### Table of Contents

President’s Message: Psychodynamic Aspects of Prosocial Behavior .......................... 3  
César Alfonso, M.D.  
Psychodynamic Psychiatry ....................................................... 5  
Richard Friedman, M.D.  
CAPA Plans Third Study Tour to China in October 2011 ................................. 8  
Michael Blumenfield, M.D.  
Integrating Psychosomatic Medicine and Psychodynamic Psychiatry ................. 10  
Mary Ann Cohen, M.D.  
Cycles of Change in Psychodynamic Psychotherapy ...................................... 12  
Gerald P. Perman, M.D.  
AAPDP/OPIFER Joint Meetings: Some Personal Reflections ............................ 14  
Marco Biacciagaluppi, M.D.  

### Articles

Jung’s Encounter with the Unconscious .............................................. 15  
Thomas B. Kirsch, M.D.  
Post-traumatic Writer’s Stress Disorder ........................................... 17  
Richard M. Waugaman, M.D.  
Framed Fantasies: Improvisation in Music and Analysis ............................. 19  
Scott C. Schwartz, M.D.  
Dramatology: A New Paradigm for Psychiatry, Psychoanalysis and Interpersonal Drama Therapy (IDT) ........................................ 22  
Zvi Lothane, M.D.  
Paradigms in Psychoanalysis ..................................................... 24  
Marco Biacciagaluppi, M.D.  
A Case of Post-Traumatic Dissociation ............................................. 27  
Costanza Palmitessia, Ph.D.  

### Book and Film Reviews

*A Comprehensive Dictionary of Psychoanalysis* by Salman Akhtar .............................. 29  
Reviewed by Richard D. Chessick, M.D., Ph.D.  
*Edward Bibring Photographs the Psychoanalysts of His Time* Edited by Sanford Gifford,  
Daniel Jacobs & Vivian Goldman ................................................. 31  
Reviewed by Michael Blumenfield, M.D.  
*Freud* by Jacques Sedat ......................................................... 33  
Reviewed by JoAnn Elizabeth Leavely EdD  
*Psychodynamic Psychotherapy: A Guide to Evidence-Based Practice* by Richard F. Summers  
and Jacques P. Barber .............................................................. 33  
Reviewed by Thomas P. Kalman, M.S., M.D.  
*Doctor Paul Weston: Psychotherapist or Cinetherapist?* TV series ...................... 34  
Reviewed by Harvey Roy Greenberg, M.D.  
*Inception: movie review* ....................................................... 37  
Reviewed by Cassandra M. Klyman, M.D.  
*Eat, Pray, Love: movie review* .................................................. 38  
Reviewed by Cassandra M. Klyman, M.D.  

### New Members

*Front Cover*
I’ve always liked medieval architecture, and so this is built as a tiny tribute to Yorkminister cathedral and town, with a quarter in front for size comparison (The whole thing is 8” x 10”). It is made completely of garbage. The buildings are of old cards, chart dividers, scotch tape, toothpicks, and staples. The scenery is of old napkins and a lot of pepper for textured foliage. The trees are napkins molded onto staples and dipped into pepper for texture. The small rocks are sesame seeds from a bagel. The ships are mounted on a sea of hais-pray, and are made of cardboard and paper with rigging made from the bristles of a discarded paintbrush. My patients love this and the 20+ others I’ve built, since they are metaphorically society’s garbage, and can see how garbage can, with care, be recreated into something of beauty and value. Photo by Co Dahl. Scott C. Schwartz, M.D.
Psychodynamic Aspects of Prosocial Behavior

by César A. Alfonso, M.D.
President, AAPDP, 2010-2012

“The traveler who hesitates raises dust on the road.”

Buddha

“What do I think of Western civilization? I think it would be a very good idea.”

M. Ghandi

In this column I will review the contributions of social scientists, anthropologists, evolutionary theorists, psychoanalysts, and neuroscientists, to our understanding of prosocial behavior.

Altruism is a word coined by the French philosopher Auguste Comte (1798-1857). Comte is considered to be the founder of the discipline of Sociology and wrote extensively on positivism. What you may not know is that he also attended medical school. He enrolled at the Université Montpellier, one of the oldest European medical schools, in existence since 1137. Rabelais also graduated from the Faculty of Medicine of the Université Montpellier. Altruism as defined by Comte, is the unselfish regard for the welfare of others, or the motivation to increase another person’s welfare. It is a traditional virtue in many religions and as an ethical doctrine it implies that individuals have a moral obligation to help, serve, or benefit others, if necessary at the sacrifice of self-interest. Prosocial behaviors, the preferred contemporary term used by social scientists, is more encompassing and includes sharing, helping, comforting and cooperating as the basis for social structure and social decency.

The psychoanalytic literature on kindness, unconditional love, altruism and prosocial behavior is scanty at best. I believe that altruism requires empathy coupled with action and its underpinnings may lie on transgenerational earned attachments. Altruism serves the purpose of building self-esteem, and in children, altruistic behavior is facilitated by positive responses from caretakers during moral development. The early psychoanalytic literature on altruism was unduly suspicious of altruistic behavior as genuine or nonconflictual. Psychoanalysts in the early twentieth century emphasized masochistic components of altruism in those perceived to be neurotically driven to help others. The recent contributions of Erikson (Eagle, M, 1997, Contributions of Erik Erikson, Psychoanalytic Review 84 (3): 337–47) are more concordant with social scientists’ reformulation of prosocial behaviors.

Freud’s earlier psychodynamic formulations on altruism may have been influenced by Lamarckian and Darwinian evolutionary constructs, where competition (aggression) was deemed necessary for survival of the fittest. Pyotr Kropotkin was a Russian zoologist and evolutionary theorist who postulated that the main factor in facilitating evolution is cooperation between individuals in societies and groups, renouncing central control and authority. Kropotkin’s seminal book, Mutual aid, a factor of evolution was published in 1902 and drew from his scientific observations during zoological expeditions to Siberia, coincidentally, during the same years that Freud began to formulate his metapsychological hypotheses.

What have we learned from research in the social sciences that could help us understand determinants of prosocial behavior? Social scientists speak of dispositional and situational factors that are causally related with prosocial behaviors. Dispositional factors include deference, intelligence, nurturance, spirituality, low level of Machiavellianism, robust self-esteem, succorance, proclivity to feel empathy for those in need, sensitivity to normative pressure from social groups, and adherence to the ethical principle of social justice. Situational factors include severity of need, similarities with those in need, and cost of helping. Early researchers (1970s and 1980s) in the social sciences concluded that situational variables are better predictors of prosocial behavior than dispositional variables (Huston, T. continued on page 4
Prosocial Behavior (continued from page 3)


In the 1980s and 1990s, social scientists demonstrated that dispositional factors become predictive of prosocial behavior when situational pressure is weak (Bandura, A., 1991; Social cognitive theory of moral thought and action. In W. M.Kurtines & W. M. Gewirtz (Eds.), Handbook of moral behavior and development: Vol. 1. Theory (pp. 45–103) Hillsdale, NJ: Erlbaum). Recent research corroborated what would fall under the biopsychosocial medical paradigm of George Engel, that is, that biological and cultural predictors combine to produce dispositional states, which combine with situational factors producing cognitive and emotional reactions. The cognitive, and most importantly, the affective reactions then become the strongest predictors of prosocial behaviors (Fiske, A. P.,1992, The four elementary forms of sociality: Framework for a unified theory of social relations, Psychological Review, 99, 689–723). Reviewing the social sciences literature on altruism can be utterly confusing. The variables are so extensive and situations are so unique, that predicting determinants of prosocial behavior becomes idiosyncratic(pertaining to or involving the explication of individual events) rather than nomothetic (pertaining to the formulation of general or universal laws) (Allport, G. W., 1961.Pattern and growth in personality. New York: Holt, Rinehart, and Winston).

Psychological theorists and neuroscientists have investigated the prosocial temperament. Interesting findings of relevance to our work as clinicians include that ability to regulate anxiety and sadness correlates with prosocial engagement. Persons with conduct and disruptive behavior disorders experience little empathy and lack capacity for remorse. Empathic responses to these individuals, especially at younger ages, may inhibit acts of aggression (de Wied M, van Bokel A, Zaalberg R, Goudena PP, Matthys M, 2006, Facial EMG responses to dynamic emotional facial expressions in boys with disruptive behavior disorders. J Psychiatr Res 40: 112–121:Eisenberg N, Eggum ND, 2009, Empathic responding: sympathy and personal distress; in Decety J, Ickes W (eds): The Social Neuroscience of Empathy. Cambridge, MIT Press, pp 71–83). Dispositional empathy could be modulated by self-perception that one is competent, docility (receptivity to social influence), and agreeableness. Emotional closeness and ability to form secure attachments can partially mediate willingness to help. Offering help and cooperation usually opens a cycle of reciprocity, provides higher social status and greater desirability, which may reinforce the evolutionary success of altruistic actions(Schroeder DA, Penner LA, Dovidio JP, Pliavin JA.,1995.The Psychology of Helping and Altruism. New York: McGraw-Hill).

Neurodevelopmental studies show that infants as young as 12 months can comfort victims of distress, and 14 to 18 month old children display spontaneous, unrewarded helping behaviors (Warneken F, Tomasello M, 2009, The roots of human altruism, Br J Psychol, 100: 455–471). The affective components of empathy develop earlier than the cognitive components, before the development of language, by reading faces (Leppanen JM, Nelson CA, 2009, Tuning the developing brain to social signals of emotions, Nat Rev Neurosci10: 37–47). Affective responses siveness relies on mimicry and somatosensorimotor resonance between the self and other. This has been observed as early as 10 weeks of age(Haviland JM, Lewin M, 1987, The induced affect response: ten-week-old infants’ responses to three emotion expressions, DevPsychol 23: 97–104). The mirror neuron system seems to be fully functioning in infants by 6 months of age (Nyström P, 2008, The infant mirror neuron system studied with high density EEG, Soc Neurosci 3: 334–347).


Although I find this research exciting and welcome further developments, I am hesitant to think that complex human behavior could be reduced to modulation by such tiny molecules. It could be, for example, as Debiec, a researcher from New York University Center for Neural Science, postulates, that intranasal administration of nanopeptides could cause feelings of elation and disinhibition, decreasing social fear and social anxiety, and through this indirect action in the amygdala, trust and cooperation are facilitated. There is no doubt that trust and cooperation serve as substrates for prosocial behaviors, but other psychosocial and cultural factors need to coexist for complex altruistic behaviors to endure.

Returning to the psychodynamics of prosocial behaviors, let us consider cooperation. Trust is essential for cooperation to exist with and within groups. Cooperation also requires high levels of compromise formation and renunciation of competition. When others, through cooperation, are perceived as similar to self, cooperation leads to forgiveness (Insko CA, Schopler J, Gaertner L, Wildschut T, Kozar R, 2001, Interindividual intergroup discontinuity reduction through the anticipation

Benefits of prosocial behaviors include enhanced social integration, placing one’s distress in a more encompassing perspective, enhanced meaningfulness, and movement away from isolated passivity towards healthier activity (Midlarsky, E., 1991, *Helping as coping: Prosocial Behavior, Review of Personality and Social Psychology,* 12, 238–264). The bioethicist Stephen Post’s meta-analysis of the literature on altruism (2005) asserts that there is a strong association between kindly emotions, helping behavior, well-being, decreased morbidity, and increased longevity. He states: “Setting aside preoccupation with purity and perfectly selfless motives, it may be that people who live generous lives soon become aware that in the giving of self lies the unsought discovery of self as the old selfish pursuit of happiness is subjectively revealed as futile and shortsighted.”

Surrendering ones’ needs as an act of compassion and sacrifice to benefit society at large or the kin group operationalizes Erikson’s concept of generativity, which refers to the behaviors benefit society and succeeding generations by establishing priorities of needs that are heavily influenced by social justice. Over-pathologizing altruism as conflict-laden and self-serving usually misses the point that altruistic and prosocial behaviors reward the greater social need in ways much greater than any possible and marginal individual gains.

*Caritas* and *ἀγάπη* (agape) form the bases of self-actualization that results from the resolution of generativity vs. self-absorption conflicts in interpersonal relations. Adults who were unfortunate not to have earned secure attachments could, as Erikson, suggested, emulate and identify with prosocial role models to attain fortitude and greater happiness. Carefully attending to the needs of generations may improve our collective mental health.

---

**Psychodynamic Psychiatry**

*by Richard C. Friedman, M.D.*

Psychodynamic psychiatry is a rapidly changing field and one whose characteristics are not firmly delineated. The term used to mean “psychoanalytic psychology applied to psychiatry.” Psychoanalysts explained depth psychology to psychiatrists in order to illuminate the motivation of their patients. The communication vector was one way, from psychoanalysts to psychiatrists. This is no longer the case. To understand how and why this meaning changed, a look at recent history in our field helps us.

Military psychiatry during WWII provides a good point of departure. Here the usefulness of applied psychoanalytic psychology was dramatically demonstrated. The psychoanalytically informed psychiatrists who were citizen-soldiers in the 1940s had models of the mind and of trauma that led to effective and practical psychiatric interventions. At that time so called “organic” psychiatrists had relatively little to offer.

Following the war, the psychoanalyst-psychiatrists returned to civilian life. Organized psychoanalysis following the war years went through a stage of insularity, rigid hierarchical structure and tight organizational control of clinical practices and professional attitudes. The formation of The American Academy of Psychoanalysis in 1956 was a reaction against this trend.

Meanwhile, American Psychiatry acknowledged the usefulness of a model of health/illness and psychological development that George Engel, an internist/psychoanalyst termed “biopsychosocial.” This was an open systems paradigm based on the deceptively simple idea that biological, psychological and social forces interact to influence behavior. Although Engel formally proposed this idea in an article published in the 1970s, he had outlined its major concepts in a book on psychological development earlier. Engel was concerned that American medicine was adopting a reductionistic and dehumanizing perspective and that a more complex way of conceptualizing pathophysiology and behavior was needed.

Psychiatry continued to use a psychodynamic framework for conceptualizing psychopathology until the adoption of the Third Edition of the Diagnostic and Statistical Manual in 1980. The major reason for the shift to a Kraeplinian a-theoretical nosological system was that the psychodynamic framework based on underlying motivation did not result in diagnoses that could be replicated by different observers at different centers. In the research sense, psychodynamic diagnoses were not “reliable.”

The Kraeplinian system has remained in place and this has had advantages and disadvantages. A difficulty that soon emerged is that many psychiatrists concluded that only behavior that met DSM criteria for psychopathology should be considered clinically relevant. All else was considered outside the “appropriate realm” of organized psychiatry. Although never formally endorsed, this dictum led to a widely practiced symptom-checklist strategy to clinical work. Such a reductionistic approach deemphasized the physician/patient relationship which was also strained by economic pressures as had occurred throughout medicine. In addition, the explosion of knowledge in pharmacology, genetics and neurobiology soon led psychiatrists to refer to entirely different behavioral paradigms than they used to. The psychodynamically informed history was seen by many to be, not only unwieldy and time consuming, but outdated.

**Psychoanalysis and Psychiatry**

As time passed organized psychoanalysis in the USA elected to devote its major intellectual resources to the *psychoanalytic treatment method.* Thus, the term “psychoanalysis” came to signify to the general public and psychiatrists as well, the long-term intensive treatment of not-very-ill outpatients seen in
private offices usually in metropolitan areas. It was not apparent
to general psychiatrists how knowledge derived from and app-
llicable to psychoanalytic patients could help them understand
and treat the very broad range of patients with which they
routinely worked.

The demedicalization of psychoanalysis in the USA was also
associated with slow but progressive separation of the fields of
psychoanalysis and psychiatry. Psychiatry continued to anchor
its basic framework in science as it had always done. Psycho-
analysis, however, tended to rely on its singular treatment tech-
nique to provide its major conceptual models for behavior gener-
ally. Although this latter trend has not been uniform (attachment
theory and infant development for example, are exceptions to
this trend); it occurs to a far greater degree than in psychiatry.
There can be no mistaking the fact that, at least in the USA,
clinical psychoanalysis has elected a narrow (albeit deep) em-
phasis, whereas psychiatry continues as it always has to focus
on a very wide range of patients. Modern psychodynamically
informed clinicians no longer simply apply psychoanalytic ideas
to pathological symptoms and syndromes in order to better
understand them. Rather, it has become necessary for such cli-
nicians to be well informed in biodescriptive and pharmacological
areas in order to modify older psychodynamic ideas in keeping
with facts not available at the time in the history of thought when
psychodynamic ideas were originally conceptualized.

For example, Dr. Jenifer Downey and I are working with
colleagues at the Group for Advancement of Psychiatry on un-
derstanding motivation in bipolar and bipolar spectrum patients.
The latter group of patients, only recently identified, includes so
called “atypical” patients with mixed affective states. It is ap-
parent that unconscious motives often influence the experience
and activity of these patients but that the etiology of the basic
disorders is psychobiological and not due to unresolved uncon-
scious conflicts. In order to understand and treat individuals
on the bipolar spectrum it is necessary for clinicians to be aware
of their unconscious motives and conflicts, but equally aware
of the primary affective regulation disorder with which they are
afflicted. There is presently an extreme lack of clinical literature
from psychodynamically informed clinicians discussing patients
such as these. This is because both the psychoanalytic literature
and the psychiatric literature suffer from selection bias in keep-
ing with the borders of the intellectual territory of the respective
professions. Bipolar patients are but one example of a general
and unfortunate) trend in modern therapeutics. Psychiatry needs
far more integration of biodescriptive and psychodynamically
informed approaches to behavior than presently exists.

**Psychodynamic Psychiatry**

The core concepts of psychodynamic psychiatry are not
universally accepted even by psychodynamically informed psy-
chiatrists. The perspective of this writer is that psychodynamic
psychiatry rests on a few easily grasped ideas: 1) Behavioral
motivations are unconscious to some degree; 2) Many psycho-
logical responses including conflicting motives are warded off
from conscious awareness because they are threatening. These
influence both symptoms and coping; and 3) Psychodynamically
informed treatments are diverse.

Treatments include crisis intervention, brief psychotherapy,
combined individual and pharmacotherapy, combinations of
individual, group and/or family therapy, sessions that are not 45
minutes long, sessions that are spaced-out as clinical judgment
indicates, not necessarily scheduled each week, psychodynamically
informed management of patients with chronic disorders,
and manual-based therapies. In addition, of course, psychody-
namic treatments include long-term intensive psychotherapy. An
important principle that guides treatment planning is that the
present context must be well understood from a biopsychosocial
perspective as well as the developmental history. Present context
includes both negative influences such as trauma and positive in-
fluences, especially assets that can assist in coping with adversity.

There are of course associated ideas that underlay the major
ideas mentioned above. For example, the notion of “threat” is a
subjective one. Different motives are threatening to different
individuals for different reasons. Also, the material that is de-
fensively “warded off” is arranged in a psychological domain
called “the dynamic unconscious” according to principles
initially described by Freud, including condensation, symboliza-
tion, and displacement of emphasis.

Another hypothesis about the dynamic unconscious is that
unconscious wishes and fears result in internally experienced
psychological conflicts which are mostly out of conscious
awareness. People are motivated in part by behaviors which
they themselves view as unacceptable and immoral. These
unacceptable behaviors are often aggressive, exploitative and
sometimes, but not always, sexual, and imagined retributions
tend to include bodily damage/dismemberment, loss of love or
of loved objects, dreaded failures of various types and death.
Representations of unconscious wishes and fears that influence
experience and particularly motivation are encoded in the mind
during childhood. It makes sense therefore that they are often
symbolically represented in bodily terms. This classical perspec-
tive is incomplete, however, as I explain below.

The recently emerging use of the internet to create social
networks has made it evident that a profound motivator of hu-
man behavior is the need to connect to others. This apparently
obvious insight had been appreciated by many psychoanalysts
years before the internet was born and was the fundamental
building block of interpersonal and relational psychotherapy as
well as object relations theory. Therapists with this perspective
had objected to the notion that psychoanalytically informed
interventions should be primarily based on making the uncon-
scious conscious, but rather should be guided by awareness of
the transmuting power of the therapist-patient relationship.
The relational approach to psychotherapy was actually preceded
by the awareness of thoughtful (non-psychiatric) physicians of the
significance of the physician-patient relationship.

No matter the name given or the frame of reference all psy-
chodynamically informed treatments should be guided by the
conviction that the therapist-patient relationship is of crucial
importance. Thus, patient motivation to participate in an ongo-
ing therapeutic plan is central. This is true no matter what the
psychiatric and medical diagnoses are, and no matter what type
of treatment strategy is employed. A core function of a psycho-
dynamically informed intervention, therefore, no matter what
other functions are expressed, is to help motivate the patient
to follow a therapeutic plan (and not to abandon treatment).

It is reasonable to assume that both conscious and (dynam-
cally) unconscious realms of the mind are involved in motivating social behavior and that the older psychoanalytic paradigm that unconscious conflict is the primary unconscious motivator was not complex enough. That should not suggest, however, the drive/conflict model is invalid or not useful. One look at the stock market for example, or the way that nations conduct foreign policy indicates otherwise. It is important for psychiatrists to be aware of the ways in which modern perspective complement older frameworks and the ways in which they replace them.

**Insight and Associations**

Another historically important idea is that the unconscious and conscious psychological domains (that Freud discussed in his topographical model of the mind) are connected to each other in hidden ways that but may become apparent via the mechanism of free association.

Arguably the single largest error made by psychoanalysis during its entire existence, however, has been the belief that uncovering these hidden associations (via psychoanalysis) would inevitably relieve psychopathology and positively change the personality. Although this sometimes occurs, today we know that symptoms and syndromes often persist despite insight into the associative connections. Other paradigms are necessary to understand pathological as well as normal behavior, however these terms are defined.

**Psychodynamic Psychiatry and the Biopsychosocial Developmental Model**

Once taken as self evident, the biopsychosocial developmental model has become an idea in need of rescue. This is true despite its powerful explanatory value and therapeutic usefulness. In fact, psychodynamic psychiatry itself despite its promising beginnings has become an endangered discipline. Despite the interest of psychiatric residents in learning psychodynamic psychiatry, most psychiatric patients presently do not get assessed or treated according to its principles. This is unfortunate and prompted the interest in devoting a journal to this topic. Although some major journals, including the American Journal of Psychiatry do include material on psychodynamic psychiatry, the field needs and deserves its own forum.

**Psychodynamic Psychiatry and The American Academy of Psychoanalysis and Dynamic Psychiatry**

The American Academy of Psychoanalysis and Dynamic Psychiatry, recognizing the fragile state of psychodynamic psychiatry in the United States has decided to change the name of its journal from The Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry to Psychodynamic Psychiatry. This writer will be its editor beginning Jan 2012, and Jennifer Downey MD will be Deputy Editor. The Journal’s emphasis will be clinical and evidence-based. It will include research not only on the process and outcome of psychotherapy, but also on all aspects of psychological functioning relevant to psychodynamic psychiatry. It will include review articles and discussions of particularly important issues for psychodynamically oriented psychiatrists to be aware of. It will provide a forum for publication and discussion of the very large range of clinical issues that must be discussed from a modern psychodynamic perspective. This includes the social part of the biopsychosocial spectrum as well as the bio-psycho part.

The journal will also have an active on-line international pres-
of psychiatry is not an adaptive solution.

The American Academy of Psychoanalysis and Dynamic Psychiatry has taken a bold step in changing the name of its Journal. The new title directs readers to take equally bold steps in their thinking about models of the mind and behavioral psychiatry. The Academy hopes that this change will foster open and critical discussion of the many scientific and therapeutic problems of vexing complexity that require clear thinking at this present time.

Dr. Richard C. Friedman is Clinical Professor of Psychiatry at the Cornell/Weill Medical School NYC and incoming editor of Psychodynamic Psychiatry, the Official Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry. His email address is rcf2@columbia.edu.

CAPA Plans Third Study Tour to China in October 2011

by Michael Blumenfield, M.D., President-Elect AAPDP

CAPA is the Chinese American Psychoanalytic Alliance which is an organization founded and directed by Dr. Elise Snyder. It provides a training program for Chinese mental health professionals in psychoanalytic and psychodynamic therapy via classes, supervision and their own analysis with video conferencing on the Internet. Many members of AAPDP teach in this program. Last October I participated in the CAPA 2nd annual study tour to China and there will be another such tour this coming October. Dr. Perman, editor of the Forum asked me to write this article about my experience traveling in China with CAPA.

There were 27 people on the tour and all were psychoanalytically oriented mental health professionals and their spouses. Most, but not all, were participating in the CAPA teaching program. The tour was led by Dr. Snyder who was accompanied by her husband Dr. Michael Holoquist a Professor Emeritus at Yale, who, like his wife, has traveled extensively in China. The guide for the tour was Simon Chen, an executive in the Chinese travel company, which organized the tour and who told me that he chooses to only accompany VIP tours. He was an excellent guide and stayed with us the entire trip. He not only told us in detail about all the places we visited and the history of China but was able to answer our probing questions about contemporary life in China. In each city which we visited, we were also joined by a local guide especially chosen by Simon who provided additional knowledge and insight about the things of interest in their locality.

There was no better place to start than the city of Beijing, which is the Capitol of China. It has a population of over 22 million people and there are tall skyscrapers, crowded streets, upscale stores, a night food market and a lot more. Yet nestled in the center of the city is the Huotong section, which is made up of a series of courtyards with houses dating back 100 years. The streets here are quite small and to explore it we needed to take a pedicab which is a small open carriage pulled by a man riding a bicycle. This was one of the occasions that we were not going around with the entire group but our guide did arrange for us to have lunch with a middle aged couple living here. After showing us around their small home they told us about their son who now teaches martial arts in San Antonio, Texas.

During our stay in Beijing we also visited the Forbidden City, which is 500 years old and was built by the Ming Emperor Yongle. It has 8,706 rooms. Nearby is Tiananmen Square, which
is the site of political drama in China from the 1960s cultural revolution to student demonstrations in 1989. Some CAPA members made presentations at Beijing University. Whenever we gave a talk we always had a translator, although many of the young people do speak English. We always had a chance to chat individually with students who would come up to us before and after the formal presentations. Then there was a very momentous moment as Dr. Snyder conducted the graduation of the first CAPA class. This was a very important event for the students and it was very special for Dr. Snyder who had worked so hard to bring this about.

It was very striking how we could be dealing with something in the modern age one day and then the following morning do something such as climb and descend part of the Great Wall of China. On another day, in the morning, we visited the Ming Tombs, which were built 600 years ago and then in the evening we went to the theater and saw the very dramatic and powerful Kung Fu show. Afterwards, we had the opportunity to chat with the participants of the show. We also saw people exercising and playing Chinese musical instruments on the grounds of the Temple of Heaven. We paid a visit to the site of the 2008 Olympics which had been held in Beijing. There even was a very artsy area called the 798 Art Zone which reminded us of Greenwich Village in New York except there were large statues on many of the streets.

Our next stop was Xi’an, a few hours southwest by airplane. It’s history dates back to 100 BC and it has a mere population of 7.5 million people. It was here that I made my first presentation at Shan’xi Provincial Hospital. I recall one of the questions asked of me after I spoke had to do with whether older therapists could treat younger patients (obviously asked by a younger person). Probably the most dramatic sight in this city were the Terracotta Warriors which were statues of many soldiers buried with the first emperor “to protect him” (he originally wanted the actual live soldiers buried with him but was persuaded against it). We bought a souvenir of one these statues which resides in our home in California. We covered a few more museums and the very fascinating evening Moslem market.

Still further southwest was our next stop in Chengdu. The city is more than 2000 years old and has a population of 10.2 million people. It is the capitol of Sichuan and is known for its cuisine. A person from our group gave a talk on Trauma, Enactment and Integration. For some members of our trip the visit to the Panda Home was the highlight. You get a chance to even hold a baby cub and to watch these cute bears frolic around in the grass. One evening we made a visit to the Chengdu opera, which is not like any opera that you have ever seen, but certainly held our interest. On another day we came across an interesting Chinese custom in the People’s Park. It seems they have a tradition of people dancing with strangers. So our entire group waltzed around the outdoor dance floor with people we had just met.

We then headed east to the coast and probably the most dramatic city of our trip and that was Shanghai. Once a muddy fishing village, its greater metropolitan area now has more than 16 million people. Since the late 1990’s there has been a great construction boom and this city now is China’s economic spearhead. The skyline matches any that we have seen throughout the world and the view from their highest tower is magnificent. In the suburbs we visited Suzhou which has been named the Venice of the East. We saw how silk paintings are made, visited the Jade Buddha and then ended up in the Eastern China Normal University where several members of our group gave talks. There also was a second graduation for students in this part of the country. We then went to Shanghai Mental Health Center where I and several other CAPA members also gave some lectures and interacted with faculty and students.

On our last evening in Shanghai we had a celebratory dinner where our guide also presented us with a special cake. Some of the group departed for the states on the following day, while my wife and I with several others went on to the famous ancient city of Kaifeng. It had been the capital in the Song Dynasty and is the place where a Jewish synagogue was built during the first century. We visited with descendents of those Jews who told us the history of the Jews in China and their desire to rebuild a synagogue there in modern times. As in every city where we traveled there were fascinating museums, Pagodas, Buddhist Temples and beautiful gardens. I even had an interesting “inci-
dent" when we took a trip on a hovercraft on the muddy Yellow River. We walked around on a small island and I sank up to my knees in mud and had to be pulled out.

It was not only the beautiful sights, introduction to the history and Chinese culture that was so worthwhile on this trip, but it was some of the insights that we developed in chatting with our guides as well as the students, faculty and other people we met. This included of course, the discussion between our fellow travelers who were colleagues from all over the United States. I came to understand how the Cultural Revolution, which occurred in the 1960s, eliminated many of the doctors and intellectuals who might be the Chinese teachers of psychoanalytic theory today. It also became clear how the Chinese are very proud of the economic growth which they have sustained in the past 20 years with the help of free enterprise and capitalism throughout the country but yet under the clear authoritarian rule of the non-democratic Chinese government. They still have a long way to raise the standard of living of the average person especially of those who live in rural areas but there seems to be a confidence that they are well on this road. They seem to have a willingness to tolerate the absence of freedom, which we in the United States take for granted but yet value a great deal. It was very enjoyable to chat with our colleagues on the bus rides or during meals while some of us still struggled with chopsticks. We were able to exchange ideas about teaching experiences with CAPA and review such issues as the meaning of China’s one child policy in the psychological make up the Chinese or about the difference between shame and depression.

Over all this was a very gratifying and stimulating three weeks. I urge you to consider participating in the CAPA program but whether you do or do not do so you should think about taking the next CAPA trip to China. You can get more information about CAPA and the next tour which will begin on October 22nd by going to http://www.capachina.org/CAPA/Events.html. You can also view a movie that I put together about our CAPA tour by going to http://gallery.me.com/ronellan#100246.

Dr. Blumenfield is President-Elect of the American Academy of Psychoanalysis and Dynamic Psychiatry. He lives and practices in Los Angeles.

Integrating Psychosomatic Medicine and Psychodynamic Psychiatry - Creating Health Care Environments to Meet Patients’ Needs and Maximize Life Potentials

by Mary Ann Cohen, M.D., FAAPDP, FACP, FAPM, DLFAPA

Discrimination and stigma in health care and two-tier systems of care were far more obvious in the 1960s than they are today. Despite enormous inroads made by civil rights, equal rights, and patient rights movements, disparities in health care are now well-documented and still exist. Persons of color, persons with mental illness, persons of limited resources, women, children, older persons, homeless persons, and gay, lesbian and transgendered persons may experience subtle and not so subtle discrimination in hospitals, clinics, offices, nursing homes, pharmacies, and clinical trials. These disparities lead to decreased access to appropriate care, fewer treatment options, inadequate pain treatment, and increased morbidity and mortality. Throughout medical school, residency training in psychiatry, fellowship in psychosomatic medicine and as a psychiatrist, I was inspired by patients, families, students, trainees, and faculty to work toward humanizing and destigmatizing health care. This has remained a driving force and inspiration to this day.

During residency training in psychiatry at Tremont Crisis Center, Albert Einstein College of Medicine in 1972, I developed an interest in addressing health care disparities through the creation of supportive health care environments to meet patients’ needs and maximize life potentials. It was not always easy to maintain the courage of my convictions and to work toward diminishing stigma and discrimination in patient care.

I was fortunate to have Drs. Christian Beels, Hugh Butts, Philip Guerin, Edward J. Hornick, Leonard Kahn, Janet Kennedy, Jay Lefer, and Jules Ranz as supervisors. Our faculty also included Drs. Leon Altman, Bernard Bandler, Walter Bonime, Salvador Minuchin, Pedro Ruiz, and Israel Zwerling. Their psychoanalytic, family, group, and systems approaches provided me with remarkable perspectives on how to accomplish my goals. Being exposed to this multiplicity of modalities enabled me to be whom the patient needed. The needs varied from patient to patient, in some patients over time. It was possible to make use of every modality from crisis intervention, networking,
During residency training I observed that some of our patients with psychiatric illness and multimorbid complex and severe medical illnesses were not getting adequate medical care nearby city hospitals. It seemed to me that discrimination and stigma led to disparities in the health care they received. As a resident, I sought to address these disparities by establishing a psychosomatic medicine service in one of the hospitals closest to our community-based residency training program in the South Bronx. With Dr. Lefer’s psychoanalytic supervision, I became Director of the first Consultation-Liaison Psychiatry Service at Fordham Hospital and continued to lead the program for one year after residency training. I developed a team of psychiatrists, psychiatric residents, a psychiatric social worker, and psychiatric clinical nurse specialists to ensure that our patients with psychiatric disorders as well as other medically ill patients received adequate and timely care. Our team educated physicians and other caregivers about the psychiatric and psychosocial aspects of medical illnesses in general care, emergency room, and ambulatory care. My goal was to establish a health care environment to meet patients’ needs and use role modeling and education to help to humanize and de-stigmatize mental illness.

During my Consultation-Liaison Psychiatry fellowship at Montefiore, I established a program to teach communication skills to residents and faculty in the ambulatory setting of the general medical clinic. There, my supervisors included Drs. Sigurd Ackerman, Jimmie Holland, Frank Baudry, James Strain, Herbert Weiner, and Fred Wiener. It was at Montefiore that I met remarkable students and residents including Sherry Katz-Bearnot and Howard Gendelman. Through case conferences, videotapes, supervision, and medical-psychiatric rounds we began a dialogue to decrease stigma through getting to know patients first as people. Stigma and discrimination were evident in care provided for persons with substance dependence and other psychiatric illnesses. Persons who were depressed made doctors angry. Persons with drug or alcohol dependence were treated with disrespect and some were severely neglected. Elderly patients were slow, took up a lot of time, had multiple chronic illnesses, thick charts, and many medications. Often, countertransference interfered with providing adequate care for patients. Dr. Holland had established a program to co-locate a psychiatrist in the medical clinic. I implemented her work as a fellow and continued as an attending in the general medical clinic until 1981. Drs. David Duffy (Director of the General Medical Clinic), David Hamerman (Chief of Medicine), and I worked together to improve doctor-patient relationships and co-authored an article about teaching communication skills in a medical clinic (Duffy DL, Hamerman D, Cohen MA. Communication skills of house officers: a study in a medical clinic. *Annals of Internal Medicine* 1980; 93:354-357).

In July 1981, I re-established a psychosomatic medicine service at Metropolitan Hospital Center, a city hospital in Manhattan, only one month after the first article about AIDS appeared in the MMWR. AIDS was a new illness that was described, defined, and named in that article and engendered fear that magnified discrimination and stigma. There, in the epicenter of the drug and AIDS epidemics, I found an illness with more stigma than any I had ever encountered before. Addictophobia, homophobia, and the combination of contagion and death resulted in the most blatant forms of discrimination that I called “AIDSism” (Cohen MA. AIDSism, a new form of discrimination. *AMA News*, January 20, 1989; 32:43). It was clear that there was a dire need for establishing another health care environment to meet the needs of persons with AIDS and provide education and support for their caregivers. I was fortunate to have had as my medical students, residents and fellows, some of the remarkable leaders of psychoanalysis and psychosomatic medicine including Drs. Asher Aladjem, Cesar Alfonso, Abby Altman, Nabil Karroum, Joseph Merlino, Andrew Roth, Scott Schwartz, and Henry Weisman.

We found that AIDS patients were isolated inappropriately, food and water were left outside patient rooms, housekeepers did not clean the rooms, some nurses requested transfers, and some physicians shunned AIDS patients. I was called to provide a psychiatric consultation for my first person with AIDS. There were trays of food left on the floor outside his room. When I entered his room, the floor was so dirty and sticky that I stuck to it as I approached his bedside. The patient was in a hospital room on a medical floor of an academic tertiary care facility but he was not receiving the care that he deserved. With the Directors of Infectious Diseases and a social worker, we organized a multidisciplinary team to provide a compassionate and care to persons with AIDS and to educate the hospital staff on all three shifts. With the help of Associate Directors Dr. Asher Aladjem and Dr. Cesar Alfonso, we established programs for the care of the medically ill as well as for employees who were in need of help. We developed a training program and the first AIDS psychiatry fellowship.

For me, AIDS was a paradigm of the complex and severe chronic medical illnesses that I had been working with until that time. It had all of the aspects of diabetes mellitus, coronary artery disease, hypertension, and cancer but was also infectious, highly stigmatized, and was associated with complex risk behaviors that posed public health risks as well. I was inspired by the fears of patients, families, caregivers, and hospital administrators to work toward humanizing and destigmatizing this new illness.

I resolved to devote much of my professional life to caring for persons with HIV and AIDS where I thought I could use all of my training as well as my passion for patients’ rights to care to create supportive health care environments and maximize life potentials. After 14 years at Metropolitan Hospital, I spent the next four years at the first nursing home for persons with AIDS, Rivington House Health Care Facility.

At the nursing home, a 34 year old with late-stage AIDS shared his story with me. He had been neglected and abused as a child and, in his early 20s, was abandoned by his fiancée shortly after they were engaged to be married. Embittered, depressed, and angry, he began to use cocaine. He lost his Wall Street job and his home and turned to sex work to support his cocaine dependence. He was first diagnosed with AIDS at a late stage when he collapsed and was found to have paraparesis due to HIV myelopathy that progressed rapidly to paraplegia. He was diagnosed with both late stage AIDS and hepatitis C. Unable to care for himself, he was transferred to the AIDS nursing home enraged, sad, and unable to deal with the multiplicity of his losses and severity of his existential anxiety. We struggled in psychodynamic psychotherapy to help him find meaning in his life. He often despaired over his losses: “I never had a wife, never raised a family, never owned a home, never finished col-
lege, or even went to a Broadway play.” I helped him to reunite with his family of origin and to work through his losses. His rage diminished as we worked together to create a literacy program for other patients at the nursing home. He spent his last Christmas at home with his family for the first time in years. I challenged him to see as many Broadway plays as he could when I found a way for him to see each play for only $7.00. He attended 6 Broadway plays in the few months before he died (Cohen MA. Psychodynamic psychotherapy in an AIDS nursing home. Journal of the American Academy of Psychoanalysis 1999; 27:121-133).

In 1998 I was appointed Director of AIDS Psychiatry at Mount Sinai Medical Center. Dr. Rosalind Hoffman was my Co-Director. We established an AIDS psychiatry program in the Mount Sinai AIDS Center. With psychiatrists co-located in the AIDS clinic, we were able to provide seamless integrated care for persons with HIV and AIDS who were grappling with multimorbid medical and psychiatric illness. The stigma of AIDS is magnified by the stigma of mental illness and this comprehensive team approach to care helped to diminish some of the stigma. Psychiatrists, HIV clinicians, social workers, nurse clinicians, neurologists, hepatologists and a gynecologic nurse practitioner were all co-located in the same clinic. I developed an AIDS psychiatry fellowship and among the fellows were Drs. Raul Condemarin, Karin Dorell, and Francisco Ricart. Our AIDS psychiatry team provided care for hundreds of persons with HIV and AIDS.

Over the years my patients, medical students, trainees, and faculty have provided inspiration for articles, chapters, and two books as well as for observational research (see reference list for some of these publications). Our first book, the Comprehensive Textbook of AIDS Psychiatry was published in 2008 and the second, the Handbook of AIDS Psychiatry, in 2010. It is clear to me from my work in psychosomatic medicine and AIDS psychiatry that psychoanalysis and psychodynamic psychotherapy are the most important treatment modalities for persons with any severe and complex medical illness and can alleviate suffering and decrease morbidity and mortality. In the AIDS pandemic, these modalities can also improve adherence to risk reduction, change risky behaviors, and decrease transmission of HIV. While many advances have improved the care of persons with HIV and AIDS, much work still needs to be done to humanize and destigmatize this devastating illness and to prevent its transmission.

Caring for persons with HIV and AIDS and other severe and complex medical illnesses continues to be a challenge, passion, and inspiration. As clinicians and teachers we need to allow our patients talk to us, to follow our passions, have the courage of our convictions, and continue practice the kind of medicine we learned about in medical school. Through the integration of psychodynamic psychiatry and psychosomatic medicine we can create health care environments to meet our patients’ needs and maximize their life potentials.
and if the transference was ever fully resolved. He arranged for patient follow-up interviews with a new analyst to attempt to answer these questions. Pfeffer concluded that transference is never fully resolved and that what patients gain is the development of new ways of managing conflict. The repetition of neurotic solutions is replaced by the repetition of healthy solutions.

Elizabeth Zetzel in 1965 wrote that early object relations determine the quality of the therapeutic alliance, the capacity for tolerating frustration, delay and separation, and the ability to discriminate between fantasy, identification and reality. Successful termination involves mourning of the analyst and the analysis and results in the integration of a stable identity. Lebovitz then described Margaret Mahler’s work and how early dyadic interactions affect the amount of anxiety associated with separation and how they affect the therapeutic alliance. He ended this section by referencing Kohut’s contribution to the concept of “mature narcissism” as an outcome of successful psychoanalysis with characteristics of wisdom, humor, altruism and creativity. Following Loewald, “the defense transference represents an alloplastic mechanism that is enacted rather than recalled.” Lebovitz said that many theoreticians presented their own formulations of defense transference: Winnicott and the false self, Kohut and the vertical split, Mitchell and the repetitive transference configuration, and Klein and her theories of defensive object relations that were later elaborated by Kernberg.

Dr. Lebovitz then turned to how the process of analysis unfolds in a cyclical fashion. According to Lebovitz, “A cycle is recognized when the patient proceeds beyond the defense transference to introduce a conflict with its attendant fantasies, dreams and transference experiences. The analytic work proceeds toward understanding until the level of stress exceeds the patient’s capacity to cope. The defense transference then returns. Restoration of the alliance concludes the cycle. As cycles of conflict are repeatedly analyzed the patient develops a capacity to observe and analyze his reactions in identification with the analyzing function of the analyst as a new method of coping with problems. A potential for new solutions is enhanced through this process. As the analysis proceeds the cycling becomes more rapid. The post analytic phase involves a consolidation of these capacities as a consequence of a process of mourning. In follow-up experiences, the former analysand repeats the process of cycling as well as his self-analytic efforts at solution in the space of six interviews.”

Dr. Lebovitz then described in detail the “multiple code theory” of Wilma Bucci published in 1997. Three stages constitute the cycling pattern in this model. The first stage is “sub-symbolic” in which reactions are primarily non-verbal. These reactions are translated into narrative form by the analyst. In the final phase, elaboration and reflection facilitate an alteration of the emotional schema. The influence of the past on the present and transferences are integrated into the patient’s awareness. Kris’s “good hour” was given as an example of this cycling. Lebovitz gave a clinical example from Bucci’s work.

The follow-up study that Lebovitz has been engaged in involves 40 patients who have been interviewed since 1963. Patients had terminated their treatment with candidates at least two years prior. He described the process of consent and safety procedures to avoid disruptive or traumatic effects on these patients. For example, the interviewing analysts reviewed process notes of the original analyses so that they would not inadvertently inquire into particularly traumatic areas. This was balanced against the concern about the analyst having too much information with resultant biases. These studies affirmed that change can be assessed in this manner, transferences quickly reappear, patients develop self-analyzing capacities to a greater or lesser degree, work with the defense transference was the crucial factor in this development, cycling is closely associated with this work and, finally, the capacity for mourning during the ending phase of treatment is crucial to solidify the changes made.

Patients were rated according to a number of dimensions having to do with the therapeutic alliance (related to a feeling that the analyst is helping), dreams, Oedipal issues, defense transference, and the analytic alliance (related to an identification with the analytic function). Specific dimensions included: basic trust, object constancy, self-constancy, dyadic object relationship, dyadic reality testing, tolerance of frustration, anxiety and depression, and triadic object relations among others.

In the CPR laboratory session the audience was presented with two case examples and had to rate the patient on the above-noted dimensions. Audience results were then compared with the real results of the seasoned analyst follow-up interviews. This part of the program was organized, and the results analyzed, by Sheila Hafter Gray along with the help of three Catholic University undergrads. The two patients were found to have gone through cycles of change and to have characteristic defensive styles that were rated similarly by the CPR audience and the study clinicians.

Jim Kleiger, Past President of the Baltimore Washington Society for Psychoanalysis, was our first discussant and he directed his remarks to what he called “broader issues related to psychoanalytic research” noting the kinds of tensions that Jonathan Shedler recently pointed out that make psychoanalytic clinicians and researchers often unable to communicate with each other. Kleiger emphasized the “complexity of the enterprise” taking note of “all the moving parts.” He highlighted the “good news” with regards to the findings themselves as a cause of optimism in our field. He commented also on the Menninger Research Project (PRP) and its similarities and differences from the Chicago study.

Daniel Buccino, Founder and Director of the Baltimore Psychotherapy Institute, was our second discussant. He provided a review of the broader psychotherapy outcome literature to underscore the fact that not only is psychotherapy in general powerfully effective, but that psychodynamic psychotherapy in particular is enormously effective and can and must be considered an empirically validated treatment. Mr. Buccino also sought to expand the research focus for the participants from a micro-level analysis of the process and mechanisms of change in an individual psychoanalytic case or set of cases to a macro-level consideration of the need for healthcare delivery and psychotherapy services research. He concluded that pursuing the science of outcomes-optimizing research will not only help the profession assume high-quality patient care but help it find better ways to measure and demonstrate this care in the pursuit of excellence, of discovery, and in service to our patients.

Discussant presentations were followed by Q&A from the audience with our discussants and Dr. Lebovitz.

The next CPR Conference will be held on Sunday, February 5, 2012 at Sibley Memorial Hospital in Washington, D.C. Our presenter will be J. Christopher Fowler, Ph.D., Austin Riggs
The AAPDP/OPIFER Joint Meetings: Some Personal Recollections
by Marco Bacciagaluppi, M.D.

I wish to speak of a tradition that has been built up, that of the yearly Joint Meetings (JM) between the Academy and OPIFER which have been held in Italy since 1999.

OPIFER (Organizzazione di Psicoanalisti Italiani – Federazione e Registro) is an organization of independent Italian psychoanalysts, on the model of the American Academy. It is a much younger sibling of the Academy, since it was only founded in 1996, and a much smaller sibling, since it only has a membership of around 150. However, our joined forces have given rise to very stimulating events, twelve so far, that have taken place in various cities and towns in Northern and Central Italy.

On the American side, these events have been organized by Joan Tolchin, with the assistance of Jules Bemporad. On the Italian side, they have been organized by myself, the Founding President of OPIFER, and by my successors, Sergio Dazzi, Sergio Caruso and Pietro Andujar, and other collaborators.

Two meetings took place in Venice and three in Florence – surely, two among the most beautiful cities in Italy. Two took place at Sestri Levante, a small resort on the Italian Riviera. The meetings were held in a hotel on a hilltop, and Joan and Matt Tolchin stayed at a beautiful hotel on a promontory.

Here is my personal experience of some of these meetings. This is a personal selection, based on my own participation and on what struck me most in other people’s contributions.

The First JM was held in Venice (Nov. 1-3, 1999), in a religious institution. I discussed two American papers. In one, Mauricio Cortina made a connection between Sullivan and attachment research, especially between Sullivan’s concept of not-me and disorganized attachment described by Mary Main.

In the other, Ann-Louise Silver, who worked for many years at Chestnut Lodge with schizophrenic patients, spoke on Frieda Fromm-Reichmann, who had been her teacher at the Lodge.

The sub-title of all the meetings is “In the Footsteps of Silvano Arieti.” Arieti – my teacher in New York in 1963-64 – was Italian-born, therefore serves as a link between our two associations. The first meeting was in Venice on the topic of “Reciprocal Influences in Psychoanalysis.” The 2nd JM (Sestri Levante, June 23-26, 2000) was devoted to him. The sub-title of the other meetings became the title of this one. I discussed a paper by John O’Brien on "Countertransference Issues in the Treatment of the Sexually Abused Adolescent and Adult." In 2001, at the 3rd JM, held in Venice at the Hotel Bonvecchiati, I gave a paper on “The Evolution of Altruistic Behavior.” At the 4th JM in Florence (June 28-July 1, 2002), I gave a paper on “Arieti and Bowlby: Convergence and Direct Influence.” At the 5th Meeting (Milan, June 13-15, 2003) I presented a paper on “Violence: Innate or acquired?” that was later published in the Journal of the Academy.

The 6th JM, held in Pisa (Arieti’s birthplace) on June 11-13, 2004 and organized by Rita Bruschi, leader of the “Associazione Silvano Arieti,” was devoted to Arieti, to mark the 30th anniversary of the second edition of Interpretation of Schizophrenia. These were the American speakers: Ann-Louise Silver, who gave the keynote address on “In the Footsteps of Arieti and Fromm-Reichmann: Interpretation of Schizophrenia in the Current Scene;” Robert Cancro (“Evolution of the Concept of Schizophrenic Disorders”); Clarice Kestenbaum (“Before the Break – the Treatment of Prodromal Symptoms of Psychotic Disorders”); and Ed Green (“The Use of the Patient’s Metaphor to Enhance the Therapeutic Alliance”).

I did not speak at the next four meetings: the 7th in Bologna (June 24-26, 2005) on “The Relational Paradigm,” the 8th in Florence (Nov. 10-12, 2006) on “A Common Happiness,” the 9th in Sestri Levante (Oct. 6-7, 2007) on “Strategies in Dynamic Psychotherapy,” and the 10th in Milan (Oct. 25-26, 2008) on “The Many Voices of Identity.” At the 8th Meeting I was struck by the paper of Silvia Olarte, “Changes in a Dynamic Practice: Integrating Therapeutic Approaches,” in which she introduced the concept of “intermittent” treatment.

I spoke again at the 11th JM (Florence, Oct. 17-18, 2009). This was held in the medieval Cenacolo (Dining Hall) of Santa Croce. The title of the meeting was “Endings in Psychoanalytic Psychotherapy: How, When and Why?” I gave a paper on “Self-Analysis as an Appropriate Ending,” which was later published on the Journal of the Academy. I also discussed two American papers. One was by Richard Brockman on “Termination or Change: Learning from the Untreatable Patient.” The other, of ethno-psychiatry, was by Helen Ullrich, on “Widowhood as an Ending: Depression and Suicide among Widows in a South Indian Village.”

The most recent 12th JM was held in Genoa in the sumptuous Ducal Palace (Oct. 16-17, 2010). Its theme was “Trauma and Identity.” I gave a paper on “The History of the Study of Psychic Trauma” (to be published on the Journal of the Academy). I also discussed the American keynote address by Clarice Kestenbaum on “Secure Attachment and Traumatic Life Events.” The Italian keynote address was by Pietro Andujar on “Trauma and the Disintegration of Identity: We Can See a Lot Through

Academy members are involved in its planning and an increasing number of Academy members have been in attendance. Mark your calendars now for an exciting and enriching trip to the Nation’s Capital next February! Visit our beautiful website at www.cpincdc.org.
the Glass of Psychoanalytic Psychology. To have this event at the Library of Congress is a validation on the collective level that there has been a sea change in the collective.

As we gather here to discuss Jung’s Red Book, I am thinking of the first generations of Jungians in the United States who pioneered Jung’s psychology at a time when Freudian psychoanalysis was at its peak of popularity. In that regard I would like to mention Elizabeth Whitney, Joseph Henderson, and Joe Wheelwright in San Francisco, Esther Harding Eleanor Bertine, Kristine Mann, and Frances Wickes in New York, and James and Wheelwright in San Francisco, Esther Harding Eleanor Bertine, Kristine Mann, and Frances Wickes in New York, and James and Wheelwright in San Francisco. They all toiled like to mention Elizabeth Whitney, Joseph Henderson, and Joe Wheelwright in San Francisco, Esther Harding Eleanor Bertine, Kristine Mann, and Frances Wickes in New York, and James and Wheelwright in San Francisco, Esther Harding Eleanor Bertine, Kristine Mann, and Frances Wickes in New York, and James and Wheelwright in San Francisco, Esther Harding Eleanor Bertine, Kristine Mann, and Frances Wickes in New York, and James and Wheelwright in San Francisco, Esther Harding Eleanor Bertine, Kristine Mann, and Frances Wickes in New York, and James and Wheelwright in San Francisco. They all toiled in relative anonymity and frequently at odds with the Freudian world of those times.

One of the exhibits in the Jung exhibit at the Library of Congress is the picture of Jung on the cover of Time magazine in February 1955. Jung was approaching 80 years of age at this time, and a long article on his psychology was the lead for that issue. At a time when television was in its infancy, the Internet many decades away, the printed page of Time magazine was an important cultural icon. I was a sophomore at Reed College at the time and it was the first sign of validation by the collective of Jung. Later that year I had the good fortune to meet Jung in July at the time of a large public birthday celebration held at the Hotel Grand Dolder in Zürich. My mother snuck me into the receiving line, and Jung was extremely pleased to meet me. He gave me the warmest handshake which both pleased me and surprised me at the same time. I recently heard one of Jung’s grandchildren who experienced remembering his grandfather’s handshake as something quite special. I was relieved to hear that, because it made me realize that this was not all projection and fantasy on my part, although there was a lot of that too.

I had an occasion to meet Jung again the following summer when my father and I had an afternoon tea in the yard. It was extremely pleasant, and Jung was still recovering from the death of his wife Emma several months before. So his energy was not great.

In 1958 I was again in Zürich and by now I had begun analysis. My father was lecturing at the Jung Institute and we were living together in an apartment. My father had an appointment with Jung but could not keep it because he had to teach at the Institute. He telephoned Aniela Jaffe and asked her if I could go in his place. She telephoned back to say that Prof. Jung would be glad to meet with me. I prepared for my interview with Jung by looking over dreams which related to what he was working on. At the time he was working on a monograph on Flying Saucers. I had a dream of intersecting circles which I presented to Jung. However, as I walked into his study, he said “So he you want to see the old man before he dies, do you?” I was bowled over by his directness, and I honestly cannot remember another thing of the interview. I have spoken with another colleague of mine who had a similar experience when visiting Jung.

With the publication of The Red Book under the supervision of Sonu Shamdasani, and the enormous response to it by the number of sales, plus this conference at the Library of Congress, we have another nodal point for the validation of Jung and his psychology. What is it that Jung represents? The Red Book Jung describes his experiences with the images and fantasies in his unconscious with which he had to grapple. All of us at one time or another is drawn into our own inner world by some experience or another. In The Red Book we have Jung’s confrontation with his unconscious and how he was able to come out the other side. Obviously the text and images have fascinated a large number of people. What we must remember is that this was Jung’s own personal journey and this may not be and is most likely not anyone else’s individual journey. In fact, my reading of The Red Book gives us all the freedom to find our own individual paths which may be quite different from Jung’s own.

When the program for this symposium was first outlined, this section was entitled “Self-Analysis.” The notion behind that
title was that both Jung and Freud had basically undergone a self-transformation without the aid of an analyst. Interpretation of Dreams arose out of Freud’s self-analysis and reveals only in part his confrontation with his unconscious, whereas Jung documents his direct confrontation with the unconscious in The Red Book. In reassessing our title, John Beebe and I decided that we would shift our focus to discuss generally Jung’s encounter with the unconscious.

His encounters began early in his life with a dream between the ages of three and four years. I will quickly summarize the dream that he reports in Memories, Dreams and Reflections: Jung was in a meadow where he discovered a dark rectangular, stone-lined hole in the ground; he descended into the hole and entered a rectangular chamber. Within stood a golden throne on a raised dais and on this throne was what he first described as a tall tree trunk. It was made of flesh and covered with skin and from its top a single eye gazed motionlessly upward. Then his mother’s voice called out, “Yes, just look at him. That is the man-eater.” Only decades later did he realize that this was a ritual phallus. But as to his mother’s warning, he could never decide where the emphasis lay: if it was on the word that, it meant the ritual phallus would devour the Lord Jesus and everything else; if the emphasis was on the man-eater, it meant that the ritual phallus, Lord Jesus, and the Jesuit whom Jung had feared as a young child, were one and the same.

Why do I mention this dream? Because it demonstrates that from a very early age, Jung’s inner life was a source of fear and wonder and curiosity and that his concerns were of a profoundly spiritual nature. According to Jung the phallus of the dream seemed to be a subterranean God “not to be named” and such it remained throughout his youth. Through this early dream of a descent into the world beneath the surface of things, Jung experienced the secrets of the earth. He described it as “an initiation into the realm of darkness. My intellectual life had its unconscious beginnings at that time.” It is important that we take note of the link Jung makes between intellect as a powerful conscious function and an equally powerful unconscious source.

This is not the place to go into the biography of Jung except to say that by 1913 at the age of 38, Jung had become a world famous psychiatrist and an early adherent of and spokesperson for Freud’s psychoanalysis; he had married Emma Rauschenbach, the daughter of a rich Swiss industrialist and they had 4 children; the 5th child would be born the following year. So his outer life was full and well established. Irreconcilable differences had arisen out of Freud’s self-analysis and reveals only a way to approach the unconscious to generate new images. All of Jung’s subsequent writings amplified this layer of the unconscious which is deeper than the personal. He alternately called it the collective unconscious and/
or the objective psyche. At the same time Jung always held that the ego must have an equal voice in the equation of the psyche: the voice of reason and the demands of outer life have equal importance to the movements of the unconscious.

We can see, then, how important the essay on the Transcendent Function was to the initial development of a scientific language for the experiences Jung recorded in The Red Book. The Red Book and Seven Sermons to the Dead are prime examples of material which Jung never published in his lifetime. They are highly personal documents, a kind of diary, which Jung was extremely ambivalent about publishing. I do not feel entirely comfortable reading certain parts of The Red Book, because the material is so personal; I sometimes feel like an intruder into his psyche and feel I have no business being there. On the other hand, I am fascinated to read much of the material, although it is heavy going. The Red Book has been in the background since my childhood, represented to me as the source of all of Jung’s important scientific contributions.

What Jung writes about the unconscious in The Red Book became the basis for all his later writings and observations. He continued to work on the text and draw mandalas until 1928 when he was given The Secret of the Golden Flower, a Chinese alchemical text by Richard Wilhelm. At that time he gave up his work on The Red Book and devoted the rest of his professional life to the study of the unconscious through alchemy. He found in alchemy the parallel to many of the dreams of modern man. He needed to find new source material for his continuing researches into the objective layer of the psyche and alchemy was a rich tradition of unwitting psychological exploration, laid out in projections onto material substances.

For first generation Jungians following in Jung’s footsteps - which meant writing down dreams, drawing mandalas, discovering the anima or animus and the wise old man or woman and engaging them in dialogue through active imagination - was the way of individuation. Now, with The Red Book it is becoming even clearer that this was Jung’s path and to be “Jungian” is to find one’s own path toward realization of what and who we are.

Dr. Thomas Kirsch is a Jungian analyst and former president of the International Association for Analytical Psychology. His email address is tkirsch@jungians.com.

---

**Post-traumatic Writer’s Stress Disorder**

_by Richard M. Waugaman, M.D._

The journal, a highly reputable one, had asked me to revise my manuscript. This was usually a sure sign they were interested. So I promptly made the revisions that they suggested and returned my new draft. But seven months had now gone by and there was no further word from them, despite my repeated inquiries. What was I going to do - I couldn’t stand waiting any longer but I couldn’t risk antagonizing this prestigious publication? Somehow, I clicked “send” to an email to the journal’s editorial office that included the following: “This is most strange. There was a message on my computer from [my submission], informing me that it had gone on a hunger strike. I see it has lost 834 words since I revised it last August. It is threatening to keep losing another 120 words per month. Naturally, that does not pose any immediate danger, since (truth be told) it could afford to lose a few words.” On impulse I had slashed my paper in the hope that this act of authorial self-cutting would get the journal’s attention.

So, am I a hopeless eccentric? Or just another ordinary case of Post-Traumatic Writer’s Stress Disorder (PTWSD)? A recent conversation led me to believe that some colleagues suffer from the misconception that those of us who publish a lot have somehow risen to a rejection-free region. I had just mentioned several recent rejections of my manuscripts, and my colleague expressed shock. When I later recounted this story to another colleague, she admitted that she got such a hurtful rejection letter the first time she submitted a manuscript to a journal that she hadn’t dared do so in the decades since.

Those of you who are new to publishing need to know that rejections are a necessary evil we need to expect and tolerate. One of the most published analysts I know has a system of choosing several journals he plans to submit a given manuscript to if the first one or more journals reject it.

My publishing journey began in college, when Walter Kaufmann supervised my required senior thesis. He suggested the terrific topic of Nietzsche’s influence on Freud. I later followed his advice to submit an article on that subject to a leading journal. He wrote to me that the editor sent it to him for peer review, and he enthusiastically endorsed it. However, the editor then rejected it. I was so deflated that I gave up on submitting it elsewhere. That was in the days of typewriters and, since I was in medical school, finding the time to rewrite it wasn’t easy. But two years later, a speaker at psychiatry grand rounds mentioned Nietzsche. Since I felt he shared a common misconception about Nietzsche’s philosophy, I felt energized to rewrite my article. This time, I sent it to Psychiatry, the journal founded by Sullivan. They accepted it. Its editor, Don Burnham, later became the supervisor of my first analytic case. Psychiatry has since published many of my articles, commentaries, and book essays, under Bob Ursano’s editorship.

Being in analytic training discourages many candidates from trying to publish. Perhaps we worry that we will embarrass ourselves by writing something that betrays the incomplete state of our training analysis. It was 13 years after my first article that I sent a brief article to the Psychoanalytic Quarterly. The editor liked it and published it four months after I submitted it. That happy experience gave me a miserably misleading impression of what was in store for me next. The next article was on the experiences of time in analysis. An editor gave me many useful suggestions for revision and accepted my next draft. I waited patiently for publication - year after year. Finally, six years after acceptance, the editor wrote that the journal had ceased publication. All was not lost - another journal did publish it.

In other cases, I waited impatiently for 6-12 months, only to learn that my manuscript never arrived; that there had been a change of editors and it had been misplaced. Or the journal had changed its focus and now considered only topical papers...
(the first topic was actually closely related to the manuscript I sent); or that the editor had not contacted me because I had not enclosed a self-addressed stamped envelope (he had my email address)! One paper seemed stuck in one of Dante’s circles of hell—the second peer reviewer liked it but the first one never sent in a review. A few months later, the editor chose a replacement for that first reviewer, who didn’t submit a review in the required three months either. Finally, nearly a year after submission, the editor wrote that “moderate revisions” were required.

In the midst of making them, I got an email from him saying that he finally heard from the long-lost first peer reviewer who recommended rejection. The editor said that reviewer was out-voted, but I should still revise with his or her criticisms in mind. I did so and sent the paper in yet again. The editor replied that he would send it out to be re-reviewed by the two reviewers who liked it. At that point my patience snapped and I replied that “I deeply abhor being in peer review limbo yet again on this paper.” This push-back was effective and the editor agreed to skip the next round of seemingly endless peer review.

One journal that I submitted to has two co-editors. I was asked to submit a paper on a given topic and did so. One editor replied that my draft was not academic enough to be sent out for review. He suggested changing the tone and adding a more extensive literature review. I complied and sent in an amended draft a few months later. Four months after I submitted the second draft, the other editor informed me that the paper was accepted. One reviewer wrote “I just re-read the article and loved it as much as I did the first time I read it a month ago.” I was thrilled - until I saw the version accepted was my first draft, which the other editor wasn’t willing to submit for review. It turned out that the two co-editors had not effectively communicated with each other. Currently, I am still lobbying to have that first version published since it better reflected what I wanted to write.

When should we just give up on a manuscript? I confided in a colleague at Chestnut Lodge that I had just gotten my sixth rejection of another article. “Rick,” he asked, “has it occurred to you that your paper might not be good enough to publish?” That’s the sort of place the Lodge sometimes was. Fortunately, I ignored that piece of supportive advice and the next journal accepted that article (that won a prize!). By contrast, my former supervisor and friend, Harold Searles, gave me invaluable encouragement and suggestions when I shared several manuscripts with him. He co-authored an article with me about a patient whose treatment he supervised - I believe this was the only article that he ever co-authored. Judy Viorst taught a wonderful elective on psychoanalytic writing. She suggested we choose an article that he ever co-authored. Judy Viorst taught a wonderful class taught by Rollo May in college, I asked him how his patients felt about ending up in his books. He implied that this was not a problem. It has become a problem. Judy Kantrowitz has investigated this dilemma in great detail. When I told her I have stopped including extensive clinical material in my writings because of the unresolved controversies it entails, she replied, “So have I.”

Shakespeare

One way I have gotten around this dilemma is to write about Shakespeare. Theoretically, this should be less controversial than writing about patients. But I have become fascinated with a surprisingly inflammatory area of Shakespeare studies—the investigation of Freud’s belief that the author of these pseudonymous works was Edward de Vere, Earl of Oxford. I now have 30 publications on this topic and the related issue of the psychology of pseudonymity. Like other authors who believe “Shakespeare” was a pseudonym (and front man), I was locked out of mainstream journals. So I published instead in “Oxfordian” journals. I was pleased that these articles have been listed in the mainstream World Shakespeare Bibliography. But I know I am preaching to the choir when I write for fellow Oxfordians. Since Freud was the first well-known intellectual to endorse the 1920 theory that de Vere was the real author, I felt that analytic journals would surely be interested in the growing evidence that Freud was right. Wrong!

Some editors of analytic journals rejected my submissions with the explanation that my article was better suited for a literature journal. Oddly, there was often a pattern where two peer reviewers were enthusiastically positive, whereas the third (a Shakespeare specialist) would condemn my article with such contempt that the editor would go with that minority opinion and reject it. I wrote one article with Roger Stritmatter, who earned the first Ph.D. in literature in the United States with a dissertation endorsing de Vere as Shakespeare. Our article was rejected so many times that I gave up on it. Invariably, though, Roger would ask me about its status, so I felt duty bound to send it out on yet another suicide mission. As a lark, I submitted it to an editor who had made his anti-Oxfordian bias well-known. I got the reaction I expected: “I take the anti-Stratfordian argument to be comparable to a belief in UFOs,” he wrote. “It is out of the question that I could accept your flight of fancy. You and I are not going to agree about this, but I have to tell you in all sincerity that you are in the grip of a delusional belief... I am sorry if I seem harsh, and I would treat all this very differently if I were responding as a clinician and not as a scholar. But you guys are asking me to take this seriously, and I have to tell you it’s hogwash.”

Oddly, this editor’s reaction provided just the energizing motivation I needed (yes, I’m a bit oppositional). I immediately sent it to yet another journal. In less than a month, that editor wrote that he had not yet heard from the second peer reviewer, but he and the first peer reviewer liked it so much they would publish it in their next issue. Although not all topics are as polarizing as the authorship of Shakespeare, any writer whose manuscript has been rejected should take heart from this story. One editor insinuated I might be in need of psychiatric hospitalization, whereas the next one “stopped the presses” to rush our submission into print.

Eventually, I started getting Shakespeare articles accepted by
leading English literature journals. That doesn’t mean, though, that they tolerated any openly “anti-Stratfordian” opinions. Instead, I acquiesced to an unwritten “don’t ask, don’t tell” policy that many of these journals seem to practice. They reject manuscripts that directly challenge the legendary author, although they do publish articles by Oxfordians and Marlovians (supporters of Christopher Marlowe as author of Shakespeare’s works) on the tacit condition that we remain silent about our authorship views. As Ann Louise Silver pointed out, being a male WASP was the tacit condition that we remain silent about our authorship of Christopher Marlowe as author of Shakespeare’s works) on the tacit condition that we remain silent about our authorship views. As Ann Louise Silver pointed out, being a male WASP.

Finally, a few words about the Academy. It has been consistently supportive of my clinical and literary work. I am a grateful example of the Academy’s wonderful tradition of reaching out to non-members. When I worked at Chestnut Lodge, my colleague Ann Louise Silver graciously encouraged me to submit papers for Academy meetings. I gave three papers at your meetings, including my first paper on Shakespeare. Similarly, your journal has welcomed four of my articles. Doug Ingram courageously took the risk of provoking heated controversy by publishing my article on The Tempest. I am most grateful to him and to Ann Louise Silver for that support—only the second time that an analytic journal had accepted an “Oxfordian” article from me. Organizations inevitably evolve over time. The Academy has a proud tradition of encouraging innovation and independence and I am grateful that it has supported this maverick.

Finally, what treatment recommendations do I have for PT-WSD? Seek lots of personal and collegial support. My wife Elisabeth P. Waugaman earned a Ph.D. from Duke in Medieval French Literature. She has been consistently encouraging with my work on Shakespeare and she often keeps track of the intricate details of the evidence better than me. Roger Stritmatter has been an invaluable source of guidance and encouragement since I first met him. Since its inception, I have taught in my institute’s New Directions in Psychoanalysis program. Its focus on writing has been of enormous help in stimulating my accelerating pace of publication. Finally, I hope that the vignettes I shared with you make it obvious that writers should not give up.

Oh—and what about that hunger strike? It still took a few weeks to get a decision from that journal. The joke was on me—they liked the trim version better than the wordier one—they even had me trim it down further after which they published it.

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 98 publications. His email is rwmd@comcast.net.

Framed Fantasies:
Improvisation in Music and Analysis

by Scott C. Schwartz, M.D.

This paper was conceived at the urging of and with appreciation toward the Program Committee, who felt that in New Orleans, there ought to be something in our program related to Jazz. I am not sufficiently conversant in the history or psychology of the women and men who composed and performed this music, and a great deal has already been written and researched on their lives, situations, and music in a magisterial way by Ken Burns and others. I would not feel qualified to add anything to their work. I do find a strong connection between one of the central elements of jazz, namely improvisation, and the therapeutic process, yet with some profound differences as well. Therefore this paper, called Framed Fantasies, looks at improvisation in music throughout the ages and in the psychoanalytic process, and contrasts the two. I am grateful to Silu Olarte, Jerry Perman, and others for inspiring certain ideas presented here.

Both music and verbal expression are characterized by a flow leading from one temporal point to another with the usual purpose of communicating a feeling or concept to an audience in order to elicit feelings or awareness. Both have as a fundamental rule a basic organization of the flow, following particular framing devices used according to the context.

Musical history can be traced and conjectured back to prehistoric times based on the design of instruments, many still being used in primitive societies today. Thus a bow, created for hunting, could be plucked to create a musical sound, the pitch of which could be changed by shortening or tightening it. By attaching a resonator like a gourd or turtle-shell, the volume could be varied, and such instruments are still in use today in the Fiji Islands. The elasticity of animal sinews led to the making of tunable strings. Reeds cut with lips and holes became flutes, while resonant rocks became gongs, and skins stretched over gourds served as drums. No specific records of musical practice have come down to us, but it is generally felt that musical tones were combined with words of praise to create hymns to the glory of a particular deity. Many references exist in the Old Testament to the use of instruments played to accompany such praise, from Miriam and her timbrel to David playing accompaniment to the Psalms. The psaltery (ancient musical instrument with numerous strings - Perman) derives from the word “Psalm” and was frequently depicted in Italian renderings of David. Egyptian wall paintings also show harps, and it is felt that even the Epics of Homer were accompanied by a harp or a decachord. Since there was no means of writing down a tonally consistent notation, we may conjecture that the words were sung improvisationally to a droned accompaniment.

This tradition of Epic singing over improvised grounds extends into the Romances of Medieval Europe, and can extend to the ‘Corrida’ of Mexico and the ‘Talking Blues’ of America, exemplified by the 60’s hit, “Alice’s Restaurant.” In liturgical music of many cultures, short congregational utterances were interspersed amidst the longer prayers or legends sung by the Celebrant. We see this in “Baruch Shmo’s”, “Amen’s” or “Al-leluya’s” in contemporary Jewish and Christian prayer. This may well have led to the Verse-Chorus concept, the verse often improvised, the chorus straightforward.
In order to give the music direction, notation was added beneath syllables, like Ta’amim, but these lacked specific tonality, and the Spanish Monk Domenico Cerone likened the Hebrew service to “Geese Cackling.” One might add that early Catholic Choirbooks up to about 1150 also lacked specific tonality, and one might wonder if such services sounded rather similar! Guido of Arezzo was the main force responsible for the creation of written tonality on a stave with specific pitch associated with a given note. This allowed tonal concordance amongst singers, but the notion of rhythm as a marked measure of time did not emerge in written music till the 13th century. We hear Gregorian Chants as freely rhythmic, depending on the breakdown of the text. With dance music and accompanied songs, a specific meter needed to be sought and, by the 13th century, notation was created to provide length of notes and, a little later, rhythmic measure. Since the time of the Troubadours, musical background accompanied poetic strophes, but though the words are often preserved, the music is often not. We can surmise that the music must have been improvised either using a monotonal drone or a particular melody that was repeated and varied by the performer.

In the 16th century, the picture of improvisation becomes more focused, based in part on the secularization of much music, the rise of Humanistic secular learning, and the change in education from apprenticeships to ‘distance learning’ through the diffusion of printed books. Many 16th century treatises teach not only improvisational techniques but show additionally how embellishment could be performed. Just as the “Ornament” developed into “Cadenza,” the “Divisions on a Ground” led to the “Theme and Variations,” still popular today. A set of notes or harmonies became the basis of improvising music often of a great virtuosity, and these sets of harmonies crossed national and cultural boundaries. The English ‘Greensleeves’ in Spain was called ‘Guardame las vacas,’ in France ‘Je voudrai mieux dormir seulette,’ in Italy Passamezzo Antico, and in Germany ‘Der BauersTanz.’

Slightly later harmonic frameworks include Pachelbel’s ‘Canon’, famous in its day and even more today because it is identical to “Puff the Magic Dragon” and “Don’t Think Twice, It’s All Right.” The I-VI-IV-V harmonic basis of Antonio Lotti’s “Vespers” and Bach’s “Suite #3” from the early 18th century forms the set of chords used in every “Golden Oldie” of the 50’s and many European popular songs. These chordal progressions differ from purely free improvisations, often used in the 16th century to check the tuning of strings and called “Tastar da Corde” (String test) having no particular harmonic basis, as seen in some free improvisations in modern jazz. The fact that the harmonies would have been well-known to players and to audiences allowed for emphasis on virtuosic variations, and the ability to dialogue tonally in coherent way.

This is mirrored in the Blues today, where the well-known progression of I-IV-I-IV-I chords allows us to appreciate the virtuosity of Stevie Ray Vaughn and the inventiveness of Eric Clapton, or the ability to sit with a total stranger, pick up instruments, choose a key and tempo, and interact creatively. This progression has been the backbone of more popular music than any other, and derives from the later 19th century American Black religious and traditional music. Its appeal lies in its indistinct major-minor tonality and boundless emotional expressiveness within a limited framework. As the great Bluesman B.B. King said, “You have to be very good chef to cook a great meal with limited ingredients.” The Blues, like the harmonies of Renaissance improvisation, are not songs in and of themselves, but are a frame into which fantasy can be injected.

The use of popular appeal is not limited to improvisational creativity. Another type of music, immensely popular and by definition opposed to improvisation arose in the 20th century as well: the jingle or singable hit. The idea of this music is to create an easily repetitive and accessible tune, devoid of complexity, and to be repeated in its pure form, without embellishment. A jingle should at best be immediately identifiable with its product and almost hypnotic in its ability to stay in your mind, almost a mantra. The music is designed to be carried with and hummed by the listener almost as a reflex. Immediate familiarity comes into play, but without the need or wish for any embellishment. At the extreme, songs like “Happy Birthday” or “Auld Lang Syne” or Las Mananitas” achieve universality with the caveat of singing them without any variation at all. Perhaps these could be likened to generalized self-help books and weekend mass seminars, providing accessible, simplified, generalized solutions.

The origins of Free Association are equally clouded in mystery, prior to the 19th century, and in like manner to musicology, we would have to conjecture about the purpose and methods in early times. Ruling out extreme approaches to mental illness like incarceration, ostracism, and exorcism, the bulk of early understanding and treatment was elaborated by clergymen rather than physicians. Melancholy, frenzy, and mania bridged the gap between the spiritual and the humoral. Almost all writers on the subject, including Thomas Wright, Edward Reynolds, Robert Burton, John Earle, and Thomas Elyot, were not physicians. Interestingly, most of them opposed the medical tendency (sadly still in vogue!) to use incomprehensible terminology, complex Latin references, and personal inaccessibility, and wrote widely available texts in English. Nicholas Culpeper, a naturalist physician who wrote for common people, was shot in the chest for his opposition to the medical hierarchy. A substantial portion of mental process was classifiable as spiritual and was of interest etiologically. Aside from the humoral understanding of Galen, writers looked into the “Passions,” the way people could pass from one mental state to another. Thankfully, both views moved away from the earlier view of Heavenly punishment or Demonic possession, leading to torture and burning alive to save the soul and prevent contagion.

If we approach the notion of spiritual fulfillment through religious study, almost every religion utilized meditation as a way of mental enhancement, and creating a state of trance was a strong ingredient since Classical Antiquity. Herodotus describes religious ceremonies on the island of Lesbos, where a certain plant was burned amidst the congregants, who inhaled the smoke and became “drunk as we do on wine.” The Delphic Oracles and Vestal Virgins achieved a trance-like state through the inhalation of hallucinogenic smoke. Incense in early Christian ceremonies might have served a similar function. People entering a medieval cathedral are quickly transported to a state of spiritual meditation by the darkness, the silence, and the severe yet symbolic
stonework, interrupted only by the rich colors of the stained glass. The addition of distant chant or organ music augments the other-worldliness of the experience. Both Painton Cowan and John James in their books on Cathedral design suggest that throughout the human growth cycle, caves represent a peaceful regression and mysterious anticipation of yet unknown mysteries. The obvious connection with a birth canal and the so-called tunnel we pass through after death could be in Jungian terms a collective unconscious awareness of the course of existence. A pilgrim entering a cathedral is struck by the darkness and the expansive size highlighted only by the distant glow of the windows in the chevet. The desired effect would be contemplation of God, the Universal Mystery, and the Direction of Life.

It would be useful at this point to differentiate the idea of a deepening awareness through meditation from the concept of support through verbal and emotional exchange, even though both exist in therapy and analysis. In the 1905 Introduction to Earle’s 1628 “Micro-Cosmography,” the point is made that in the 16th century the idea of exploring the world led to the study of the macrocosmos. In the 17th century, the emphasis moved away from the dramatic conquests of the previous years onto the understanding of the micro-cosmos – the internal world of the individual.

Though very little comes down to us from before the 17th century on the techniques of supportive therapeutic intervention, a central notion could be understood through the act of Confession. The owning, confronting, expressing, comprehending, and expiating of sin, all central to Confession, are pillars of Christian doctrine, and central to the foundations of all psychotherapy. Though specific techniques of conducting or amplifying the ritual are not specifically elaborated, we may make certain deductions from early art. The anonymity and detachment of the past two centuries are absent in medieval depictions, where the priest is shown sitting with and hugging the penitent sinner, who is stretched over his lap, consoled and mollified in his pain, similar to a child snuggling with his father.

The bonding and obvious support belie a closer, more personal relation, putting the priest into a more central emotional role than anything that happens in our modern age. This role, as in pre-marital counseling, would have been improvised and set up according to the need of the individual parishioners, probably known to the priest for years, as opposed to reductionistic “classes” given today prior to a wedding. It is possible that part of the growth of the therapeutic alliance could have become a substitute for the depersonalization of the Confessional Alliance. Since the 17th century beginnings of psychotherapeutic education, the idea of listening to the patient, following the process, making meaningful interventions, and being supportive have been curative elements in exploring psychic pain. Some authors provide “case examples” of interventions. Wright dealt with a mother’s grief upon learning of her son’s death in battle. Huartes approached a student who simply could not handle academic challenges, and Burton counseled a meek honest person edged out of a promotion by a shark. These pro-therapeutic responses are directed at specific types of problems, and show the reader how to approach them.

When Freud and Bleuler originally formulated the methods of analysis, they drew on a long line of relaxation techniques that culminated in the work of Mesmer, Charcot and others, always within a given improvisational framework, all of which is a coalescence of meditative and supportive approaches, and to a great degree are followed today. Central aspects of the framework are that (1) treatment occurs within a dyad of patient-therapist, (2) there is a pre-established place and time-frame, (3) there are parameters of behavior like screaming, taking things, payment, and acting out, (4) there is defined focus on the patient rather than the therapist, so personal issues of the therapist are not sought.

In general, analysis may be considered a more meditative pursuit than therapy. While both are used to rectify symptoms, analysis serves, particularly in a training analysis, to expand the understanding of self within the experience of life. In that regard, it can be said that analysis is oriented toward the prevention of problems, whereas therapy is more geared toward treatment. Given that framework, we can surmise that analysis can, with discipline, be carried on through meditative introspection, without necessarily requiring an external listener, just as musical improvisation can be performed alone, without an audience. Analogously, a book is written to be read by many whereas a diary is often locked and never shared. Both may be therapeutic in their creation, but the meditative is generally more intimate.

Great thinkers have always used self-analysis, from St. Augustine to Karen Horney. The presence of an audience changes the framework and therefore the nature of expression. Embarrassment, transference, feedback, and analyst facial expression absolutely influence the flow of material, yet at the same time can bolster safety, relief, and productivity. Similarly, the presence of an audience can easily induce stage-fright or performance anxiety, but it can also induce the musician to soar even more adventurously if a positive response is felt. In a well-flowing analysis, there can even be a harmonic, mutual free-associating between the patient and analyst, like a good improvisational duet, where each one resonates to the other’s creative surge.

In more problem-oriented psychotherapy, especially when medications are included, the presence of a guiding force to help in symptom reduction, providing alternate approaches to a blockage, or helping with concrete needs becomes more of a central focus. Here the external auditor, the audience, is the ruling force and vital to problem resolution. Improvisation is kept at a minimal level.

The fact that free expression is a central feature in improvisational music and free association establishes an immediate similarity between them. The fact that free improvisation is not disorganized cacophony and free association is not word salad or incoherence establishes a usable framing concept that makes them each communicative and meaningful.

Scott Schwartz is an Attending Psychiatrist at Kings County Hospital and Director of the New York Medical College Psychoanalytic Institute. Email is scottswartz829@gmail.com.
Birth of the Person

People of all ages live with other people and express themselves in conduct and communication. From the beginning, the developing person is an agent, one who acts, alternating as active and passive, giver and receiver, and increasingly aware of right and wrong. Action entails interaction, i.e., interpersonal action and communication, with or without words, to assure individual and social survival. The bond between mother and child as persons progresses from bodily contact and communication via touch and the other four senses to communication with words. In this process the infant learns about language and love, the foundation of all future interpersonal relationships, including the therapeutic one. Sullivan made “interpersonal” a household word and, like Sullivan, I use interpersonal as a reality and as a methodological concept, not a name for a psychoanalytic school. Interpersonal relationships is not a pleonasm, for we can have relationships with inanimate objects as well. As a therapist Freud was dyadic, or interpersonal (Lothane, Freud and the interpersonal, International Forum of Psychoanalysis, 1997; 6:175—184, 1997). As a theorist Freud was monadic and organicistic, e.g., in his libido and death instinct theories.

The person as agent creates a history, or story, his story or her story, about a life. That history contains events and incidents of dramatic action (from the Greek root dran, to act). Webster’s defines drama as “a series of events invested with dramatic unity,” e.g. the drama of war, or a family drama, as “situation or series of real events involving interesting or intense conflict of forces suggesting the characteristics of a play.” Thus real life dramas become fictional dramas, enacted by actors, i.e. those acting on a stage, with gesture and word, with costume and scenery; or screenplays for films and sitcoms, all of the above representing a story in action and dialogue. Shakespeare’s “all the world’s a stage, and all the men and women merely players” does not abolish the difference between real-life dramas and fictional dramas, but merely underscores their shared focus. In life we act ourselves or perform various professional roles; on stage actors impersonate the lives of others, which can also happen to people in real life.

For life dramas I proposed the term dramatology (Dramatology in life, disorder, and psychoanalytic therapy: A further contribution to interpersonal psychoanalysis. International Forum Psychoanalysis, 2009; 18:135-148) distinguishing it from dramaturgy, the art writing and performing written dramas. Dramatology also proposes a paradigm shift from narratology, the composing or telling of narratives. In 1982 Donald Spence extolled narrative truth over historical truth and claimed that the narratives created by the analyst cure the patient. I submit that dramatic truth is both inner experience and outer action and completes historical truth. Life dramas are primary and the stories made of them are secondary, whether the latter are first-person accounts or third-person biographies, or case histories. Narratives utilize description and may contain dialogue or may not; dramas are not descriptive and are all dialogue. The events and scenes depicted in narratives are visualized through imagination (Lothane, Imagination as a reciprocal process and its role in the psychoanalytic situation. International Forum Psychoanalysis, 16:152-163, 2007) and relived vicariously by the reader. Real life dramas and staged dramas are witnessed, usually with greater emotional resonance, and with catharsis or abreaction.

While medicine deals with monadic medical conditions of the body, psychiatry deals with interpersonal conduct in society. In spite of the current return to viewing neuroses and psychoses as brain conditions, what we call psychiatric symptoms are conducted: actions and communications that are interpersonal, from one person to another, or intrapersonal, thoughts and emotions directed to oneself. Ruesch & Bateson (Communication The social matrix or psychiatry, 1951) extended Sullivan’s ideas to “build a new psychopathology based on the criteria of communication.” My project is similar: to build psychopathology on dramatology. Sullivan differentiated between observation of the medical patient and participant observation of the psychiatric patient. Dramatology goes further: therapy is a participation in the patient’s real life drama and is itself a dramatic process.

Discovery of Dramatology

Returning to Vienna after a brief absence Breuer “found the patient [Anna O.] much worse. She had gone entirely without food the whole time, was full of anxiety and her hallucinatory absences [French] were filled with terrifying figures, death’s heads and skeletons. … As she relived these things, she partially dramatized [tragierte] them through talking, so that people around her understood their content” (1909, p. 20 my translation). Strachey translated the crucial word as “she acted these things through” (Standard Edition, 2:27, correcting the mistaken 2:26 in the original article). Tragieren is obsolete for composing and performing drama on stage, acting a role. Anna O.’s trauma of transient abandonment was enacted as a drama of terror, both consciously and unconsciously. Ten years later Freud’s Dora “acted out [agiert]… her memories and phantasies instead of reproducing them” (SE 7:119), strictly her transference, with little awareness of his own counter-transference. Today there is growing literature about reciprocal enactments, i.e., dramatizations, by patients and analysts.

Dramatization comes in three forms: 1. dramatization as embodiment, as above; 2. dramatization in thought: images and scenes lived in dreams, daydreams, and fantasy scenarios (dramatization was Freud’s name of the pictorial nature of dreams), accessible via free association and spontaneous recall of the past; and 3. dramatization in act: in real life scenes and situations of love and hate, faithfulness and betrayal, ambition and apathy, triumph and defeat, despair and hope, genuineness and make-believe, living and dying, and calling for here-and-
now clarification and confrontation.

In 1894 Freud held that distressing or incompatible ideas and emotions are defensively “sums of excitation transformed into something somatic, for which I would like to propose the name of conversion” (SE 3:49, Freud’s italics), couched in quasi-physiological terms. For George Engel (Mental Development in Health and Disease, 1962) conversion was a metaphor: when forbidden wishes, ideas, or fantasies are blocked, “they are kept out of consciousness [and] translated (‘converted’), not into words, but into some bodily activity, or sensation, which suitably represents it in a symbolic form. It is a token gesture, so to speak, which substitutes for the real thing. … A useful analogy for understanding of the conversion reaction is the game of charades. In this game one is asked to translate a verbal (cognitive) message into bodily terms, as pantomime, gesture, or other movements” to be guessed by onlookers (p. 369).

Freud lives on in DSM-IV: Conversion Disorders and in Somatization and Somatoform Disorders: “Conversion symptoms [of Conversion Disorders and Somatoform Disorders] are referred to as “pseudoneurological” … it does require that psychological factors be associated with their onset and exacerbation” (pp. 452-453). Such charades are also classed as histrionic personality disorder, from the Greek word histrion = actor, suggesting conduct striking or inappropriate, affecting an emotionalism deemed excessive or insincere, as “theatrical” and “melodramatic.” Dramatology is more charitable. From the perspective of dramatology, a hysterical paralysis is neither a genuine nor a pseudo-paralysis, it is no paralysis at all - it is embodied metaphor, it is behaviour of a person enacting or impersonating or dramatizing the imagined behaviour of a para-
lytic, a patient who frequents medical and psychiatric emergency rooms, inpatient and outpatient services, and private offices.

**Case Vignette**

Gwen was the eldest child of her prim and proper mother, who died of multiple sclerosis; and a loud, vulgar and adulterous father. Gwen’s brother was born when she was 2; and a congenitally deformed, mentally retarded sister when Gwen was 8. Mother “fattened her up” gave her enemas until age 15. Gwen remained emotionally tied to her parents until they died. Father was obsessively curious about Gwen’s sexuality and beat her brother with a belt, sometimes dragging him across the room. Brother called her a fat whale, tore the head off her favourite doll, tortured insects, drowned her kitten, and was eventually diagnosed with schizophrenia. He apparently died of starvation. Brother and sister, who apparently slipped from Gwen’s grasp, were her “big secret” and inhibited her ability to focus on what on what people were saying to her in the moment. She had to “burst the bubble” to reconnect with the world.

She would arrive at her sessions with scripted speeches filled with dramatic depictions of current calamities and crises, accompanied by descriptions of aches and pains in various parts of the body, which resulted in phone calls for extra sessions, which were never granted. She complained of dizziness when she felt angry with me.

At a start of a recent session, Gwen showed me a 1975 US Government telegram about her brother’s death. She then pointed to the flowers on my table, and the following (reconstructed) dialogue ensued:

Gwen: Where did you get these lovely daisies?

Dr. Lothane: These are not daisies, these are chrysanthemums.

G: No, they are not!

L: you are insulting my veracity! (my voice deliberately raised).

G: You sound like my mother, she would take it personally.

L: Why do you insist that these are daisies?

G: The best defense is a good offense. Of course, I knew these were chrysanthemums.

This mundane interchange illustrates interpersonal drama therapy. Gwen defended herself against the pain of anger at her brother and parents and also anger with herself, for having wasted so much of her life, unable verbally to challenge her parents, her brother, or her previous therapist. She also harbored anger at me for not having cured her yet. As in many previous incidents, Gwen’s behavior was infuriatingly perverse, deliberately denying the truth of her perception by calling my flowers daisies. She needed to be confronted with her talking without thinking of the consequences, a habit that repeatedly got her in trouble with people.

In this episode Gwen displayed her habitual stubborn contrariness and rebelliousness, and her demanding dependency. The enactment then led to how past character traits interfered with her performance on the job. Over time Gwen was able to give up dependence on all her medications, dispense with her defensive maneuvers, accept herself as she is, be more in touch with herself “in the moment,” and be more direct and forthright in communicating with people. In my work with patients like Gwen, I combine confrontation with “reality coaching,” which works on both a cognitive and emotional level. I teach patients social skills and psychological self-regulation.

In her own assessment of our work, Gwen wrote: “Dr Lothane uses humor and confrontation to let you reveal yourself. Since she was eight, Gwen nurtured an imaginary companion, a “foetus, enclosed in half an almond-shaped shell in my stomach, a healthy child to compensate my mother for my sister.” This imaginary scenario produced another fantasy: being split into a “good Gwen” and a “bad Gwen” and “living trapped in a plastic bubble.” This splitting of the self was insurance against “making mistakes or being angry. It was the dad Gwen’s fault. If you knew the real you would love me. This way no one could hurt me or abandon me.” In the course of free, association Gwen dramatized “birthing sessions,” complete with screaming, “the wet foetus leaving my body and soul forever.” These fantasies were her “big secret” and inhibited her ability to focus on what on what people were saying to her in the moment. She had to “burst the bubble” to reconnect with the world.
He sees through lies and self-deceit. He always listens with the “third ear.” He allows me to be aggressive and angry, to wish him dead out loud. He can talk in psychotic language and understands before I do what makes me tick” (modified from Lothane 2010, Dramatology: A New Paradigm for Psychiatry and Psychotherapy. Psychiatric Times, June issue, pp. 22-23).

In response to calling daisies chrysanthemums I was guided by my intuition of the right tactic, tact, and timing in favor of confrontation. Following my intervention she gave her associations: she was consciously and unconsciously imitating her mother who had a ritual of speaking in opposites, e.g., you are wearing a cotton blouse that was wool. Confrontation may sound combative or harsh, but, as Freud remarked, if you want to make an omelet you must break the egg. Confrontation creates a stronger sense of conviction for the patient (Lothane, 2010, Sandor Ferenczi, the dramatologist of love. Psychoanalytic Perspectives, 7(1):165-182). As the focus shifted from symptom neuroses to personality disorder and innovations in psychoanalytic characterology, thanks to Reich, Alexander, Kohut and Kernberg, confrontation becomes an essential complement to free association (Gabbard, G. 2009, Psychoanalysis and psychodynamic psychotherapy. In: Oldham, Skodol & Bender, eds., Essentials of personality disorders. American Psychiatric Press).

Confrontation is a way of pointing something out, of saying to the patient: look at what just happened and tell more. As such, confrontation leads to clarification: new memories emerge and a past episode or a long-standing character trait is illuminated. It is essential for making the patient aware of how she deceives herself and how she repeatedly wants to deceive the therapist, for defensive and emotional reasons such as covert triumph over the analyst or keeping a secret from him.

Conclusion

Interpersonal drama therapy is a new synthesis and paradigm based on the dramatic nature of interpersonal relations and can be helpful to professionals who do not limit themselves to practicing psychoanalysis - who can these days? - but who also practice psychodynamic psychiatry. The dramatic perspective facilitates observing the person as a whole gestalt, in all his particularity and the uniqueness of the emotional event, paying close attention to the facts of bodily appearance, dress, mental makeup, character, temperament, intellect, speech, culture and social status. Such observation precedes preparation of narratives and premature reaching for closure in diagnosing disorder, resistance, transference or any other formulaic interpretations. It opens the door for comparing the analysand’s and analyst’s interpretations, a source of learning for both. Dramatology and interpersonal drama therapy approach the two participants not as abstractions or generalities but as unique individuals in their aliveness, in their emotions, in their mutual need to love and to be loved in return.

In dramatic interactions patient and doctor are drawn into conscious and unconscious enactments which take both members of the therapeutic team by surprise and then offer considerable heuristic and healing value. Such enactments also transcend transference and counter-transference, which are determinations to be made after the fact of the enactment, nachträglich, as Freud said. Such enactments are inevitable. They pose no danger if both participants keep faith with the procedure, process, and principles of ethics and mutual responsibility. In the drama of the therapeutic encounter patient and doctor work as a team in search of love, justice, and truth.

---

Paradigms in Psychoanalysis

by Marco Bacciagaluppi

When we see patients we always apply scientific theories. Some are conscious and explicit, as when we believe we are Kleinians, Jungians or whatever. Others are implicit. In this paper I try to make explicit the scientific theories which I find useful in my work with patients. Others could add other theories. I call these theories paradigms, following Thomas Kuhn, who introduced this term in his 1962 essay, The Structure of Scientific Revolutions. (The University of Chicago Press, Chicago & London, 1962) Our practical aim is to integrate the paradigms after having made them explicit. In what follows I make these integrations explicit.

I list seven paradigms: neurobiology, attachment theory, the trauma paradigm, the relational model, the family system, Fromm’s psychoanalytic social psychology, biological and cultural evolution. They belong to different systemic levels. To use the distinction introduced by Max Weber and applied by Karl Jaspers to psychopathology (General Psychopathology, The University of Chicago Press, Chicago, Ill., 1963), the appropriate method to apply to the first paradigm is “Erklären” (explanation), whereas “Verstehen” (understanding) is the appropriate method for the other paradigms, though the two are often intertwined.

1. Neurobiology

The material in this section is based on Solomon and Siegel. (Solomon, M.F. and Siegel. D.J., Healing Trauma, Norton, New York and London 2003)

In the first year of life the brain is still immature. Myelination must be completed. Connections have to be established, both horizontally, between the two hemispheres, and vertically, between the cortex and subcortical areas which regulate emotion (the amygdala), memory (the hippocampus) and hormonal secretion (the hypothalamus). The right hemisphere, which is dominant during the first three years of life, is the seat of nonverbal communication; the left hemisphere is the seat of language and logic. This asymmetrical development is the reason why, in a double bind, the nonverbal message prevails. A crucial center of integration is the right orbitofrontal cortex, which, in particular, regulates the ANS (autonomic nervous system). It is also a higher center for the regulation of emotions. Finally, it enables a coherent autobiographical narrative. In front of a predator (integration of paradigms 1, 2, 3 and 7), the sympathetic branch of the ANS is activated. If there is no escape, surrender, freeze-
ing, catalepsy, sets in, mediated by the parasympathetic branch. Secure attachment ensures maturation (1/2). On the contrary, traumatic experiences, both neglect and abuse, lead to the interruption of integrative processes and thus to brain damage (1/3). Traumatic attachments inhibit the development of the right hemisphere. This leads to an inability to regulate aggression. The consequence is the development of the psychopathic personality, characterized by cold-blooded rage, and the borderline personality, characterized by hot-blooded rage.

On the other hand, the brain is also endowed with neuroplasticity. At the neurobiological level, psychotherapy leads to new neural connections and may even initiate the growth of new neurons. At the biological level, one more comment concerning genetic predisposition. A fundamental principle of genetics is that the phenotype is the result of the interaction of the genotype with the environment. In psychology, the first environment is interaction with the primary caregivers. If there is predisposition towards, let us say, bipolar disorder, this may lead to chronic hypomania in an optimal environment, but, in the case of severe trauma, a manic attack may ensue (1/2/3).

2. Attachment theory

The strength of Bowlby’s attachment theory (Bowlby, J., A Secure Base, Routledge, London 1988) lies both in the empirical method by which it was constructed (the direct observation of children, prospective longitudinal research instead of the retrospective method of psychoanalysis) and in the strength of the theories on which it is built: ethology, namely the study of animal psychology in natural conditions, and, behind that, the theory of evolution.

Among Bowlby’s direct observations, the most fundamental is the observation of the three phases in the reaction of a small child to separation from the mother, which may also be due to the mother’s emotional detachment: (1) at first there is protest, which is made up of anxiety and anger; (2) if separation continues, despair sets in, in which the anger of hope becomes the anger of despair, which corresponds to Fromm’s destructive aggressiveness; (3) finally, the child takes on a detached attitude, which is only apparent and covers up underlying and continuing despair. These direct observations at a clinical level should be integrated with the more minute observations of infant research.

At a theoretical level, Bowlby points out that the child’s attachment and the mother’s complementary caregiving behavior is an innate pattern which we share with all mammals (therefore, other species in the same class) and with many birds (another class). This pattern was selected in the course of evolution because of its survival value, which consists especially in the defense from predators. It is in our genes. The original environment in which this pattern evolved is called by Bowlby “the environment of evolutionary adaptedness” (EEA). Mental health can only arise from this environment. Any environment which departs beyond a certain point from the EEA gives rise to psychopathology (2/3/7).

Fromm distinguishes between sadism (the victim must be kept alive in order to be tormented) and necrophilia (the victim must be killed). We now live in an unnatural environment, like the monkeys in London Zoo cited by both Bowlby and Fromm. This leads to destructive aggressiveness, in which an important component is destructive envy.

Attachment provides a child with a secure base from which to explore. This formula includes two basic inborn needs: at first the need for attachment, and later for autonomy. In pathological families needy parents keep the child bound in a reversal of roles, in which both basic needs of the child are frustrated. Symbiotic families are thus created, characterized by the interaction of the frustrated dual basic needs of parents and children (2/5). Role reversal explains the violence exerted on infants. The needy parent who wants to be taken care of is confronted with the infant who is incapable of caring for the parent and, on the contrary, asks to be taken care of. This may cause destructive aggressiveness in the parent leading to the horrifying radiographs of fractured skulls and long bones in infants in The Battered Child by Helfer and Kempe. (Helfer, R.E. and Kempe, C.H., The University of Chicago Press, Chicago and London, 1968) (2/3)

This description of attachment theory is at a behavioral level. The theory also contemplates internal models of self and other.

Bowlby has provided the mother-child relation, highlighted by Ferenczi, with a solid evolutionary basis (2/4). With the interspecific reference he attains the highest systemic level of all, at least in the life sciences. Its temporal dimension is millions of years (2/7).

At a therapeutic level, sooner or later the vicissitudes of the primary relation emerge (“psychotherapy is a form of attachment relationship:” Solomon and Siegel, op. cit., p. 44), with various forms of insecure attachment, among which D-type (disorganized-disoriented) attachment, described by Mary Main in 1986 and leading to borderline pathology, is of primary importance. This type of attachment arises when the mother is unavailable at birth. This is the severest trauma (2/3).

Evolution did not foresee this event (2/3/7). The infant is unable to cope and can only react by disintegrating. The literature on infant research has disproved the existence of an autistic phase followed by a symbiotic phase in the course of normal development. (D. Stern, The Interpersonal World of the Infant, Basic Books, New York 1985) The infant is in touch from the very beginning and only asks to enter into a mutual attachment relationship.

3. The trauma paradigm

The material in this section is chiefly based on Judith Herman’s book Trauma and Recovery. (Basic Books, New York 1992)

Freud started his work with the childhood sexual traumas reported by his patients. Then, in 1897, he changed his mind and claimed that these memories were the product of fantasies. In this phase he developed essential instruments such as the method of free associations and the analysis of dreams. The importance of trauma was rediscovered by Ferenczi who, because of this, was excommunicated by the Freudian orthodoxy. After World War II psychic trauma was investigated in various fields. At present, PTSD (post-traumatic stress syndrome) observed in Vietnam veterans and incorporated into the DSM-III in 1980, is regarded as the paradigm of psychic trauma. This paradigm describes the consequences of psychic traumas due to multiple causes: war, natural catastrophes, detention in extreme conditions, the taking of hostages, sexual violence in women, and the psychic, physical and sexual abuse of children.

This is the category in which we are most interested as clin-
cians. Obviously, the distinction among various types of abuse in children may be useful for descriptive purposes, but actually also physical and sexual traumas are psychic. This is a typical sequence which serves to keep a child bound to the family (3/5): initial rejection-maltreatment-seduction. Another means to prevent a child from leaving is to discourage it when it is learning to walk (3/5). To use Bowlby’s paradigm: if a parent inflicts these abuses, instead of defending the child from predators, she/he becomes the predator. Since danger elicits attachment behavior, the child reacts in a paradoxical way: it clings to the very person who threatens it (2/3/7).

In order to show the importance of this paradigm at a clinical level I will describe the consequences of its failed application. Typically, the sexual abuse of a child in a family is surrounded by a wall of silence. If a patient with this past history goes to a therapist who neglects this issue, the traumatic residues which show in dreams, somatic symptoms and symptomatic behavior, will not be addressed. The patient therefore re-experiences the wall of silence. Instead of being cured the patient is re-traumatized. This sort of error may explain the failure of many therapies. If there was a trauma and it is not addressed, the therapy fails.

4. The relational model

Greenberg and Mitchell, in their famous book of 1983, *Object Relations in Psychoanalytic Theory* (Harvard University Press, Cambridge, MA and London, England), contrast the relational model in psychoanalysis with the drive model of orthodox Freudians. The relational model originated with Ferenczi, who was the first to claim the primary nature of the mother-child relationship. His influence was exerted on both sides of the Atlantic. In Britain, both directly through the Balints and indirectly through Melanie Klein, Ferenczi was influential in giving rise to the object relations school. In the United States, thanks to Clara Thompson who was analyzed by him, and to Fromm, a great admirer of his, Ferenczi was influential in giving rise to the interpersonal-cultural school (Sullivan and Fromm). All these authors may be defined relational in a wide sense. Later, Mitchell himself, together with others, gave rise to the relational school in the strict sense.

All relational authors view the therapeutic relationship as an interaction between two participants, each of whom brings her/his past into the relationship, thus giving rise to transferential and countertransferential phenomena. In the therapeutic relationship the patient’s past is re-experienced and corrected, not only through what Greenberg (Greenberg, J.R., *Prescription or description: therapeutic action of psychoanalysis, Contemporary Psychoanalyis*, 17, 239-257,1981) calls “participation with” by the therapist, namely empathic participation, but also and especially through “participation in,” namely the therapist’s temporary identification with figures of the patient’s past, due to the therapist’s predisposition based on past experiences (today this is called “enactment”). In any case, the starting point of the therapist’s interventions should always be what the therapist feels.

I find it useful to widen this dyadic view to David Malan’s “triangle of person.” According to Malan, who deals especially with brief psychotherapy, in every session attention shifts among three sets of relations viewed as the three vertices of a triangle: current relations outside therapy, the relationship with the therapist, and past relations (I find it useful to distinguish between the distant and the recent past). (Malan, D. and Osimo, F., *Psychodynamics, Training and Outcome in Brief Psychotherapy*, Butterworth-Heinemann, Oxford 1992, p. 34, Fig. 6.1)

Up to the ‘90s, what relational psychoanalysis lacked was integration with the trauma literature. This was accomplished in 1994 with *Treating the Adult Survivor of Childhood Sexual Abuse* by Davies and Frawley (Basic Books, New York 1994), that addresses female trauma, and in 1999 with *Betrayed as Boys* by Richard Gartner (The Guilford Press, New York & London, 1999), that addresses male trauma.

5. The family system

Von Bertalanffy’s general system theory provides a description at various levels of organization. It is a formal description to which we must add tangible content. The therapeutic relation may be described as an asymmetrical dyadic system, to which both participants bring their membership in a family system, in which they play a certain role and the rules of which they obey.

The family system is one level higher than the dyadic system. The systemic family level has been studied especially by Mara Selvini Palazzoli, who initiated the Milan School of Systemic Family Therapy. (Selvini Palazzoli, M., Boscolo, L., Cecchin, G. and Prata, G., *Paradox and counterparadox*, Jason Aronson, New York 1978) There are then supra-ordinate systemic levels, such as the socio-cultural level.

Many other family therapists have made clinical observations and developed theories that have value for individual therapy: Minuchin, Boszormenyi-Nagy and others. I find Helm Stierlin’s concept of “Bindungskraeft” (binding forces) of special value. From it I have derived my own concept of multiple binding mechanisms, where binding refers to the family. (Bacciagaluppi, M., 1989, *Attachment theory as an alternative basis of psychoanalysis, The American Journal of Psychoanalysis*, 49(4), 311-318) Another important contribution from this literature is the concept of transgenerational transmission, also present in attachment theory (2/5).

From all this tradition, at a clinical level I find the idea of “systemic move” (with reference to Selvini’s approach) or “strategic move” (with reference to the Palo Alto approach) of special value. This is something new, unexpected, a move which the therapist makes, or that the therapist advises the patient to make, and that unlocks a rigid and repetitive situation.

6. Fromm’s psychoanalytic social psychology

This paradigm addresses a systemic level higher than the family, namely the socio-cultural level. According to Fromm (Fromm, E., *Escape from Freedom*, Farrar & Rinehart, New York 1941), every society tries to reproduce itself by creating the suitable character structures in individuals. This is the social character, made up of traits common to the majority. In creating the social character society makes use of the family as an intermediate agency.

A clinical example everyone is familiar with is emotional detachment, which is the social character of modern society. The hyperactive executive, entirely devoted to an alienated job, in order to function well must be detached from his emotions and from emotional relations. This character is normal in a statistical sense and pathological in reference to basic human
Beginning the treatment

The first dream he brought into therapy after the second session was: “I am in a crowd. I have to go on a journey, but I lose my bag and become anxious.” He told me that he often dreamt of a crowd. He got the sensation of a child, now a man, who had not lived his own life. Each time he tried to catch a train he missed it. At the outset, two pieces of behavior were significant. In the first few sessions he could not tolerate the distance between our chairs – an acceptable distance for my other patients. He assumed that the arrangement of the furniture was an attempt to keep him at a distance. He firmly pulled his chair up close. Secondly, in the course of a phone call, he garbled my name and called me “Dr. Puritan.”

During the sessions he withered, rubbed his abdomen, bent over with cramps. At times he was half-conscious. He also asked me to tell him if I planned to go on a trip, so that he could foresee what would happen.

History

The history of this patient as a child is like something out of Dickens. Like Oliver Twist, Mr. F. was born in the wrong place. His disorganized personality was the result of multiple pathogenic factors. There may have been a constitutional predisposition, for there was bipolar disorder in his forebears. He described his mother as having been detached. Next to an inadequate relationship with his mother, the family environment was characterized by violence. Mr. F. was born into a promiscuous peasant family, where many sons and daughters with their families lived together. The patriarch was the despotic paternal grandfather. The aunt was “a sadistic witch who tormented children.” The uncle was deeply depressed. The socio-economic structure, based on the exploitation of land and people, created a hostile environment, human needs for relatedness and love were ignored.

When the patient was six, things took a turn for the worse.
He was obliged to assist his grandfather in his daily dealings with customers. His grandfather had lost his voice and was no longer able to carry on his commercial activities. He kept the child on his knees as if he were a puppet. His grandfather emitted distorted sounds reproduced by an amplifier that were incomprehensible to onlookers. The child had to translate these sounds to the customers. The content of these communications was of no interest to the child, but he was obliged to transmit them accurately. If he happened to misunderstand, the grandfather would beat him on the legs, and the child had to redouble his efforts. This task was a burden, but it ensured the grandfather’s protection.

However, since he was only six years old, he soon wished to escape his bondage. The role he was expected to perform was too far removed from what he felt. In order to bear his situation he began to develop a parallel fantasy life. On summer afternoons, from the window of his house, he could hear children playing in the fields. He was stimulated to join them. As he caught sounds and voices, as in a story by Proust, he imagined being in other places, apart from his real experience. He thus became able to direct his attention to a multiplicity of perceptual stimuli.

In moments of respite, our mind may wander and we may have day dreams. But in Mr. F.’s case, this led to the creation of subpersonalities. Fantasies and daydreaming organized his thinking. This became a habit about which he did not criticize himself and that led to constant, autobiographical, consoling narratives.

These were not the only real traumas endured by the patient. When he was seven he suffered sexual abuse from a man. This was consistent with the exploitative family style. In therapy he reported explicit homosexual desires. He felt attracted by coarse men, like those who had exploited him. He was attracted to the idea of being possessed. This was in keeping with his early experience. Those who dealt with him exploited him by possessing his body, like the grandfather who kept him on his knees. The emotionally detached mother left him in the hands of predators.

At around ten he started having obsessional thinking concerning his intestinal functions. He feared catching infections especially from the toilet. He always took toilet paper with him to school because he worried that, if he did not find it there, he would not be able to clean himself. He also had selective eating habits: he was afraid of suffocating and dying on account of indigestible food. During adolescence, after the sexual abuse had ceased, he had spells of depersonalization that allowed him to keep his anger and despair at a distance.

At twenty he found a job as a traveling salesman. This allowed him to be always on the go and to deny his failure of self-realization. Fast forwarding, after retirement he went back to live with his parents and attempted to establish an emotional network. As with combat survivors, he was seeking social support. However, his family had few social contacts and he himself was introverted and had difficulty in creating a network. This led to a life of extreme isolation. He became severely depressed to a psychotic degree.

Shortly after, he approached occult science and became a fortune-teller. This new role had an antidepressant function. It allowed him to anesthetize pain and despair. He specialized in the diagnosis of illness and the ability to forecast the future. In his trance-like states he had mainly visual experiences.

After he endured a loss, his dissociation became more severe. He told me that when his depression worsened he started to interact with his intestines. He invented stories about his intestines in which they spoke to himself and to me. In the course of therapy, this ventrilouquistic activity abated and was replaced by a longing for purity.

**Discussion**

The discussion will focus on the patient’s choice to become a fortune-teller. From the very beginning I considered a diagnosis of dissociative psychosis with depressed mood. In his altered states of consciousness he developed a hypersensitivity. The quality of his psychic functioning then led him to the paranormal. The ideology of the occult justified his irrationality.

His first trauma was a rejecting mother. According to Mary Main (Main, M. and Solomon, J., 1986), this can lead patients to develop an insecure-disorganized/disoriented attachment pattern. (In: T.B. Brazelton and M.W. Yogman (Eds.): *Affective Development in Infancy*. Norwood, NJ: Ablex), referred to as a D-type (disorganized/disoriented) attachment. Self-experience depends on the presence of the caregiver. According to Main, if the caregiver is absent, the infant experiences psychological annihilation. Infants who survive deny the caregiver’s malevolence through a narrowing of conscience. This defense reduces the capacity to reflect on one’s mental states.

To this traumatic experience in infancy was added the grandfather’s exploitation in childhood. In this situation the patient developed the capacity for dichotic listening as discussed by Bowlby (Bowlby, J., 1980, *Attachment and Loss, Vol III, Loss: Sadness and Depression*. New York, Basic Books, 47-9) and that presumably strengthened the dissociative tendency. Consciousness, the patient fixed his attention on the grandfather’s utterances, with the aim of reporting them faithfully. At the same time he listened to the sound of the children playing. These sounds were encoded in short-term memory and fuelled his fantasies. This situation is an example of Lenore Terr’s Type II (repeated and prolonged) trauma (Terr, L.C., 1991, Childhood trauma: An outline and overview. *American Journal of Psychiatry* 148:10-20) that, according to Judith Herman, leads to complex PTSD (Herman, J.L., 1992, *Trauma and Recovery. From Domestic Abuse to Political Terror*. New York: Basic Books. 119-20).

Finally, the sexual abuse at the age of seven is an example of Lenore Terr’s Type I trauma (a circumscribed trauma leading to simple PTSD).

A picture of multiple traumas, typical of pathological families, thus emerges.

In his trance-like states the patient’s experience was mainly visual. This calls attention to trauma-related alterations in the CNS. According to Van der Kolk (Van der Kolk, B.A.,1988, The trauma spectrum: the interaction of biological and social events in the genesis of the trauma response. *Journal of Traumatic Stress*, 1, 273-290), high levels of stress hormones produce a return to sensory modes of early life. The summoning of illusory figures was an attempt to find security, in the absence of secure parental relationships.

Later, the need emerged to feel special and identify with holy figures. According to Herman (op. cit.), abused children often have the need to feel special. The aspiration to purity protected Mr. F. from the experience of a filthy intestine-self, into which the people who exploited him discharged their needs. These
very people, especially the grandfather, stimulated his talent for dissociation.
The phobias in preadolescence protected the patient from psychogenic fragmentation. His discontinuous and fragmented self-experience gave rise to an identity disorder due to multiple and successive relational traumas.

What singles out Mr. F.’s psychopathology is the strategy he found. The profession of fortune-teller led to a stable self-image. His therapy sessions provided him with a continuity of experience such that he did not have a problem reconstructing his daily life. Also, his immersion in the unconscious during trance states had a stabilizing effect. Janet’s studies on hysteria (Janet, P., 1898, Névroses et idées fixes, I; Paris: Félix Alcan) and those by Hans Bender on paranormal phenomena (Bender, H., 1984, Umgang mit dem Okkulten. Freiburg i. B.: Aurum) have confirmed the tendency, in altered states of consciousness, to create dissociated personalities which prevent psychotic fragmentation. Finally, the feeling of belonging to the world of the occult was a form of social adaptation. It was a magical and illusory alternative to a real-life self-realization.

It is appropriate to report how the patient recalled the memory of his sexual abuse. Before coming to me he had undergone hypnotic treatment. The memory was recalled during hypnosis. The retained memory was split off. That therapy, unlike Freud’s early therapies, did not entail an emotional discharge, but only allowed the recovery of information. The patient reported the incident without affect, as if it did not concern him. Emotional detachment is a defense against unbearable traumatic events (Herman, 1992, op. cit.). In his early work, Freud described the pathogenic effect of the affects connected with trauma. In The Etiology of Hysteria, Freud (Freud, S., 1896, The Aetiology of Hysteria, Standard Edition, Vol. 3) claimed that the origin of neurosis was to be found in childhood sexual traumas that had harmful and enduring effects on the psychic life of the victims. Patients’ symptoms displayed dissociated features of the traumatic experience. Freud’s early discussion is therefore highly relevant to the case of Mr. F.

Conclusion of the treatment

Notwithstanding the patient’s defenses, the discontinuity of self-experience produced great anxiety in him. I was helped in trying to hold him (Winnicott, D.W., 1965, The Maturation Processes and the Facilitating Environment, London: The Hogarth Press) through my conscious fantasy that in every session I was holding a new-born baby. According to Ferenczi, “it was not enough for the analyst to observe and to interpret; … he had to be able to love the patient with the very love which the patient had needed as a child” (Fromm, 1960, Psychoanalysis and Zen Buddhism. In: D.T. Suzuki, E. Fromm and R. De Martino: Zen Buddhism and Psychoanalysis. New York: Grove Press, p. 111).

Treatment addressed Mr. F.’s basic needs. He asked to be accepted and protected. There was no real protection in the illusory world he had built to avoid uncanny experience. In that world there was no protective figure. I “held him” to allow hope and trust within the context of a caregiving relationship.

In one of the last sessions Mr. F told me a secret. “I want to tell you something I never told you,” he said. “For some time I have had a fantasy. I meet the extraterrestrials and make friends with them. They give me a crystal magic wand. However, I do not use it. I keep it until the time comes to use it. I had this fantasy up to a short time ago.” I said: “When you were small you wanted to be stroked by your mother and father, so that everything would be all right.” He smiled and pulled his chair nearer. This behavior should have warned me of his difficulty in accepting separation.

We were approaching summer vacation. I told him that we would be interrupting the sessions for four weeks. During his final session, he thought of people who minister to those who suffer: doctors, psychologists, priests and saints. He claimed that their vocation, when authentic, would have led them to stay near the suffering one.

He was not able to stand the long vacation separation. He never came back.

I saw this patient six years ago. Retrospectively, therapy was characterized by caregiving and holding, but the patient did not succeed in overcoming the experience of the summer vacation, that presumably reproduced the trauma of initial rejection. I should have arranged for telephone appointments during the vacation. The sound of my voice would have provided an analogic type of communication ensuring closeness.

Dr. Palmitessa is a member of OPIFER, IEFS, and IRFP. Her email address is costanzapalmitessa.palmitessa@gmail.com.

BOOK AND FILM REVIEWS

A Comprehensive Dictionary of Psychoanalysis
Reviewed by Richard D. Chessick, M.D., Ph.D.

In a fifty year career I have written literally hundreds of book reviews, but this is the first I have ever had to begin with a disclosure in the interests of honesty. I did an enormous amount of work in preparing for this review and read through this dictionary from cover to cover, a process which took many hours of concentrated reading. Perhaps this was a mistake, because I became aware that on many of the pages and on a great many subjects Akhtar refers to his own publications. As one reads through the dictionary it becomes increasingly irritating, or at least it irritated me. A second source of irritation is his habit of referring to the politically important people in our field as “prominent” and “luminaries” and the like, which, it seems to me, does not belong in a dictionary. In fact he is the most incredible name-dropper I have ever read and there are many definitions in which he just gives a long list of names without giving any references at all. For example, under “ego psychology” he writes,

The most prominent representatives of the ‘ego psychology’ (sic) however, include Jacob Arlow, Charles Brenner, David Beres, Martin Wangh, Humberto Nagara, Paul Gray, Steve Levy, Lawrence Inderbitzin, and Fred Busch in North America. (p.91)

It is difficult to understand how this helps to define ego psy-
chology, which is the task of a dictionary. The most spectacular name dropping I have ever seen is in the item “Development” (p.76) in which he drops 29 full names (without references). As I review this and other various problems with the book I will give at least one example and then note the items and the page numbers of many others.

On the back cover of this elegant book there are superlative praises for Akhtar’s book by Campbell, (U.K.), Nosek, (Brazil), Kernberg, (U.S.A.), Dalewijk (Holland) and Canestri (Italy) – a “monumental achievement,” a “magisterial compendium,” and so on. Indeed, from all of the above mentioned features I got the impression that the title of this dictionary should have been “Paean to Doctor Salman Akhtar.” Clearly Akhtar is a very smart man and extremely industrious in producing not only many psychoanalytic books and papers but also “six collections of poetry” (p.vii); it is unclear if these are his poems or by others, or both. The 47 Akhtar references listed in the dictionary are brought up on many, many topics. As I went on in reading the dictionary I became puzzled that the only reference to my 17 books and 300 publications in professional journals in our field was to none of these but to a book review in which I said the book was too heavy. Ay, there’s the rub! (Hamlet III,1,65). And it rubbed harder as I read on through many topics that I have written about. So because of this narcissistic wound I have tried especially hard to read it carefully and judge this book fairly.

Most important, the definitions in this dictionary are usually of high quality and there would be no objection from me if the reader turned to them to get information, and that of course is the main purpose of a dictionary. Doctor Akhtar obviously has an interest in inter-cultural matters because numerous topics from this area are included.

There are a number of personal remarks and oddities which seem to represent some attempt at humor and some attempt at expressing his political views. Probably the most annoying comment is on p. 293, where we are told that one of the sources of “Transgenerational transmission of trauma” is “the current American pillage of Iraq.” (also see remarks such as “God rest her soul” in “Bad-enough object” [p.33], a poor pun in “On castropheilia” [p.44], a derogatory reference about the French in “Interpersonal psychoanalysis” [p.151], and what he considers an amusing remark by George Groddeck (one of my heroes among the psychoanalytic pioneers) without considering what Groddeck had in mind, in “Pseudo-sexuality [p.226])."

Some of the items are simply unclear, for example, “Ganesha complex” (p.119), and there are a number of others I had trouble with understanding, or comprehending, or even taking seriously for various reasons (“Escape into reality” [p.98], “Generational filiation” [p.120], “Geopolitical space” and “Geopsychoanalysis” [p.122], “Homovestism” [p.132], “Multisensory bridges” [177], the long last sentence under “Narcissistic fantasies” [p.180], “Narcissistic state of consciousness” [p.182], the very condensed item “Negation” [p.185], the indefinite term “Neuropsychosynthesis” [p.187] (the first sentence of this item is a gem of trivia), and “No-entry defenses” [p.189]). We are also told by Akhtar that “the Western mind in general…abhors non-existence, not to say longing for it” (p.189). Perhaps that will be the subject of his next book, but does it belong in a dictionary? There is a huge philosophical literature, both eastern and western, on “non-existence.” I also found the items “Psychic genera” (p.228) and “Race and transference” (p.238) to be especially controversial and confusing.

There were a small number of items about which I simply disagreed with Akhtar, for example in “Instinct theory” on p. 148 and also on this in several other places, where he keeps writing about Freud’s “two” dual instinct theories by which he means the first and the fourth. The intermediate two instinct theories of Freud are simply left out. This is the first time I have seen that omission anywhere, certainly not in the standard texts. That item, by the way, is made even more confusing by the Akhtar reference included in it at the end that he labels a “tongue-in-cheek statement.”

The item “Universal dreams” on p. 301 actually contradicts itself. Akhtar begins by correctly telling us that the “meanings of a dream can only be deciphered by knowing the dreamer as a person and listening to his own thoughts about the dream.” He then goes on to give us seven universally experienced dreams and an analysis of the meaning of each of these dreams. By the way, his interpretation of falling dreams might be strongly contradicted by Kohut (I did not see Kohut mentioned anywhere as a “luminary” or “prominent” psychoanalyst; perhaps I overlooked it). Kohut’s views are not noted in the item. There is a foolish debate listed on p. 192 over Bion’s term “O.” Three explanations (one of them Akhtar’s of course) are offered as to what might have been in Bion’s mind when he came up with that term. The explanations are very fanciful and really have nothing to do with defining terms in a dictionary nor is it at all possible to know what Bion had in mind since he is not around to tell us.

On p.99 under the item “Evenly suspended attention,” Akhtar tells us that the “highly respected Charles Brenner” writes that “those analysts who still believe that evenly hovering attention is the proper analytic attitude are, I believe, mistaken in citing Freud in support of that belief.” This is highly controversial and I think Akhtar presents it as if it had been finally decided, the kind of mistake Bacon in the 17th century labeled as based on “idoles of the cave.” He finds it necessary under the item “Psychosomatic disorders” (p.233) to tell us about McDougall’s optimism that for patients with psychosomatic disorders, “Analysis can overcome their affect intolerance, dissolve bodily symptoms, and replace them with transference affects” (pp.233-234). He tells us that she has made “significant contributions to this realm,” but I do not think this is one of them. As it stands her claim is very misleading and it is the kind of claim that led psychoanalysis into great trouble in the middle of the 20th century.

There are a number of really excellent definitions offered, two of which are the items on “Death instinct” and “Death instinct reformulated” (pp.67-68), a topic that I have written about at length, but my references are not cited. There are other unusually good definitions, such as on “Affect” (p.7), “Depletion anxiety” (p.74), “Envy” (p.96), “Factor C” (p.103), “Hanuman complex” (p.128) - although I don’t know why it is called a “complex” or what it has to do with psychoanalysis, “Mutual analysis” (p.178), “New object” (p.188), “Other” (p.200), “Perverse defenses” (p.208), “Therapeutic alliance” (p.285), “Therapeutic misalliance” (p.286), “Unconscious fantasy” (p.299), and perhaps most important of all, “Unitary theory” (pp. 300-301). So the book certainly has value and is worth consulting although it is extremely ambitious and there are other dictionaries that are already available. In my opinion it certainly is not a “classic reference book” as the back cover notes, but it might become one with thorough revision and editing.
That leads to my main complaint about the book, which is directed to the copy editor of Karnac publishers. It is inconceivable to me that a reputable publisher could have gone over this manuscript and not found the printing errors that are present on p. 17, 68, 87, 98, 167, 185, 195, 289, and 302. On p.23 George Pollock’s name is spelled wrong although it is correct in the list of references. Furthermore, the copy editor should have realized that sometimes Akhtar in listing his references refers in the manuscript to the full name of the author and at other times, as is usually the custom, to just the last name. The most striking example of that is on p. 233 where the item “Psychosexual theory” contains some last name only references and the following item, “Psychosis”, contains many first- and-last name references and then the next item on “Psychosomatic disorders” again gives a combination of some first name references and some first-and-last name references. Where was the copy editor? Some of the items in the dictionary have no references at all and simply seem to be the opinion of the author.

The book would have been enormously helped by an author index showing on which page each author is cited so that someone interested in the work of a given author could find those items where the author has contributed.

There are also a number of really trivial items included that could have been easily skipped, such as “Civilizing influence of the daughter” (p.47) which is dubious to say the least, “Geopolitical space” (p. 122) which seems to have nothing to do with psychoanalysis, “Hyphenated identity” (p. 134), “Anagogic interpretation” (p.13), “Autochthonous cosmogony and alterity” (p.30), which is overwhelming in complexity, “Need gradient” (p.184), and “Wound of return” (p.310).

I did not appreciate the reference to Margaret Mahler on p. 30 where, we are told, the editors of Mahler’s selected papers, published while she was still alive, referred to a “quasi-autistic daughter” (p.47) which is dubious to say the least, “Geopolitical space” (p. 122) which seems to have nothing to do with psychoanalysis, “Hyphenated identity” (p. 134), “Anagogic interpretation” (p.13), “Autochthonous cosmogony and alterity” (p.30), which is overwhelming in complexity, “Need gradient” (p.184), and “Wound of return” (p.310).

People who are interested in psychoanalytic theory are usually quite fascinated with the period of time in which these ideas emerged and the people who developed them. Therefore a book of photographs of these people taken by one of them should be a valued treasure. This must have been part of the impetus that led the editors to put together this book which is supposed to be the first of a series of publications by the Boston Psychoanalytic Society and Institute based on material from their archives.

The photographs span the time period between 1932 and 1938. These are photographs taken by Edward Bibring at the 12th IPA Congress in Wiesbaden in 1932, the 13th IPA Congress in Lucerne in 1934, the 14th IPA Congress in Marienbad in 1936, the Vierlandertagung (which was a meeting of analysts from the four Central European countries) in Budapest in 1937 and the 15th IPA Congress in Paris in 1938 as well as some miscellaneous photographs. Biebring used a Rolleiflex, which is a small camera that allowed candid pictures. It produced a nearly square format and the pictures in the book are all 4 x 4
½ inches, in black and white of course.

Individual portraits were not the main theme of the book but there were some excellent head shots of Ernest Jones, Max Eitingon, Abraham A. Brill, Sandor Ferenczi and Sandor Rado at the beginning of the book. There also is a self portrait of Edward Bibring which appears on the cover of the book. It would be quite easy to obtain very good individual pictures of other subjects by editing the pictures where there was more than one person in the photograph.

Most of the photographs are groupings of people. While there are some in which all are smiling at the camera or eating food together, most show the subjects engaged in conversation with each other. Perhaps it is my imagination but it appears that they are intensely involved with their discussions. I wish I could know what Anna Freud and Melanie Klein were talking about (perhaps they were discussing their disagreements about psychoanalytic theory).

There were many excellent photographs of various people with Anna Freud and one of her brother Martin Freud, the eldest son, standing by himself. There were no pictures of Sigmund Freud and I can only assume that he did not attend these meetings although I do not know for sure.

Although I did not do a count, some people were in many more pictures than others. Max Eitingon, President of the 12th IPA Congress, and Ernest Jones, President of the 13th and 14th IPA, were in various photographs with many different people. Marie Bonaparte seemed to get around and was in many pictures. Understandably, Grete Bibring, wife of the photographer and also an analyst was amply represented. There were many other well known names and some of their spouses. They were all dressed in the fashion of the times with many of the men wearing vests and hats and the women in long dresses.

There was a particularly endearing picture of Helene Deutsch sipping a tall drink with a straw while Heinz Hartmann sits next to her with his arm draped around her chair, smiling at her with a cigar in his hand.

The last 30 pages of the book were short biographical sketches of many of the subjects in the book. This gave the reader not only a thumbnail view of the individuals but reflected the professional interactions of the times. It was very interesting to also see how the spread of the Nazi regime impacted on the people involved in the psychoanalytic movement.

There were many photographs of a woman named Vilma Kovacs about whom I knew nothing and was not included in the biographical sketches. A good book will often stimulate further thinking and I became curious about the role she may have played. I could not find any reference to her in the Ernest Jones or the Peter Gray biography of Freud where just about everyone else in the analytic movement seems to be listed in the index. I did track down information about her with an Internet search (International Dictionary of Psychoanalysis by the Gale Group, Inc.) that I will summarize below to give an example of the lives and contributions of the extraordinary people who were photographed in this book.

Vilma Kovacs-Prosznitz, the Hungarian psychoanalyst, was born at Szeged in Hungary on October 13, 1883 and died in Budapest in May 1940. She was the third daughter of a provincial bourgeois family and her father died while she was still very young, less than six years old. The family found itself destitute, and Vilma was married at the age of fifteen and against her will to a cousin, Zsigmond Székely, who was 20 years older than she. By the age of 19 she was the mother of three children. Alice, the eldest, later married Michael Balint. Vilma contracted tuberculosis and had to spend prolonged periods in a sanatorium. It was there that she met Frédéric Kovács, an architect, whom she married after a difficult divorce that separated her from her children for several years. A serious case of agoraphobia led Vilma into analysis with Sándor Ferenczi. He was quick to spot his patient’s talents and during the 1920s he trained her as a psychoanalyst, making her one of his closest collaborators.

In 1925, Vilma Kovács became head of the training committee. A highly reputed training analyst, she organized the Hungarian Psychoanalytic Association’s clinical seminars and along with Sándor Ferenczi she elaborated the Hungarian training method: the candidate’s analyst supervises the candidate’s first case on the couch. Vilma Kovács’s work related almost totally to training. Practically every Hungarian analyst of her time frequented her clinical seminars at one time or another. More specifically, she analyzed Imre Hermann and Géza Róheim. She published only five articles, but one of them, Training Analysis and Control Analysis (1935), is a classic of psychoanalytic literature and has been translated into several languages. In another article, Examples of the Active Technique, dating from 1928, she provides a remarkably clear presentation of this technique that her mentor, Sándor Ferenczi, had just introduced, illustrating it with several examples. Through her clear-mindedness, her remarkable clinical sense, and her organizational skills, Vilma Kovács left a profound mark on the Hungarian school of psychoanalysis.

I have two suggestions for future editions of this book or similar types of publications of historical photographs. It would be useful to have an index so that people of interest can be easily located. Also it would be helpful to have an accompanying DVD of digitalized photographs so that when we write about these people in the future we can to pull up these wonderful photographs and continue to share these images with future generations.
Freud
By Jacques Sedat
Translated by Susan Fairfield
Other Press, NY 2005 pps 166 [paper; $23.00]
Reviewed by JoAnn Elizabeth Leavey, EdD

Originally a neurologist and later a psychoanalyst, Sigmund Freud sought to evolve the scientificity of psychoanalysis into the literary realm by crafting his case histories into the “story” format. He created his patients’ distinctive histories through an understanding of their unique psychic activity, utilizing attributes of both the analysand and the analyst: Freud viewed the person’s history in analytic terms rather than through a history of her symptoms. In essence, Freud rejected the idea that psychic distress resolves around the physician and her interpretation of the patient and the patient’s experience. Instead, Freud introduced the notion of the analytic process centered on a transferential relationship in which the analysand refuses to accept the physician’s story and instead embraces her own subjective past. Sedat has chosen to focus on Freud’s psychoanalytic work, culling this out of other areas of his influence as he founded a new discipline through his voluminous writing, lectures, and conferences.

Within the framework of understanding Freud’s clinical work through a literary lens, storytelling from the analysand’s perspective is considered psychic privilege. Freud’s focus is on the metapsychological, a depiction or expression of psychic activity aimed at assisting the analyst in finding the patient’s points of transference and warning against a position of suggestion, mastery, or superior knowledge. Rather, the analyst should be moving with the patient from one psychic position to another.

Sedat underscores the importance of Freud’s work on psychic processes, stressing the importance of the dynamic relationship of both the analyst’s and patient’s psychic processes. In this pursuit to create a new discipline and a way of looking at person’s psychic difficulties, Freud was prolific in his search to seek out meaning in behavior that was detached from medicine, religion and philosophy. Freud opted to confront the notion of how families and cultures impact us and, when they do, how we understand the results. Sedat points out that Freud decided to categorize this new discipline not in the humanities but instead among the natural sciences to allow it to evolve through scientific inquiry and to keep it closely flanked by clinical observation.

It would be hard to dispute Freud’s voluminous contribution to the foundation and practice of psychoanalysis. However, he has been criticized and often ignored or disputed in more recent renditions of psychoanalytic theoretical frameworks by such contemporary theorists as Jean Baker Miller, Nancy Chodorow, and Carol Gilligan from the United States and Julia Kristeva, Luce Irigaray, and Helene Cixous from France, whereby for example, it is recognized that there are difficulties in constructing a theory of sexual difference that can evade the consequences of either biological essentialism or its reverse, social constructionism. Whether or not you agree with Freud from a theoretical frame, Sedat reminds us that Freud expected evolution and change to his theories simply by placing his discipline in the category of the natural sciences.

Sedat reports on Freud’s methods and analytic technique and he outlines Freud’s work chronologically without commenting or analyzing the application of his methods over time. He approaches Freud in a manner that will challenge the reader/practitioner to provide his or her own insights and will demand further reading to interpret Freud’s work in their own modern context. In other words, Sedat’s rendition is largely historical. He presents Freud’s work in the order in which it occurred beginning with infantile sexuality and continuing with, in sequence, the unconscious, the ego, the sense of guilt, repression, the Oedipus complex, transference, libido, masochism, group psychology and the repetition compulsion. Sedat presents a separate section outlining the context in which the psychoanalytic process takes place.

The function of Sedat’s text will be one of an historical representation for students as well as for practicing psychoanalysts. The interpretation of how Freudian psychoanalytic theories and methods are applied in clinical practice, and deciding if they are relevant to various populations both clinically and culturally, is left to the reader.

Psychodynamic Psychotherapy: A Guide to Evidence-Based Practice
By Richard F. Summers and Jacques P. Barber
Reviewed by Thomas P. Kalman, M.S., M.D.

We are all familiar with the warning that if something seems too good to be true it probably is. So having searched unsuccessfully for years for a concise, comprehensive, readable yet sophisticated, synthesizing text on psychodynamic psychotherapy, I approached this book with understandable reservations. Unless subsequent re-readings undercut my perusal of this clear volume, I believe I have found a professional reference text that I have dreamed about for decades. Since completing my own analytic training nearly thirty years ago, I have often struggled with questions relating to professional identity – am I a classical analyst? Do I subscribe to object-relations theory or self-psychology? How can I be an analyst if so much of what I say to my patients sounds like cognitive behavior therapy? Must I have a unitary, dominant theoretical orientation? If these and similar questions sound familiar, then Psychodynamic Psychotherapy by Drs. Summers (a psychiatrist) and Barber (a psychologist) is a must read.

Re-labeling psychodynamic psychotherapy as pragmatic psychodynamic psychotherapy (PPP), the authors systematically redefine treatment in light of current research, other psychotherapeutic approaches, profound societal changes, and practical realities of current mental health care (including combining individual psychotherapy with pharmacotherapy, couples and family therapy). For these authors, both of whom are involved in psychotherapy education, the importance and legitimacy of psychodynamic psychotherapy is expressed from four perspectives.

The authors first discuss the major research efforts (the relevant recent studies are covered) and the fundamental dearth of quality studies. They point out the complexity and pitfalls involved in studying psychotherapy and comparing psychotherapies and note that, in an “evidence-based” age, a treatment approach (psychodynamic psychotherapy) that deals with complex diagnostic challenges (i.e., real-life, Axis II pathology) rather than unitary, clear-cut phenomenological diagnoses, is at a disadvantage in the world of grants and sponsored research.

The second perspective underscoring the value of PPP is the
legacy of more than a century of psychotherapy experience. The authors point out that most other psychotherapies have evolved from the “incubator” that was psychoanalysis and psychoanalytic psychotherapy, suggesting that dynamic work attracts “those with empathy and provides a meaningful model for a deep emotional exchange with a patient.” (p. 15) They contend that discussing issues of great personal importance stimulates creative thought that sometimes leads new therapeutic ideas.

The third validating theme for psychodynamic psychotherapy is the importance in our culture of the personal narrative, now recognized as a fundamental human characteristic. The authors do not recapitulate all the Freudian ideas that permeate Western culture, but they assert as given that such ideas are embedded “in our culture’s picture of the individual, the life cycle, and interpersonal relationships.” (p. 16)

Lastly, the authors point out the documented finding that when psychotherapists choose treatment for themselves, they will opt for a psychodynamic approach over the newer, proliferating psychotherapies – perhaps, the authors suggest, because the emphasis on “affect and ways of understanding intense affective experiences provides therapists with the clarity and resilience needed to work with distressed and suffering individuals.” (P.16)

Summers and Barber propose six “core” problems that are the targets of practical psychodynamic psychotherapy: depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma. This is a volume refreshingly free of DSM language and nosology, yet no less systematic. After a core problem is identified, PPP calls for the development of a comprehensive formulation, which provides the “blueprint” for the treatment to come. They have written perhaps the clearest, most usable chapter that I have yet encountered on how to prepare a formulation - an achievement that may address the inadequate use of this important tool in clinical practice. The authors recognize and incorporate other theoretical models and through their excellent use of tables illustrate how different models relate to one another. Examples include one chart summarizing and differentiating Ego Psychology, Object relations, and Self-psychology; another contrasts CBT with PPP; and another, a masterful one-page document, catalogues the essential elements of 14 major psychotherapies. How different theoretical models would view each of the six case studies (one for each “core” problem) used to illustrate the principles of PPP is the focus of another, profoundly creative chart.

The text is organized into five major sections consisting of 15 chapters. Part I, Context, deals with defining practical psychodynamic psychotherapy and the author’s technical approach, while offering the above-mentioned comparisons to psychoanalysis and other psychotherapies. Part II, Opening Phase, deals with the six core psychodynamic problems, the psychodynamic formulation, and goal setting in treatment. Part III amplifies the role of the personal narrative, describes critical “moments,” or junctures, in treatment. This section discusses the mechanics and process of change in psychotherapy, characteristics of effective therapists, countertransference, and specific technical matters such as therapist personal disclosures. Part IV deals with the integration of therapies, including pharmacotherapy, couples, and family treatments. The concluding sections deal, appropriately, with termination. Throughout, the authors rely on six richly detailed case studies used to illustrate the six core problems addressed by PPP.

This is a book for practitioners of all levels including psychotherapy educators and the most seasoned of psychoanalysts. This book may come to represent the “state of the art” of psychodynamic psychotherapy and become the standard text for psychiatric residencies and other mental health graduate programs.

Doctor Paul Weston: Psychotherapist or Cinetherapist? TV series review by Harvey Roy Greenberg, M.D.

HBO’s In Treatment is based on the popular Israeli series, Be-Tipul. Like Be-Tipul, each episode of In Treatment comprises a session with a psychologist - here, Dr. Paul Weston - and each of four patients on succeeding days. The week ends with a session between Weston and Gina, his supervisor/quondam therapist, with whom he has had a stormy relationship dating back to his student days.

The sociocultural basis for Be-Tipul’s enormous success in Israel has been amply addressed elsewhere. This piece chiefly addresses Dr. Weston’s ambivalent reception by American psychotherapists, then probes the cinematic necessities which shaped his character and capabilities.

Dr. Weston certainly has serious professional flaws and counter-transferential contretemps. He intensively needs to be needed; presumptuously injects himself into his patients’ lives from the launch of therapy. Although he sees patients once each week and face-to-face, his working model is classically psychoanalytic, often to the neglect of weekly treatment’s subtleties.

Weston’s initial session, and virtually every one thereafter, is chock-a-block with transference-heavy interpretations - frequently simplistic and ill-timed. As a result, he often provokes irate negative therapeutic reactions that in real life would send patients hurting out the door forever.

Weston’s default stance is passive, a curious meld of orthodox psychoanalytic/Rogerian strategies. Sometimes he spends nearly an entire session answering questions with more questions. However, he can turn activist on a dime, frenetically admonishing and advising patients when more prudence is indicated (as when he demands that a young woman freshly diagnosed with lymphoma commence chemotherapy immediately).

Weston’s abortive romance with Laura, an alluring anesthesiologist in her early thirties, provokes his most disturbing delerictions of duty. His erotic obsession spurs a crescendo of glaring lapses in judgment, counter-transferential acing out, and culpably unethical behavior. Laura is an exemplar of the high-functioning borderline: her capable façade conceals a host of alarming psychopathologies - including a disastrous capacity for manipulative betrayal and masochistic self-deception in her relationships with men.

She entered therapy a year ago to resolve her ambivalence about marriage. In the first session of season one, she discloses that she has been in love with Weston from the moment they met. With the uncanny perspicacity of such patients, she has sussed out the withering of his spirit, and the ruin of his marriage. Weston replies he can only be her therapist, not a soul mate. Although he’s now thoroughly smitten, he keeps rejecting her fursome adoration for awhile.

Weston is also treating Alex, an appealing jet fighter pilot who was grounded with post-traumatic stress, after destroying an Afghani school. Laura accidentally meets Alex coming out
of Weston’s office, and promptly seduces him. Both Laura and Alex then spare Weston no lurid detail of their one night stand.

Goaded beyond endurance when Alex calls her a worthless bitch, Weston throws coffee in his face and attacks him physically. Alex later accepts Weston’s apology, and resumes therapy. Only then does Weston admit to Laura that he cares for her.

Several sessions later, Alex claims he’s “cured” and begs Weston to certify his return to flying. Knowing Alex is still tormented by guilt and grief, Weston nevertheless complies. Alex dies shortly afterwards in a training accident - possibly a concealed suicide. Weston and Laura break off their unconsummated relationship.

Weston’s failure to register Laura’s summary infatuation during a year of therapy is striking. His blind spot doesn’t stem from deficient empathy, but from the desperate denial of his growing infatuation. In real life, once aware that her “love” completely dominates both her treatment and outside life, he would have to choose between several hard alternatives.

He could labor on to winkle out the neurotic roots of her fatal attraction. But if her transferential distortions definitively undermine her capacity for ego-distance, Weston should terminate her therapy, however painful that may be on both sides of the couch, and urge her to seek help elsewhere.

But what if Laura’s affection for Weston is genuine? As Gina reflects, isn’t love always based on some degree of transference? If Laura’s love is indeed authentic, the outcome could be even bitterer. Authenticity offers scant solace if the patient’s sentiments are not reciprocated.

But what if Weston is also genuinely in love? Conceivably he could continue Laura’s therapy while undertaking treatment himself. However, maintaining therapeutic objectivity while noodling around with one’s countertransference under these circumstances is, I think, impossible.

Some investigators of client-therapist romances advise a cooling off period of variable duration before the parties begin “dating” again. It’s recommended that both also use therapy to confirm that their love is not based on unconscious neurotic distortions.

Other analysts prescribe permanent amputation for the problem. Again, no easy matter, for wisdom may languish when libidos are inflamed on both sides of the couch. Human nature being what it is, absence from felicity often plays better in novels or onscreen than in practice. All too commonly, the affair continues. In the Big Apple, we all know where those bodies are buried.

In typically muddled fashion, Weston manages to have the worst of all possible worlds. Ethical constraints and an innate timidity make him shilly-shally about commitment. Laura’s affair with Alex, undertaken with malice and forethought, finally forces him to recognize that he indeed loves her deeply - even as that insight inalterably subverts her treatment, replicating her propensity for impossible, often sordid relationships. Laura’s fling with Alex drives Weston into an Oedipal delirium, which fatally infects his work with both of them.

An affair between patients is almost always rooted in complex neurotic transferences and must, I believe, be strongly discouraged. Weston should have immediately interpreted the destructiveness of Laura and Alex’s affair, indicating that he cannot treat both should it continue.

Attacking Alex would ordinarily constitute grounds for termination. Instead, Weston asks for and receives pardon, then continues to grind down Alex’s defenses with traumatizing interpretations about his driven perfectionism and competitiveness.

Weston allows Alex’s return to duty, while some part of him knows he is too depressed to fly. Laura shares Weston’s guilt. Awareness of their mutual culpability plays a major role in killing their relationship before it gets off the ground.

Countering Weston’s formidable technical deficiencies and counter-transferential quagmires, at other times he can be puzzlingly competent, dedicated, and compassionate; can eschew his Groddeckian inclinations, and make apt, well-timed interpretations. When in the vein, he’s a careful listener; possesses a fine-honed sense of humor with which he promotes the patient’s healing ego-distance. He can artfully reassemble a fragmented narrative into a plausible timeline, fostering insightful connections between past and present.

Weston is also a therapeutic multitasker, moving easily between treating adults of all ages, couples, children, and teenagers. In fact, he’s at his best with kids and adolescents. His understanding of developmental tasks is excellent. He dexterously shapes his interventions to the age and stage of each young patient. Unlike his treatment of adults, he doesn’t push transferential issues, focusing his efforts on the “here and now.” His dealing with parents is exceptionally skilful. He adroitly addresses their concerns without jeopardizing his young patient’s treatment.

In season one, Weston evaluates Sophie, a 15 year old promising gymnast for suicidal ideation, following a suspicious accident. Despite resistance to therapy from every side, he wins her confidence; encourages her to explore her doubts about continuing an athletic career. Her ambivalence is compounded by pressure from her separated parents, and the blandishments of a coach who seduced her. Through her working alliance with Weston, she frees herself from crippling guilt about the affair with her coach, decides to leave skating for college, and makes peace with her parents.

Will the real Dr. Weston please stand up? Setting Weston’s manifest deficiencies against his impressive gifts, it’s difficult to determine whether he suffers from mid-life depression, compounded by narcissism and sociopathy, or severe multiple personality disorder. The diagnostic riddle Weston poses to a clinician is tidily resolved by the film scholar.

For be it understood: there is no single Dr. Paul Weston. There is a character called Dr. Paul Weston, who practices that dubious sub-specialty I have elsewhere named “cinetherapy.” Investigators delineate three cinetherapeutic types: Dr. Dippy (after his debut in the 1906 comic short Dr. Dippy’s Sanitarium), perennially wackier then his clientele; Dr. Evil, psychiatry’s version of the mad, bad scientist; and Dr. Wonderful, the therapist as ever bounteous Good Parent.

A nonpareil of empathy, insight, and patience, Dr. Wonderful is available anytime, anywhere, behind the couch, over the telephone, by your bedside or tennis court. Fees are rarely mentioned. He seems to treat no other patient but the protagonist. A wounded healer, his marriage and family life are devastated by decades of caring for others. Attraction to a female patient, fatal or otherwise, is a staple of cinetherapy narratives. Overviewing these criteria, once concludes that Dr. Weston may just be the
most wonderful Dr. Wonderful ever.

The summary alarm about Weston’s faults, or about the accuracy of In Treatment’s depiction of psychiatric illness and treatment, ignores the film industry’s sovereign aim. With rare exception, mainstream movie and TV dramas are not made to educate audiences about anything. They are created to generate huge profits by satisfying our ancient appetite for compelling stories.

This is not necessarily a bad thing. Stories may be compelling and educational, fueled by the worthiest motives. But even the makers and backers of admirable films like Schindler’s List and Saving Private Ryan hoped for boffo box-office.

Both these films sometimes adhered to historical fact, but also contain notable inaccuracies. The latter are not due to inadequate research, but stem from the implicit mandate to keep viewers riveted to the screen. In this regard, In Treatment is at times faithful to clinical reality. But if character or narrative development demand sacrificing clinical accuracy, depend upon it, that price will be paid.

The cinetherapist’s native skills facilitate effective unfolding of a film’s narrative. Glen and Krin Gabbard observe that a cinetherapist is an enormous asset for the beleaguered screenwriter. Cinotherapy generates exposition through flashbacks; incites spectacular revelations and confessions; illuminates traumas from the unquiet past.

Weston’s character has essentially been “subcontracted,” reconstrued from one episode to the next. (The same is true for each patient and Gina.) I submit that Weston’s “reconstructions” may also have been influenced by other production team members, of greater or lesser significance, from editor to best boy. Several therapists have been informal or formal consultants to the show. (Reliable sources indicate that these suggestions often go partly or totally unheeded.)

Each of these individuals bring to Weston’s persona his or her particular knowledge and biases about the mental health field. One cites - inter alia - formal education; beneficial or disastrous experiences in therapy; information derived from other sources of variable reliability, notably the media.

Contributions to Weston’s persona by people outside the production team are impossible to know, but always play some part, from the wings as it were, in creating every play, film, or TV drama. Such proxy participants comprise a giddy congeries of husbands, wives, children, other relatives, friends and lovers; their therapists; financial backers; reviewers; fans, et cetera.

In Treatment: Cui Bono?

As “applied analysis” of cinema escalated over the last four decades, so have disputes about the beneficial or deleterious effects of portraying therapy in film or television.

Nay-sayers insist that cinematic depictions of psychotherapy are harmful to the public and to the profession. Mutatis mutandis, enthusiasts about cinetherapy - often cinemophiles themselves long before becoming practitioners - now wax so sanguine as to recommend using films in mental health training. Movies and TV are also employed in individual and group therapy settings, to implement fee association, stimulate discussion of shared problems, et cetera. In this context, one has heard it said that Weston is a superb role model.

But there are no reliable studies about the tutelary benefit of cinema for practitioners, anymore than hard evidence for helpful or dire effects upon patients exposed to cinitherapy. One can only offer personal conjectures vis-à-vis In Treatment’s impact upon the public or our profession.

I believe the series has had far less influence on mental health than therapists of whatever conviction would like to think. A few potential patients may avoid therapy because they fear becoming the object of a therapist’s madcap maladroitness or maddened lust. A few may seek help, mistakenly believing that their therapist will be wonderful as Weston. But most viewers I interviewed for this article have regarded the series merely as reasonably well-executed entertainment.

I have elsewhere written that: “Cinitherapeutics continues to privilege the quick fix over the boredom and sweat of therapy. (Cinotherapists)…push catharsis without insight, common sense direction one could get over the fence and the perennial blaming of parents…”

In Treatment has at least has captured something of the sweat and - yes - occasional boredom of psychoanalytically-oriented psychotherapy, instead of the decerebrate quick fixes still being served up at the Simplex.

At one point, Gina admonishes Weston that we must always
be listening compassionately, as participant observers of the treatment process. But we should go no further than illuminating the occulted causes of suffering. We strive to remove the blocks that nurture and nature, character and constitution, have put in the way of our patients becoming whatever they were meant to be. Inappropriate personal involvement and a plethora of advice, however well intentioned, only interfere with the work.

Of course, that same Gina, the Idealized Therapist who professes such wise counsel, takes on Paul and his wife Kate in couple therapy, totally bungles the job, and finally tells Weston in Kate’s presence to go to Laura. It’s bad business clinically - but it’s also show business, in the grandest tradition of cinetherapy.

Movie Review: *Inception*
Directed by Christopher Nolan, starring Leonardo DiCaprio.
By Cassandra M. Klyman, M.D.

This mega-grossing Hollywood film was greeted with much hype and remains a #1 box-office success in mid-summer 2010. Psychoanalysts will go to see it because their patients will be talking about it and movie reviews abound—from Entertainment Weekly, to the New York Times, to the New Yorker Magazine and Time. My 17 year old grand-daughter exclaimed, “I loved it, but the Hollywood industry has totally warped my sense of a good or bad movie.”

I found it heavy on the manifest content and light on psychodynamics. However, interestingly enough, all of Nolans’ past several films—Insomnia, Momento—have been about the vagaries of the mind. In an interview he states that he has been working on this theme of a dream factory for the past 9 years until he finally got his sci-fi thriller funded by a major studio. And we can easily see how it took millions to make as dream scenes double and re-double upon themselves in contexts all over the globe. Unfortunately some technical information must have leaked since some scenes bear an uncanny resemblance to the computer and Ford Fiesta ads that have been aired on regular TV where things fly about and buildings unfold or explode in either slow or fast motion. Nolan and others have created a metaphor of our “digital era of immersive, interactive entertainment” but uniquely verbalize that “planting an original idea inside the mind of our ‘digital era of immersive, interactive entertainment’ but uniquely verbalize that “planting an original idea inside the mind is more dangerous, yet ultimately more rewarding, than merely trading ideas.” (Entertainment Weekly 6/30/2010 p.39)

The plot is thin but with an interesting twist. DiCaprio, as Cobb, is hired for a heist in which he is asked to change his *modus operandi* and, instead of entering his victims’ dreams and stealing their industrial secrets, he is to implant an idea that will help a Japanese energy company decimate a Western company upon the death of its CEO and its inheritance by his son. Supposedly the inception of the idea into the heir-apparent is that he not follow the old man’s steps but break-up the company into smaller components, to be his own man - with his own vision that will then allow the company’s take-over.

Cobb’s price? He will be granted immunity from an inquiry that he had killed his wife, Mal, and be allowed back with his two young children currently in their grandparent’s custody. This subplot, though portrayed rather anemically, is up our professional alleys as clinicians as much or more than his sensational attempt to probe and cinematically portray the primary processes of dreaming. Rather late in the film we understand that Cobb and Mal played with their dreams and she got lost. Without intact reality-testing she thought she could jump off a window ledge and not die. He and we watch helplessly as she does not defy gravity and smashes on the pavement. Ridden with guilt and grief he periodically takes a symbolic elevator down to deeper levels to be with her or she unexpectedly pops up in his dreams with weapons or with blood on her face. She won’t pardon him no matter what governments may be persuaded or bribed to do.

How often do we evaluate or treat widows, widowers or parents of those who have committed suicide? Too often, for sure. Those survivors deal with their remorse, regret and relief in various ways. Survivors’ guilt can lead one to: take great personal risks; reparatively aim much higher and achieve more than before; idealize and memorialize the lost beloved; and at the same time we want them to die, die, die and give up their haunting so we can come to terms with the past.

Having been involved with dream research as a medical student with William Dement, M.D., it is exciting to speculate that *Inception* may stimulate even more novel investigation and funding. (Things in the outside world do have such an effect---some of my research was a result of the government’s interest in knowing how the N. Korean’s uses of sleep deprivation and LSD on the P.O.W.’s were such successful torture devices.) Nolan’s film already brings forward the newer findings that there is non-REM dreaming in which hypotonia is absent so that paramnesic phenomena like sleep-walking, eating and sexual behavior can occur. Other related more current information has to do with studies and medication for narcolepsy and cataplexy and the role of orexin in the sleep/wake cycle. Could some of those movie scenes be likened to hypnopompic or hypnagogic hallucinations where the individual upon falling asleep or waking struggles to escape the sensory/visual experience? With our returning Gulf veterans’ PTSD and the signifying nightmares and flashbacks undoubtedly more attention will be paid to the possibilities of the behavioral modification technique of self-directed dreaming at bedtime so that from stereotyped beginnings new and better endings can be created, rehearsed and made part of a new day residue.

In *Inception*, where one is not ever certain what is dream or wakefulness, action abounds. More typically we find that in the dreams of children where there is a greater emphasis on unbridled wish-fulfillment—“Oh, Mom, I had the greatest dream last night, I was SuperHero X and I killed the bad man” or “I got first prize in the spelling bee.” Regrettfully my dreams and those I hear from the couch are more pedestrian in their manifestation. Maybe that is why I was so ambivalent about the movie—maybe just a little bit jealous that my nighttime adventures are not that thrilling.

Dr. Perman reminded me that that *Inception* also draws upon George Orwell’s 1984 where “O’Brien’s and by extension Big Brother’s efforts to get inside the mind of Winston Smith was by rearranging how he thinks about and remembers things.” Stanley Kubrick was another cinematic genius who gave us a stunning version of mind control in the classic *Clockwork Orange*. Transmuting interpretations, reconstructions and all therapeutic interventions by virtue of neural plasticity also create mental changes. The aim and the level of greed and self-aggrandizement factors make all the difference as to whether it is an ethical pursuit. This *Inception* was certainly not immaculate!
Movie Review: Eat Pray Love
By Cassandra M. Klyman, M.D.

This highly acclaimed and popular novel by Elizabeth Gilbert is now a film that can be characterized as a ‘chick flick’ but it is hardly one for the 2nd generation liberated 21C woman. Or is it? Julia Roberts has created a new Pretty Woman, Liz, decades later, who is still looking for love but it is father-hunger in disguise. Just as when she played a very young female prostitute in her famous debut, she is seemingly without a family and searching for one. Not to be a parent or even an adult child, but to be a cherished child.

When the movie opens, we find Liz observing her friend’s domestic scene in which Liz hands her friend’s baby over to her (Liz’s) new husband who is equally and literally at a distance. Liz is not ready for motherhood and she is also not ready to support her bridegroom who wants to return to graduate school. She looks around at her new home and thinks “is this all there is?” Feeling miserable and inchoately unhappy, she abruptly files for divorce. Her husband tries to hold her captive to get her to talk with him about her unhappiness or to go through marital counseling. When Liz follows through with her threat to divorce, her husband does not divide the marital assets. After a brief fling with a wannabe actor, she throws it all to the wind and leaves.

Liz goes to India where a toothless guru, Ketut, reads her palm. He tells her she will have one short and one long marriage and gives her a talisman drawing of a headless figure with legs moving in opposite directions but arrows pointing to its heart. His wife in the background tells her she needs a man. This advice, against promiscuity and for marriage, is repeated by her elderly landlady and by the mother of her language tutor when she goes to Rome - even by the woman-healer in Bali who admits to being divorced herself but for the legitimate reason that her husband was physically abusive and leaving was the only way to survive and keep her daughter safe.

In the meantime our adventurous heroine looks to find a father in religion - in Ganesh - but either falls asleep while meditating or “can’t get into it” despite demeaning herself by scrubbing floors and living as a celibate. The older man she meets in the Ashram tells her to forgive herself as he now for-gives himself for nearly driving over his eight year old son in an alcoholic state a decade earlier. He, like the young woman she befriends, both leave to return to pick up their past family ties. Robert’s character returns to Bali and is nearly run over by an émigré tour-guide who has a substantial portable career in import-export. He takes her for medical care, checks up on her, guides her to beautiful places, and falls in love with her. She in turn is touched by his wisdom and the tenderness of his relationship with his son. He can embrace this 19 year old in a way her ex-husband could not even with a nine month old. This is a Dad one can count on. He suggests they dance, take a boat for two together, make a life together.

She has to make the choice to stay or go back to New York where a speculative career of writing awaits her. What plays into her decision? Not just that he loves her but the way each has shown generosity. Hers was manifested by the fact that, instead of celebrating her birthday long-distance with gifts for herself, she asked her NY friends to send checks – that amount to 18 thousand dollars(!?) - to help the woman-healer build her own house. The pleasure she received from her charity drive was fulfilling: it satiated the maternal part of her she had never experienced since usually she was the one doing the feeding. Now perhaps she could be in a relationship where she could not be a little girl but an adult-child to the older man who wanted one.

This is a traditional story for the modern woman who thinks she wants it all but has passive longings to be taken care of in a romantic way. Especially so if those needs have not been met by a good-enough Dad when she was a child. There is no mention of her family of origin in the movie and little in the book. So for the movie story my remarks are speculative.

This story of early marital disillusionment is not an uncommon one in our consultation rooms. We see young women who are anxious, tearful or even suicidal that “happy ever-after” hasn’t happened. Sometimes they have just followed their hearts, sexual drives or hypomanic choices, but it is often because the work of most enduring relationships is unexpectedly hard work. When that work has not been done in the family they left behind they are poorly prepared for negotiation and compromise. It is too bad that insurance companies will usually not pay for couples’ therapy. This would otherwise result in savings for the cost of the psychosomatic illnesses that result from the unexpressed grief and despair that these young people, and sometimes their children, carry forward.

For the casual movie viewer there is much to enjoy in Eat, Pray and Love. There is the travelogue aspect of visiting India, Bali and Rome and seeing not just the tourist sites but places like the Ashram and an Indian wedding ceremony. The acting is excellent and the characters, came and otherwise, are memorable. Ryan Murphy, creator of Glee and Nip/Tuck, and Jennifer Salt, have created a faithful screenplay. There is a shortage of intelligent romantic comedies. This movie fits the bill.

We want YOU to write for the Academy Forum!

In a relaxed and casual atmosphere, the Forum does not have a formal peer review, but instead invites its authors to enjoy the opportunity to express their ideas with a personal touch in a 2,500 word essay. With an avid Academy readership, the Forum enhances our sense of community and friendship. We hope you will join the community of Academy authors by contacting us today.

Gerald P. Perman, M.D., Academy Forum Editor: gpperman@gmail.com
Sarah C. Noble, D.O., Book and Film Review Editor: NobleS@einstein.edu
New Member Profiles – Accepted

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

Medical Student

Zainab Al-Dhaher  Brooklyn, NY
Sponsors: S. Schwartz and C. Gimenez

Ms. Al-Dhaher, originally from Kuwait and raised in Canada, received her BS in Anatomy and Cell Biology from McGill U, Canada in 2005 and her MS in physiology in 2007. She is currently attending St. George’s U Medical School in Granada, West Indies with graduation anticipated in 2011. She has worked as a teacher’s assistant, on two medical research projects, and she has participated in multiple community service projects from 2000-2009. She has received four scholarship awards. She belongs to the APA and American College of Physicians. Dr. Al-Dhaher speaks English, Arabic, and French and is learning Spanish.

Dr. Gimenez, a fourth year psychiatric resident and one of Dr. Al-Dhaher’s sponsors, worked with her for a month and was impressed with her interest in patients’ cultural, family and dynamic factors and using the therapeutic alliance. Dr. Schwarz similarly worked with her on a clinical rotation and praised her knowledge about dynamic issues, cultural interactions of women and the value of the therapeutic alliance.

Paul Fehrenbacher, MS-III  Chicago, IL
Sponsors: S. Schwartz and R. Turco

Mr. Paul Fehrenbacher is a third year medical student at the Northwestern Feinberg School of Medicine, Chicago, IL. He graduated U Notre Dame Summa Cum Laude with a 3.9 GPA and Departmental Honors in 2000. He has had interesting work experience between college and medical school in hospital ethics, providing tutoring for ACT/SAT as the head of his own company, in commercial real estate, in a Christian Mission in Haiti, in advertising and in environmental research. He was student-body secretary, VP and treasurer in college. He is interested in psychiatry.

Psychiatric Associate

Lada Alexeenko, M.D.  New York, NY
Sponsors: S. Schwartz and G. Perman

Dr. Lada Alexeenko is a third year psychiatric resident at SUNY Downstate Medical Center in Brooklyn, NY. She received her MD in 1995 from the Medical Institute in Novosibirsk, Russia and her MPH (2005-6) with a 3.86 GPA from the University of North Texas Health Science Center in Fort Worth, TX. She has worked on research projects in the US that have included CBT, the metabolic syndrome, paranoia, schizophrenia and the homeless. She made a strong personal statement in her application that suggests that she is a mature, curious, hard-working and humane young physician.

Rozy Aurora, M.D.  Valhalla, NY
Sponsors: C. Alfonso and S. Schwartz

Dr. Rozy Aurora is a third year psychiatric resident at the Bronx-Lebanon Hospital Center in Bronx, NY. She attended medical school at Lajpat Rai Memorial Medical College in Meerut, India from 1986-1991. She did an internship in several medical specialties (not including psychiatry) from 1992-1994. She worked on internal medicine clinical rotations and at the Greenville Mental Health Center in South Carolina in 2005. She speaks several Indian languages. She is a first year medical student in the New York Medical College two-year psychodynamic psychotherapy certification course and received strong recommendations from both of her sponsors.

Meaghan Connors, M.D.  Hartford, CT
Sponsors: A. Price and C. LaRoca

Dr. Connors received her BA from U of Massachusetts, Amherst graduating Magna Cum Laude in 1993, did coursework in Core Sciences for a year at U Mass, Boston, received her M.D. from U Mass Medical School, Worcester, MA, trained in psychiatry at the Institute of Living in Harford, CT finishing in 2007, and had three years of psychoanalytic training at the Western New England Psychoanalytic Institute from which she is currently on leave. She has been in private outpatient practice since 2008 and has worked in community-based treatment since 2010.

Parikshit Deshmukh, M.D.  Cleveland, OH
Sponsors: D. Mintz and C. Alfonso

Dr. Parikshit Deshmukh is a third year psychiatric resident at Case Medical Center in Cleveland. He received his Bachelor of Medicine and Bachelor of Surgery Degree in 2004 from Indira Gandhi Govt. Medical College, Nagpur University in India. In 2007 he received a Post-Graduate Diploma in Psychological Counseling and in 2008 an MS Degree, both in Bombay. Also in 2008 he received a certificate in “Philosophy of Mind” from an online course in Oxford, UK. In addition to his residency program in Cleveland, he is taking certificate courses in CBT at the Cleveland Center for CBT and in Psychoanalytic Psychotherapy at the Cleveland Psychoanalytic Center. He holds several administrative positions including Chief Resident. He has published, contributed to book chapters, presented numerous posters and received several awards and honors. He was highly recommended by his two sponsors.

Vicente José II Liz Defilló, M.D.  New York, NY
Sponsors: C. Alfonso and S. Schwartz

Dr. Vicente Liz Defilló is a PGY-4 psychiatric resident at the Albert Einstein College of Medicine in the Bronx. He grew up in the Dominican Republic and received his MD from Universidad Nacional Pedro Henriquez Urena in 1999. He then completed a one-year postgraduate neurosurgery internship, also in Central America. He did a second one-year postgraduate internship in psychiatry at Yeshiva University, Albert Einstein College of Medicine from 2007-8. He has had additional neurosurgery internships in Chicago and Miami. He served in the Dominican Republic army from 1993-2006. He was in private practice as
a GP from 2001-6. He is in his second year at the NY Medical College psychodynamic psychotherapy program.

**Joshua Green, M.D.**  Philadelphia, PA
Sponsors: D. Cotzen and K. Best

Dr. Green received his BA from the U of PA graduating Magna Cum Laude in 1993, his M.D. from Albert Einstein College of Medicine with Distinction in Neuroscience in 1997, his Ph.D. in Neural Science from NYU, and he completed residency training in psychiatry from Thomas Jefferson U Hospital in 2008. He works two days a week at the Council for Relationships in Philadelphia and is in private practice in Philadelphia three days a week, both with a strong emphasis on psychodynamic psychotherapy. He is on the Voluntary Faculty of Thomas Jefferson in the Department of Psychiatry. He has received several awards and published in the general psychiatric literature. He has taken post-graduate courses in short-term dynamic psychotherapy and Experiential Dynamic Psychotherapy. He was highly recommended by his sponsors.

**Nataliya Gulyayeva, M.D.**  Bronx, NY
Sponsors: S. Schwartz and C. Alfonso

Dr. Gulyayeva is a 3rd year resident in psychiatry at the Bronx-Lebanon Hospital Center and the Albert Einstein College of Medicine, NY. She received an M.D. from the Krasnojarsk Medical Academy, Russia in 1977 and an M.D. from I.M. Sechenov Moscow Medical Academy, Russia in 1979. She received a Ph.D. from the Ukrainian Scientific Research Institute of Pulmonology and Thoracic Surgery, Ukraine Allergy and Immunology in 1992. There is no information about her undergraduate training in Russia. She worked in a municipal hospital in internal medicine in Russia from 1979 until 2000. She was a preceptor at the Fresnius Medical Care North America in Orlando, FL from 2000 to 2007. Dr. Gulyayeva is fluent in English, Russian and Ukrainian. She is in the Dynamic Therapy program of the N.Y. Medical College Psychoanalytic Institute.

**Fayaz A. Ibrahim, M.D.**  Brooklyn, NY
Sponsors: S. Schwartz and C. Alfonso

Dr. Ibrahim is a 4th year psychiatric resident who attended Pre U College in India for pre-med courses and Rajiv Ghandi U of Health Sciences for medical school in Bangalore, India. He began his MPH studies at U Mass Amheast without completing this degree. He is a resident in psychiatry at SUNY Downstate. Dr. Ibrahim has a California medical license and is IRB certified in Biomedical Investigation. He has worked at five psychiatric clinics in NYC. He has an interest in schizophrenia, has given workshops, and is a reviewer for several psychiatric publications. Dr. Alfonso describes him as having a genuine interest in psychodynamic psychiatry.

**Xavier Jimenez, M.D.**  Pittsburgh, PA
Sponsors: J. Merlino and C. Alfonso

Dr. Xavier Jimenez received his BA from the University of Miami, his MA from Case Western Reserve in Cleveland, OH in Biomedical Ethics, and his MD from Ross University School of Medicine, West Indies graduating with Highest Honors. He is a PGY-3 resident at the University of Pittsburgh Medical Center having relocated from St. Vincent’s Hospital when it closed. He is concurrently pursuing additional training in psychodynamic psychotherapy at the University of Pittsburgh. His publications and presentations include human rights, social issues and medical ethics.

**Christina Kitt, M.D.**  New York, NY
Sponsors: C. Alfonso and A. Hyun

Dr. Kitt graduated Magna Cum Laude from Georgetown University in Washington, D.C. in English and Psychology in 2001, received her MD from Georgetown University School of Medicine in DC in 2008, and is a third year psychiatric resident in the Department of Psychiatry at NY Presbyterian Hospital-Columbia Campus/NY State Psychiatric Institute. She has engaged in extensive and impressive social volunteer work over the past 10 years. She is conversant in Thai, Spanish and Italian. She has expressed interest in psychosomatic medicine and psychoanalysis and is highly regarded by both of her sponsors.

**Andrea L. Mow, D.O.**  Pleasantville, NY
Sponsors: C. Alfonso and S. Schwartz

Dr. Andrea Mow is a 3rd year psychiatric resident at NYMC-Westchester Division and a first year student in the NYMC Psychoanalytic Institute Certification Course in Psychodynamic Psychotherapy. She received a BS in Equestrian Studies in Billings, MT in 1996, a BS in Biology from U. RI where she graduated Summa Cum Laude, and she obtained her D.O. from the NY College of Osteopathic Medicine in Westbury NY in 2008 where she was a member of the Phi Sigma Alpha National Osteopathic Honors Society. She plans to do an elective in a psychiatric hospital in China during part of her PGY-4 year.

**Andrei Nagorny, M.D.**  Valhalla, NY
Sponsors: S. Schwartz and C. Alfonso

Dr. Andrei Nagorny is a 3rd year psychiatric resident at Bronx Lebanon Hospital/Albert Einstein College of Medicine. He obtained his M.D. degree in Samarkand, Uzbekistan in 2000 and an MS in social work at Columbia U in 2002. He has worked extensively as a social worker in a variety of psychiatric, pre-school and substance abuse settings. Dr. Ngorny is fluent in Russian and speaks Uzbek and Tajik. He actively participates in training programs, Grand Rounds and other conferences. He is in the Dynamic Psychiatry Program of the N.Y. Medical College Psychoanalytic Institute.

**Sanjay Patel, M.D.**  New York, NY
Sponsors: C. Kestenbaum and B. Beebe

Dr. Patel is a PGY-2 resident at the Mt. Sinai School of Medicine from where he also received his MD. He obtained his BS from the University of Chicago with honors in Economics. He then entered Columbia University’s difficult and competitive Post-Bac program to prepare him for medical school (GPA 3.7/4.0). In medical school and in his residency he has received several honors and awards. He has participated in a variety of research, teaching and mentoring activities. He is interested in psychodynamic psychiatry and he has worked with Dr. Beebe in her research lab.
and seminars she conducts. He was highly recommended by his two sponsors.

**Jennyfer Peralta, M.D.** New York, NY
Sponsors: S. Schwartz and C. Gimenez

Dr. Peralta received her BS from Florida International U in Miami, FL in 2003, her MPH in 2005 and her MD in 2010, both from St. George’s U School of Medicine, St. George, Grenada. She has participated in several community service projects, including helping victims of Hurricane IVAN, and she is a member of the APA and NAMI. She is fluent in Spanish.

Dr. Gimenez has worked with her on several residency rotations and described Dr. Peralta as a “gifted person and clinician who has made extraordinary efforts to understand patients on various levels and to make interventions based on a deeper than average understanding of the factors in their lives.” Dr. Schwartz also recommends her highly.

**Sharath Puttichanda, MBBS** Brooklyn, NY
Sponsors: S. Schwartz and G. Perman

Dr. Sharath Puttichanda is a third year psychiatric resident at SUNY Downstate Medical Center in Brooklyn, NY. He received his MD from the JMM Medical College, Davangere, Kamataka, India Bachelor of Surgery and Bachelor of Medicine (MBBS) in 2006. He has been involved in several residency-teaching initiatives, a psychiatric movie club and completed a six-week course on “Introduction to Theory and Technique in Psychoanalysis and Psychotherapy” at the NYU Langone Medical Center.

**Malak Rafia, M.D.** Elmhurst, NY
Sponsors: C. Kestenbaum and J. Tolchin

Dr. Rafia received his International Certificate for Secondary Education in 1994 from the Arab Academy for Science and Technology in Alexandria Egypt, his Bachelor’s Degree in Medicine and Surgery in 2003 from the Alexandria University, Faculty of Medicine, and his Diploma in Psychiatric Practice in 2006 from the Ains Sham University, Faculty of Medicine, Cairo, Egypt. He worked in psychiatric hospitals in Egypt until 2006. At the Mount Sinai School of Medicine/Elmhurst Hospital in Queens he completed his psychiatry residency (2007-2010) where he was Chief Resident. He began his Child and Adolescent Fellowship in July 2010 also at Mt. Sinai. He is in psychodynamic treatment and plans to apply for psychoanalytic training. He is currently studying at the psychodynamic psychiatry program of the Columbia Psychoanalytic Center and he was described as a gifted therapist by Dr. Kestenbaum.

**Psychiatric Member**

**Joanna Chambers, M.D.** Indianapolis, IN
Sponsors: S. Katz-Bearnot and C. Alfonso

Dr. Joanna Chambers received her BS from U. of Georgia in 1992, her M.D. from the Medical College of Georgia in 1996 and trained in psychiatry at Yale U. School of Medicine in the Neuroscience Track. She has been the Residency Training Director in the Department of Psychiatry at Indiana State U. since 2010.

Her program is the recent winner of the Teichner Award. She has had a personal psychoanalysis for over four years, has had psychodynamic cases supervised and designed a psychotherapy training program for the Indiana State U. She has received numerous honor and awards, has been in multiple leadership positions in professional societies, and has had wide-ranging professional experiences in neuroscience, community mental health and academic psychiatry.

**David A. Straker, D.O.** New York, NY
Sponsors: G. Brenner/R. Wharton

Dr. David Straker is in private practice and an Attending Psychiatrist and Fellowship Director at Northshore Long Island Jewish Health System (LIJHS). He received his BA from Washington U, St. Louis in 1994, his D.O. from NY College of Osteopathic Medicine in 2000, trained in psychosomatic medicine in 2004-5, and is Associate Director in Psychosomatic Medicine at LIJHS, North Shore U Hospital. He received psychoanalytic training at the NYU Psychoanalytic Institute from 2005-2009. He has received numerous awards and honors and has had extensive teaching experience.

**Psychiatric Fellows**

**Stewart Adelson, M.D.** New York, NY
Sponsors: R. Friedman and J. Downey

Dr. Adelson received his BA with honors from Yale U in 1983, and his M.D. from NYU School of Medicine in 1988. He trained in psychiatry at the Payne Whitney Clinic, finishing in 1992, received a certificate in Child and Adolescent psychiatry in 1994, and completed a Fellowship in Public Psychiatry in 1995. He has had multiple academic and hospital appointments at Cornell, Columbia, New York Presbyterian and Weill-Cornell. He has been in private practice with adults, children and adolescents since 1995 and has worked at the NY State Dept. of Health AIDS Institute since 2008. He is has been vice chair of several positions within CARING at Columbia U that provides community-based prevention programs. He has written about, taught and presented extensively on lesbian, gay, bisexual and transgender issues.

**Psychoanalytic Fellow**

**Elizabeth L. Auchincloss, M.D.** New York, NY
Sponsors: S. Katz-Bearnot and J. Downey

Dr. Elizabeth Auchincloss is Vice-Chair for Graduate Medical Education and Director of Residency Training in the Department of Psychiatry at Weill Medical College of Cornell University. She is also Senior Associate Director at the Columbia Psychoanalytic Center for Training and Research where she is a Training and Supervising Analyst. At the Center, she is Chair of the Curriculum Committee. Dr. Auchincloss has an extensive CV and has received many awards for teaching and scholarship and has published many papers in a variety of psychiatric and psychoanalytic journals. She is co-Editor-in-Chief, along with Eslee Samberg, MD, of the latest addition of Psychoanalytic Terms and Concepts. She is interested in applying for a Teichner Scholar award.
Luis Angel Garza, M.D.  New York, NY
Sponsors: C. Alfonso and C. Kitt

Dr. Luis Garza received his BA from Texas A&M in 1994, his MD from U Texas Medical School in 1998. He completed residency training in psychiatry from NYU Medical Center in 2002, a Public Psychiatry Fellowship at Columbia U in 2003, and the Adult Psychodynamic Psychotherapy Program at the NYU Psychoanalytic Institute in 2004. Dr. Garza has been a psychoanalytic candidate at the NYU Psychoanalytic Institute since 2005 and anticipates graduating within the next several months. He is Assistant Clinical Professor in Psychiatry at Columbia U College of Physicians and Surgeons.

Dr. Garza has been an Attending Psychiatrist at Lucy Wicks HIV Mental Health Clinic at Columbia Presbyterian since 2002 and has been in the private practice of psychiatry and psychoanalysis since 2003. He has had various previous practice experiences and he belongs to seven professional associations including the American Psychoanalytic Association. He mentored one of his sponsors, Dr. Kitt, who chose to specialize in psychiatry as a direct result of Dr. Garza’s mentoring of her.

Giobatta Guasto, M.D.  Bogliasco, Italy
Sponsors: J. Tolchin and M. Tolchin

Dr. Guasto graduated medical school in 1978 and completed his residency training in 1982, both at the Facolta di Medicina e Chirurgia in Genova, Italy. He has had a personal psychoanalysis and a training analysis. He speaks Italian, French and English. He has worked at the Azienda Sanitaria Genovese since 1980, teaches at a private school of psychotherapy, and has been in private practice since 1980. He has had years of psychoanalytic coursework and supervision. Dr. Guasto is the Executive Physician, Co-founder, Senior Psychotherapist and Coordinator of the Centre for Sexually Abused Children. He founded “Orpha,” a seminar for Ferenczian readings, and is a member of OPIFER. He has published a number of papers on the topic of unwanted children and child abuse. He has a paper that has been accepted for publication by the Academy Journal. He meets the criteria for psychoanalytic fellow.

Craig Lichtman, M.D., M.B.A.  Philadelphia, PA
Sponsors: K. Best and Mary Ann Cohen

Dr. Craig Lichtman received his BS degree from the U of PA and the Wharton School in 1976, his MD from Case Western Reserve U in 1982, and his MBA from Saint Joseph’s U Haub School of Business in 2000. He trained in psychiatry at U of PA and was a candidate in psychoanalysis at the Institute of the Philadelphia Association for Psychoanalysis, Bela Cynwyd, PA 1986-1994. He was on the Clinical Faculty in the Dept. of Psychiatry at the U of PA School of Medicine from 1987 through 1998 and has been in the private practice of psychiatry, psychoanalysis and psychosomatic medicine from 1986 until the present. He has worked as Medical Director for the Family Services of Philadelphia and has had multiple positions as a consulting psychiatrist and on the medical staff of various PA hospitals. Dr. Lichtman belongs to multiple local, national and international professional and scientific societies. He has given many psychoanalytic presentations over the years on diagnostic and therapeutic topics.

John Terry Maltsberger, M.D.  Lexington, MA
Sponsors: R. Eisendrath and E. Beresin

John Terry Maltsberger, M.D. is a nationally-recognized child and adult psychiatrist and adult psychoanalyst. The following is taken from his narrative statement. Dr. Maltsberger’s principal contribution has been as a teacher and he has taught medical students, residents, attendings and allied professionals for the last 48 years. Almost all of his teaching has been under the auspices of Harvard University. He has lectured across the U.S. and in Europe. He was appointed a Visiting Professor at the Mayo Clinic in 2001. He has led the well-known Boston Suicide Group of Harvard-affiliated colleagues. His lifelong interest is in the psychotherapeutic treatment of suicidal patients with a special interest in Dialectical Behavioral Treatment since 2005. Almost all of his many publications deal with suicide. He is former president of the American Association of Suicidology for which he was awarded the Dublin Prize. He is a member of numerous psychoanalytic and psychiatric organizations including the International Academy of Suicide Research and the International Association for Suicide Prevention.

Scientific Associate Member

Volney P. Gay, Ph.D.  Nashville, TN
Sponsors: J. Wolfe and D. Cabaniss

Dr. Volney P. Gay received his BA in Philosophy from Reed College, Portland OR, and his MA and PhD in Psychology and Religion from the U. of Chicago. He completed graduate clinical training in psychotherapy from the U. of Chicago in 1998 and psychoanalytic training from the St. Louis Psychoanalytic Institute in 1990. He is a training and supervising analyst in St. Louis. He has received numerous awards, has a long list of relevant publications, and is a member of a dozen psychoanalytic, psychological and religious organizations. He recently stepped down from being the chair of the Department of Religious Studies at Vanderbilt to become the Director of Psychotherapy Training in the Vanderbilt Department of Psychiatry.

Ruth Lijtmaer, Ph.D.  Ridgewood, NJ
Sponsors: C. Alfonso and S. Olarte

Dr. Ruth Lijtmaer is a psychologist in private practice and is a training and supervising analyst at the New Jersey Institute for Training in Psychoanalyst (NJI). She received her BS in Education in Buenos Aires Argentina in 1964, her Licentiate in Psychology from U Buenos Aires in 1970, her MA in Psychology from NYU in 1972 and her Ph.D. in Psychology also at NYU in 1978. Her thesis was “Learning Disabilities and Bilingualism in Spanish Speaking Children.” She completed her psychoanalytic training from the NJI in 1989. She is currently in private practice and on the faculty of the NJI. She has published over 20 papers and has two book chapters in press. She has given over 60 presentations in her career, focusing on cultural and transcultural issues. She has presented at several Academy meetings and has published in the Academy Journal and Forum. She has been active on numerous committees throughout her career.
Save the Date
May 3-5, 2012
American Academy of Psychoanalysis
and Dynamic Psychiatry
56th Annual Meeting
in
Philadelphia, Pennsylvania

Psychodynamics in Contemporary Psychiatry:
Mutual Influences

Deadline for submissions:
September 12, 2011
Go to www.AAPDP.org for additional 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
info@aapdp.org
www.aapdp.org