<th>Advance</th>
<th>On-Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member of the Academy</td>
<td>$250.00</td>
<td>$275.00</td>
</tr>
<tr>
<td>Non-Member Spouse/Accompanying Guest*</td>
<td>$110.00</td>
<td>$130.00</td>
</tr>
<tr>
<td>Name &amp; Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Member Professional*</td>
<td>$290.00</td>
<td>$340.00</td>
</tr>
<tr>
<td>Non-Member Spouse/Accompanying Guest*</td>
<td>$110.00</td>
<td>$110.00</td>
</tr>
<tr>
<td>Name &amp; Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member and Non-Member Professional Outside of U.S.</td>
<td>$110.00</td>
<td>$130.00</td>
</tr>
<tr>
<td>Non-Member Spouse/Accompanying Guest Outside of U.S.</td>
<td>$65.00</td>
<td>$65.00</td>
</tr>
<tr>
<td>Name &amp; Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-Day Registration</td>
<td>$155.00</td>
<td>$175.00</td>
</tr>
<tr>
<td>Day _________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Candidate, Psychoanalytic Institute (Requires current letter from Training Director)</td>
<td>$55.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>Resident in Psychiatry or Medical Student (Requires Resident/Medical Student ID)</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Student (Full time Student ID Required)</td>
<td>$55.00</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

Total Registration Amount ____________________________  

MASTERCARD AND VISA ACCEPTED (please circle one)  
Card No. ___________________________ Exp. Date: __/____ Security Code: _______  
Signature ____________________________  

Please complete and return this form with your check (in US dollars and drawn on a US Bank) or credit card information:  

AMERICAN ACADEMY OF PSYCHOANALYSIS AND DYNAMIC PSYCHIATRY  
One Regency Drive, P.O. Box 30, Bloomfield, CT 06002  
Phone: (888) 691-8281  Fax: (860) 286-0787  
Email: info@aapdp.org  Website: www.aapdp.org  

43