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**Front Cover**  
*Portrait of Marianne H. Eckardt, M.D.* by fellow photographer.

My hobby is photography. This picture was taken on an Elderhostel trip for photographers beginning at Dixie College, St. George, Utah and after which we explored Zion, Bryce, and Grand Canyon. We were invariably up before dawn to catch the sunrise and home after dark so as not to miss the sunset. A spirit of great congeniality existed and we shared our photographic visions. The retirement community I live in devotes one of their clubhouses to arts and crafts studios, among them sculpture and pottery, lapidary work, jewelry, a huge wood shop and a photographic studio with a special digital lab equipped with the latest editions of Photoshop and printers. Should you want to retire or half retire, as I have, this is the place to consider. We call it paradise.
Dear Colleagues,

I’ve just returned from the Academy’s outstanding Eleventh Joint Meeting with the Organizzazione di Psicoanalisti Italiani Federazione e Registro (OPIFER) held in Florence, October 17-18, 2009. The topic of the meeting was “Endings in Psychoanalytic Psychotherapy: How, When and Why; In the Footsteps of Silvano Arieti.” Academy Fellow Dr. Richard Brockman, a faculty member of the Columbia Psychoanalytic Institute, writer, playwright and clinician, gave the American Keynote Address, Termination or Change: Learning from the Untreatable Patient. Dr. Brockman described his sensitive and successful work with a difficult patient and was able to connect the treatment with recent findings in neuroscience.

Dr. Marco Bacciagaluppi, an Academy Fellow, a Founder of OPIFER, and its first President, gave the Italian Keynote Address on Self-Analysis as an Appropriate Ending, illuminating an important aspect of a clinician’s work. Academy Trustee Dr. Helen Ullrich, a widely published and respected expert in transcultural psychiatry, described her insightful research in India in her presentation, Widowhood As An Ending: Depression and Suicide Among Widows in a South India. There were numerous other interesting and informative presentations.

We are very grateful to Dr. Sergio Caruso, the immediate Past President of OPIFER and Chair of OPIFER’s Scientific Organizing Committee, Dr. Pietro Andujar, President of OPIFER, and the entire Committee for their exceptional efforts in making the conference so successful. The venue for the Joint Meeting was the extraordinary Cenacolo of the Church of Santa Croce. The audience sat in a tranquil auditorium surrounded by masterpieces from the Italian Renaissance, including frescoes by Gaddi and a crucifix by Cimabue.

Dr. Caruso and his wife Titta hosted a gracious dinner party at their home on Friday evening, October 16, to welcome the Academy’s attendees. Additionally, OPIFER’s Organizing Committee arranged for an Opening Reception for the conference at the restaurant Finisterrae, on the Piazza di Santa Croce. The discussions after the presentations were thoughtful and stimulating. As is usual in the Joint Meetings, there was a rich and warm exchange among colleagues from different countries.

OPIFER was founded in November, 1996, with a pluralistic approach and rejection of dogmatism, its “model...the American Academy.” In a Special Section of the Academy Journal in Spring, 1998, Dr. Bacciagaluppi, OPIFER’s first President, presciently wrote: “Because of the myriad interests shared by OPIFER and the Academy, I hope that a cooperation between the two organizations will lead to fruitful encounters and joint projects.” (JAA, Vol. 26, No. 1, 1998)

In 1999 I was Secretary of the Academy. Dr. Bacciagaluppi, Dr. Jules Bemporad who is a Past President of the Academy and was then Editor of the Journal, and I organized the first Joint Meeting in Venice. The meetings have continued on a yearly basis at different venues in Italy. As a result of the meetings, more than 14 OPIFER members have become members in the Academy. Additionally several Americans, including David Lopez and Sandra Park, were introduced to the Academy through Joint Meetings and went on to become leaders in our organization.

At the end of the Eleventh Joint Meeting, Dr. Caruso spoke for both OPIFER and the Academy, when he said, “Here’s to eleven more years.”

Best regards,
Joan Tolchin
The First Teichner Scholar Visit

Victor J. Teichner was an innovative psychoanalyst, public sector psychiatrist, and educator who was President of the American Academy of Psychoanalysis and Dynamic Psychiatry before his untimely death 26 years ago. A grateful patient has given our Academy a grant to set up a teaching fellowship in his name. The purpose of the fellowship is to support a Visiting Scholar to visit a residency training program that wishes to supplement its training of psychodynamic psychotherapy. The expenses for the Scholar are entirely paid through the Teichner endowment. Our first year with this award proved to be very exciting. We had fifteen applicants from residency programs across the country. The winner of the first award was the University of Kentucky, and the scholar chosen was Jennifer Downey, M.D. The following two articles are a reflection of their experiences.

January 2008 – Kentucky’s “ice encrusted roads” welcomed Dr. Downey for the first Teichner Scholar Visit.

From left to right: Mitch Douglass, M.D. a PGY-5 Triple Board resident, Jennifer Downey, M.D. Teichner Scholar, and Becca Timme, D.O. a PGY-2 Triple Board resident.

From left to right: Dr. Debra Katz, M.D. Residency Program Director of the University of Kentucky and Jennifer Downey, M.D. Teichner Scholar.

Dr. Downey and the University of Kentucky Resident group following her sexual history taking workshop.
The First Teichner Scholar Visit: 
Views from the Scholar 

by Jennifer I. Downey, M.D.

In 2006 the AAPDP with AADPRT (American Association of Directors of Psychiatric Residency Training) founded the Victor J. Teichner Award to promote the teaching of psychodynamic principles to psychiatrists-in-training. 

Victor J. Teichner, a former President of the AAPDP, was a respected psychiatrist/psychoanalyst who died at the age of 56. The award was created in his name with a donation from a grateful patient. She wanted to ensure that Dr. Teichner's creative psychodynamic approach would be part of the learning of the next generation of psychiatric clinicians. Honoring his extraordinary dedication to his patients, she funded the Visiting Scholar Award in his name.

The Award is made annually to one Psychiatric Residency program on the basis of an application to the Award Committee, composed of representatives of the AAPDP and AADPRT. The winning Psychiatric Residency Training Program receives a 1-3 day visit from a Visiting Scholar chosen from scholar volunteers affiliated with AAPDP. The choice of Visiting Scholar and structure of the visit are made by the Program. Visits take place in the year after the award to the winning program is announced (AAPDP web site, 10/11/09).

I was fortunate to be chosen as the first Teichner Scholar and visited the University of Kentucky in January 2008 for a three-day teaching intensive. The task of making such a short visit a meaningful educational experience for young trainees was an extremely challenging one. Luckily, my partner in this endeavor was Debra Katz, M.D., Training Director at University of Kentucky for the Adult Psychiatry Residency, Child Psychiatry Fellowship, and Triple Board Program. Debbie is energetic and full of ideas. She understands group process and involved her residents extensively in planning the visit. She also arranged for them to have released time to attend the teaching sessions - a big commitment for three days from a program with 4-5 years of trainees and busy clinical services.

For my own part, I decided to put aside the usual behavior of the visiting expert as much as possible. Because I wanted the residents to be active, not passive, I asked them to present their cases to me rather than talking about my own cases. I tried hard to focus on practical “hands-on” clinical knowledge, not theory. I used the sexual history, a topic I teach in my own institution, to focus the residents on a skill they could learn and apply every day in their clinical work. I tried to “walk in the shoes” of the residents-go to their work places, interview their patients, and discuss their cases. Given that this goal involved driving me around in the middle of the worst ice storm Kentucky had had in 50 years, that we were able to do it seemed like a miracle.

The experience of visiting the University of Kentucky enlightened the teacher as much as the trainees. I found the residents and fellows concerned about their patients, informed about their work, and eager to discuss how my ideas (which they already knew about) could be applied to their cases. Huddled in ice-bound conference rooms and auditoriums, we had the spirit of guests at some far-off resort where the elements forced us to stay inside, relate intensely, and develop rapport. In the months following the visit, I received notes, photographs, and emails from trainees about how the experience had informed their work. In fact, one of those fellows will be the Early Career Psychiatrist Presenter on the Academy’s panel at the APA meeting in New Orleans in 2010.

I will return to Lexington this year, this time funded by the University of Kentucky, and look forward to teaching more about the practical use of psychodynamic thinking. This Teichner Scholar returned from Kentucky not depleted but inspired and enriched. This wonderful teaching opportunity was made possible by the Teichner Committee, the Academy, the University of Kentucky and Debra. As my patients say, “How great is that!”

Dr. Downey is a Clinical Professor of Psychiatry and Faculty, Center for Psychoanalytic Training and Research, Columbia University College of Physicians & Surgeons, NY, NY. Her email address is jid1@columbia.edu.
The First Teichner Scholar Visit Award: Views from the Program
by Debra A. Katz, M.D.

In January 2008, in the midst of one of the worst ice storms in Kentucky, the first Teichner Award visit took place between Jennifer Downey, M.D. and the University of Kentucky. Despite lack of power and ice encrusted roads, the visit was warmly received and judged to be a resounding success by everyone involved! As a testament to their commitment to taking advantage of all that this award offered our program, residents and faculty braved the weather to attend the three days of sessions that were scheduled as part of the visit. The Teichner Award has reinvigorated interest in dynamic psychiatry amongst the resident group and has fostered a close connection between Jennifer and the residency program which will continue with a follow up visit this year. I would like to extend my deepest thanks to the Academy for making this experience possible and to share with you the impact of this award on the program.

Applying for the Award

I first learned about the Teichner Award at the American Association of Directors of Psychiatry Residency Training (AAD-PRT) meeting when the award was announced to the membership which consists of psychiatry residency program directors from around the country. As a program director, I was concerned about the lack of respect residents seemed to have for dynamic psychiatry and worried about the lack of resources and role models within my program. I had trained in a program where there were many analyst supervisors and knew how important it was to have both teachers and supervisors who approached understanding patients with an appreciation for the complexity and uniqueness of human experience and who could impart these skills to residents. I could not do all of this singlehandedly in my program and was eager to find some help and support. I thought that having a visiting scholar would allow residents to see that a prominent faculty member from another institution embraced psychodynamic ideas and understood and treated patients (very similar to the kinds of patients our residents see) with psychodynamic principles in mind. My hope was that during the course of the visit residents would realize that psychodynamic psychiatry was not just one “type” of psychiatry but would learn but that psychodynamic concepts informed all interactions with patients. I also hoped that a visiting scholar would make residents curious about themselves, their own histories and relationships and the unique impact of their personal backgrounds on their work with patients. I filled out the application and was thrilled when we found out we had won!

Choosing a Scholar

Our residents and faculty were honored to have won this award and were eager to be actively involved in the scholar selection process. I quickly received a packet of possible choices for our visiting scholar and knew that we would have a very hard task choosing a scholar given the many possibilities. I quickly realized I needed help and arranged a series of group meetings to carefully review the potential scholars. The 32 residents in my program took this task very seriously, and I received numerous e-mails and questions about the pros and cons of various people. The residents considered this “their award” and “their scholar,” and, in retrospect, I think this sense of ownership set the tone early on for how the entire visit would go with residents actively involved in planning and orchestrating all aspects of it.

We were eventually able to narrow our choices to four of five people. One of these people was Jennifer Downey, M.D., a scholar the group was intrigued with because of her background as a researcher, psychoanalyst, teacher and an expert on sexuality and gender. The resident group was very interested in learning more about a number of topics Dr. Downey listed on her application. These included how to take a sexual history, sexual development in heterosexual, bisexual, gay and lesbian patients, how to understand and work with internalized homophobia and the psychology of women throughout the life cycle. Since we have a number of women residents in our program, the group was especially excited about having a woman scholar and focusing on issues relevant to women and sexuality. I thought that having a topic like sexuality might serve as a way to anchor a psychodynamic understanding of patients that would engage residents and serve to illustrate many aspects of dynamic psychiatry that might be less threatening than talking about dynamic issues directly.

Preparing for the Visit

Preparing for our Teichner visit was a crucial part of ensuring its success. One of the most important aspects of this process was releasing resident from clinical responsibilities to attend the planned sessions. Doing this underscored the importance of the visit and demonstrated my ability to take care of them in a way that emphasized my commitment to their learning. Over many months, I had the opportunity to meet with the resident group to solicit ideas, concerns and logistic issues regarding the visit. Residents had wonderful ideas about how to structure the three days with a mix of small and large group sessions and were instrumental in developing the schedule. They felt strongly that they wanted to share Jennifer with the wider university community in a grand rounds jointly sponsored by the departments of Pediatrics, Internal Medicine, Obstetrics and Gynecology and Family Practice. This served to showcase our department, Jennifer and the award. Residents wanted sessions geared towards residents of all levels as well as child and adolescent psychiatry residents and faculty. During this planning phase, I also had the opportunity to meet Jennifer in person at a meeting and talked with her on the phone a number of times about her ideas for the visit. We immediately connected on a personal level and worked through the many decisions about the structure of the visit. The final schedule consisted of three case conferences, a
hospital-wide grand rounds, a departmental grand rounds, an
inpatient interview, a sexual-history workshop and a faculty-
supervision workshop.

Prior to Jennifer’s visit, I arranged three sessions with resi-
dents to read and discuss several papers she had written. This
served to introduce residents to Jennifer’s ideas and areas of
interest and increased enthusiasm for the visit. The resident
group had a chance to think about their own questions in rela-
tion to the topics we would be discussing during the visit and
had already begun to think about dynamic psychiatry with more
respect and curiosity.

The Visit

Jennifer arrived in Lexington just before the airport shut down
for a major ice storm! Despite the chill outside, the atmosphere
inside was warm and lively. Residents and faculty were excited
about finally meeting Jennifer and anxious to learn from her.
Despite power outages, day care closings and icy roads, the
turn-out at all the sessions was phenomenal, a testament to the
enthusiasm and importance of the visit for our program.

In the case conference sessions, residents presented their own
cases, asked wonderful questions and came away with a deeper
understanding of their clinical work. Jennifer’s decision to hear
residents’ cases, rather than to present her own, was crucial and
demonstrated that a dynamic understanding was relevant to all
patients, including rural, poor and very sick patients. In the child
psychiatry case conference session, an adolescent girl who called
herself a “drag king” was presented. This highlighted the inter-
section of dynamic issues with sexuality and allowed residents
to consider theoretical and practical issues regarding family,
cultural and developmental influences on gender identity and
sexual orientation. Jennifer commented about local differences
in social attitudes and values when the resident presenting the
case described how the child’s school had been picketed by a
“God Hates Fags” group because of her presence there.

On the inpatient unit, Jennifer interviewed a fascinating
patient who had been admitted after slashing her throat a day
earlier in a suicide attempt. Residents were impressed and
awestruck watching Jennifer interview this patient and seeing
how she carefully and sensitively developed an understanding
of what had led to this woman’s depression and suicide attempt.
She also demonstrated how this woman’s psychiatric problems
could not be understood without understanding who she was as
a person which included much more than a symptom checklist
or a depression inventory. Jennifer illustrated how exploring
this woman’s early and recent losses, current relationship with
her husband and financial stressors led to a much fuller under-
standing of why she made such a dramatic and serious suicide
attempt. The PGY-1 and 2 residents who watched this interview
and discussed it afterwards were impressed with both the way
in which the patient had been interviewed as well as by how
much they learned about her which impacted on their treatment
plan and recommendations for follow-up care.

All residents attended a full afternoon workshop on taking a
sexual history which was rated as one of the best sessions of
the visit. Jennifer reviewed the content of a sexual history in a
practical and helpful way for residents. This served to illustrate
how much more there was to learn about patients’ sexuality
besides the sexual side effects of antidepressants, the main area
of inquiry about sex that residents tend to pursue. Discussing
the content areas of a sexual history also helped residents know
how to ask these questions in a practical, jargon-free way and
reduced anxiety about this task. Residents began to feel inspired
about actually doing this with their own patients and began to
see the importance, from a dynamic perspective, of a patient’s
sexual history in the overall context of their life. Jennifer il-

lustrated how residents at Columbia integrated this information
into a psychodynamic formulation by reading several of their
summaries which allowed residents in my program to real-
ize that they were capable of doing this too! Residents were
extremely enthusiastic about this session and came away from
it with both practical skills as well as a deeper appreciation of
the importance of a sexual history in their overall understanding
of their patients.

Both grand rounds sessions were well-attended and highly
rated. The university-wide grand rounds served to showcase
the award as well as psychiatry in general and enhanced respect
from the medical colleagues about what they could do to assess
and understand their patients’ sexual concerns. It also led to an
appreciation of the unique contributions psychiatrists can make
in helping patients in areas such as sexuality that cut across
multiple specialties. The grand rounds for psychiatry covered
topics such as psychodynamic ideas on women’s sexuality, sex
differences in erotic behavior, developmental influences on sexu-
ality and the impact of biological events such as menstruation,
pregnancy and childbirth. The link between biological and psy-
chological research on female sexuality and dynamic issues with
female patients was extremely interesting and well-received.

Survey Information

A pre- and post-visit anonymous survey of residents and fac-
ulty confirmed the perception that the visit had been extremely
successful. The overall visit as well as the individual sessions
were rated at the highest level by the vast majority of residents
and faculty. Residents rated their interest in psychodynamic
psychiatry as having increased significantly as a result of the
visit and stated that their skills as therapists had improved as
well! While it is hard to judge the impact of this visit on resi-
dents’ clinical skills, the group was clear that they felt much less
anxious about talking with patients about a variety of issues,
including sexuality, and saw a dynamic approach as relevant
to the wide range of patients they were seeing. The Teichner
visit also influenced residents’ overall perception of dynamic
psychiatry with group viewing it much more positively than
they had prior to the visit. Feedback about ways to improve the
visit included more sessions for faculty, more informal events
for residents with Jennifer (e.g., lunches and dinners) and more
case discussions and live patient interviews. In retrospect, we
had to make hard decisions about how to structure Jennifer’s
time during the visit and wish we could have extended the visit
for several more days to accommodate all of these requests!

Final Thoughts

The Teichner Award was extremely important in enhancing
a sense of respect for psychodynamic psychiatry amongst the
resident group and reinvigorating dynamic teaching within our
program. Jennifer allowed residents to see how she utilized
a dynamic approach in thinking about and interacting with patients
of all kinds and demonstrated how much richer clinical work
could be when practicing from a dynamic perspective. Residents
and faulty were able to appreciate the impact of a dynamic perspective on clinical work through the personal connection that developed with Jennifer during the visit which allowed them the chance to get to know her, to discuss her ideas and areas of interest and to ask questions. It has led to a strong wish to keep Jennifer involved with our program. We now have plans in place to bring her back for a follow up visit and grand rounds this coming year.

I personally benefited from seeing how Jennifer teaches and interacts with residents and have been grateful for her ongoing interest and availability to help with didactic and curricular issues. Being the first Teichner winner has also led to my involvement with the Academy, a group I knew little about before this experience, and which has fostered a number of new and wonderful relationships and opportunities for me. I have encouraged my residents to get involved as well and have urged other program directors to apply for the award. In closing, I would like to extend my deepest appreciation to Sherry Katz-Bearnott and the members of the Teichner committee for developing this award and to Jennifer Downey, M.D. for making this experience such an overwhelming success.

Dr. Katz is Associate Professor of Psychiatry and Neurology, Vice Chair for Education, Child and Adolescent Psychiatry, and Residency Program Director, University of KY, College of Medicine, Lexington, KY. Her email address is d.katz0@email.uky.edu.

Trauma, Resilience and Psychodynamic Psychiatry: 54th Annual Meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry, New Orleans, LA

by Raul Condemarin, M.D.

The 54th annual meeting of the AAPDP will take place in New Orleans, Louisiana, May 20-22, 2010. The theme of the meeting is, “Trauma, Resilience, and Psychodynamic Psychiatry.” The destruction that Hurricane Katrina produced in New Orleans when it struck the Gulf Coast of the United States in August 2005 initially displaced more than a million people from their primary place of residence. Subsequently they faced multiple challenges such as physical injuries, poor conditions of living, and significant mental health distress, so surely New Orleans is an appropriate place for a meeting on this theme.

Trauma can affect people in different ways, but primarily it disrupts the pattern of psychological life and disorganizes all sorts of interpersonal relationships. The effect of trauma and psychological resilience to it continues to be a main area of study for psychoanalysts and dynamic psychiatrists. There is always a strong interest in new findings that can serve as protective factors to improve treatment outcomes in such patients. We will explore these themes among others at our next meeting in New Orleans.

The co-chairs for this meeting, who began work in August, are Raul Condemarin and David Lopez. They benefitted from the advice of the Chair of Scientific Programs, Eugene Rothe, and the assistance and support of program committee members Silvia Olarte, Matthew Tolchin, Debbie Katz, Nisba Hussein and Tim Lacey. At the time this article was written we have received many interesting submissions and already have a tentative program that promises to be very exciting.

Here are a few of the topics:

During last year, a productive dialogue occurred between psychoanalysis and neuroscience in order to expand that discussion we will continue to implement panels that explore the interface between these two disciplines under the direction of Matthew Tolchin and Tim Lacey. They are working on tentative topics such as Insight, A Neurorelational Framework for Interdisciplinary Practice, A Representational Framework for Dynamic Phenomena, and others.

It is well known that maltreatment in childhood is a risk factor for adverse influences in infant development as well as altering the developmental capacity of the self. Child psychiatrists and psychoanalysts deal often with these issues so Debbie Katz has organized a child psychiatry panel that includes Charlie Zeenah, Marty Drill and Joy Osofsky. Charlie is the Director of the Child and Adolescent Psychiatry Program at Tulane University. His academic interest and research includes disturbances and disorders of attachment, and PTSD symptomatology in young children. He has multiple publications on attachment disturbances in Romania’s children, and children in orphanages. Joy Osofsky is a researcher and recently published a study on PTSD in children after Hurricane Katrina. This panel will certainly attract the interest of clinicians and will be chaired by Nisba Hussein. The Opening Night Speaker for our meeting will be Howard Osofsky, the Chair of the Department of Psychiatry at Louisiana State University. He is a recognized leader in the advocacy efforts to help children and families exposed to violence and terrorism. In conjunction with Joy Osofsky, he published a large study to examine factors related to the development of PTSD in children and adolescents after Hurricane Katrina.

Glen Gabbard, a teacher well known to our Academy, will be the Keynote Speaker. He is the Brown Foundation Chair of Psychoanalysis and Professor of Psychiatry at Baylor University
School of Medicine in Houston and the Joint Editor-in-Chief of the International Journal of Psychoanalysis. Glen has authored or edited 20 books and more than 200 papers. His clinical interest is in personality disorders, psychoanalysis, psychiatrists in film, as well as combining psychotherapy and pharmacotherapy.

Silvia Olarte is organizing a panel about long term psychotherapy cases that will include instructive case presentations from experienced analysts. The inclusion of resident panels concerning psychodynamic psychotherapy has been a welcome addition to our program. This year we have invited the psychiatry residents of the Harvard Longwood program to present and discuss their struggles and challenges with long term psychotherapy cases in other settings in their training.

There will be a variety of other topics that will appeal to all sorts of interests. Even the topic of jazz and psychoanalysis will be present at our meeting, for Scott Schwartz is going to discuss Improvisation in Music and Analysis (tentative title).

A group of clinicians and anthropologists from the department of Psychiatry and from Social and Global Medicine at Harvard Medical School will present ‘Reflections on a Cultural Sensitivity Course for Psychiatry residents’ after more than 10 years of teaching this course. Ralph Wharton is working on a panel on Pain and Psychotherapy. We have received additional wonderful contributions from academy members that we are in the process of including in the program. Some of these are: the initial dream and other dreams, self states, the self and depression, the elusive private self, episodic memory and neuroanatomy, self hatred as a transitional object, religion and trauma.

We would like to invite you to attend the New Orleans meeting and enjoy this very exciting program which continues the spirit of innovation and scientific freedom that characterizes our Academy. It also offers you an opportunity to meet a variety of new and old members of the Academy in a warm and social atmosphere.

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**New Orleans: Post-Katrina Tour**

*by Helen E. Ullrich, Ph.D., M.D.*

New Orleans has something for almost every age and every interest group. The pirate Jean Lafitte, who played an important role in the U.S. victory over the British in the Battle of New Orleans, may still have buried treasure in these parts. The diverse city gives evidence to French, German, Spanish, Italian, Irish, Acadian, plantation, American, and African-American cultures. These are reflected in the food, music, and architecture. I will begin with an historical background to New Orleans. In a mailing to the Academy membership, I will take you on a tour of the all-important cuisine, the neighborhoods including a discussion of the impact of Katrina, the museums, the music, and finally the areas beyond New Orleans. This is the order in which I would treat a guest. As the meeting is in New Orleans, in a sense you all are my guests.

The city is formed like a saucer with the highest area beside the Mississippi River. This ‘sliver by the river’ remained dry during Hurricane Katrina. Not surprisingly, this was the area where the French first settled. In 1700 while Bienville was exploring the Mississippi from a base camp in Biloxi, he met an English frigate near New Orleans. Telling the English that he was part of a small exploratory force from a larger French settlement upriver, Bienville was responsible for the English turning back and thus secured the area for the French. Since then the area where the British turned back has been known as English Turn. You may have heard of English Turn as golf course that has been the site of prestigious tournaments and as a prominent residential area.

In February 1718, Bienville instructed his engineers to design New Orleans. This oldest section is the French Quarter. In 1727 six nuns arrived to establish the Ursuline Convent to educate women and to care for the sick. More than 280 years later the Ursuline Academy in another location continues to educate women. Among its graduates are the retired Congresswoman Lindy Boggs and the current Louisiana United States Senator, Mary Landrieu. Those who enjoy walking may walk through the French Quarter for a tour of the Ursuline Convent (1114 Chartres St.). Closely is the Beaufregard-Keyes House on 1113 Chartres St. For chess aficionados this was the birthplace in 1837 of the champion chess player Paul Morphy; for Civil War aficionados this was General Beauregard’s home; later it became the home of the novelist who wrote *Breakfast at Antoine’s.*

To encourage settlers the French government provided dowries to women who came as brides for the single males who had come initially in the 1700s. The Spanish acquired Louisiana in the Treaty of Fontainebleau (1762) and the treaty of Paris (1763) and then returned it to the French (1801) who then sold it to the Americans as the Louisiana Purchase (1803). The Cabildo, now a museum in the French Quarter, was the seat of government during the Spanish Colonial period, rebuilt after the 1794 fire, and is one of the few surviving structures of the colonial era.

New Orleans, a city below sea level, is between the Mississippi River and Lake Ponchartrain. The sliver by the river and the French Quarter, the first areas originally settled, are on higher ground and consequently did not flood when the levees broke after Hurricane Katrina. The areas that flooded during Hurricane Katrina were invariably reclaimed marshland. 'The Crescent City' reflects the importance of the Mississippi River, as New Orleans is located on a bend in the river. Because the river fails to follow predictably north, south, east and west, New Orleanians give directions as riverside or lakeside. Uptown and downtown are the other coordinates for directions. The French Quarter is downtown and was the area settled by the French and the Spanish. When the Americans came, they moved uptown. After the Louisiana Purchase the Americans settled in the Garden District and Uptown. Canal Street, which had a canal along part of the street until 1858, separated the two areas. One may find many elegant old homes in the French Quarter, along
Esplanade on the side of the French Quarter opposite Canal Street, along St. Charles Avenue, and in the Garden District.

‘The Big Easy’ has long been known for its relaxed life style, Mardi Gras, jazz, and its food. Usually on a weekend one can find a festival. To avoid Jazzfest is a primary reason the New Orleans APA meeting in later than usual. At Jazzfest there are few hotel rooms and getting around the city is a challenge. Other New Orleans festivals include Mardi Gras, the Southern Decadence Festival, the tomato festival, the seafood festival, and the French Quarter Festival. The first Saturday evening of each month the art galleries along Julia Street hold open house. White Linen Night for the art galleries along Julia Street is followed the next week by Dirty Linen Night for the art galleries along Royal Street in the French Quarter. One can also find information about New Orleans on the Internet.

The Consortium for Psychoanalytic Research 17th and 16th Annual Conferences: Worthy of Your Attendance

by Ann-Louise Silver, M.D.

I am urging Academy members to come to Washington, D.C. to attend the 17th annual conference of The Consortium for Psychoanalytic Research, the latest in a wonderful series nurtured by long-time Academy Fellow Sheila Hafter Gray. These meetings are consistently profoundly informative. Regular attendance leaves one increasingly capable of evaluating research papers and constructing one’s own research questions. Please reserve Sunday, February 21, 2010 when Patrick Luyten, Ph.D. and the participants will address the topic, “Mentalization as a Multidimensional Concept: Implications for the Treatment of Patients with Trauma-Related Psychopathology.” As is increasingly evident, trauma triggers an ever wider variety of mental ills. Dr. Luyten is a psychoanalytic researcher and clinician from the Catholic University of Leuven, Belgium (founded in 1425).

He applies emergent research findings to mentalization, the metacognitive ability to reflect on internal processes, looking at a range of conditions: anxiety and eating disorders, antisocial and borderline pathology and functional somatic complaints. He will demonstrate a link between different diagnostic categories and different types of impairment in mentalization, and will show how his research supports a developmental, biobehavioral model of the relationship between stress, individual differences in attachment, and mentalization. I believe we will see how research can support our own intuitive sense of the development of our patients’ difficulties. Thus we will come away from the meeting feeling both strengthened and supported. Academy leaders Gerald P. Perman and Sheila Hafter Gray will serve as co-chairs. Discussants in the afternoon’s panel will be Melanie Starr Costello, Jill Savege Scharff and Shoshana Ringel. The registration fee is just $68 for most of us (continental breakfast and boxed lunch included) and $38 for students and active military personnel. Physicians, psychologists and social workers can earn 6 hours of CE credit. The registration deadline is February 7. The brochure including registration application can be found at www.CPRincDC.org.

Last February, Jane Tillman, PhD, who is on the staff of the Austen Riggs Center in Stockbridge, Massachusetts, presented aspects of her work to the attendees of the 16th annual Consortium for Psychoanalytic Research. Then she introduced us to the quantitative research exercise, and we went on to discuss it. As always, we met in the auditorium of the Sibley Hospital for an all-day Sunday event. It began with our completing a questionnaire which we would revisit after the morning’s presentation. We then had a lunch break, reconvening for the research arm of the day’s event. Our topic was intensely emotionally challenging: What are the psychological effects on the clinician of the suicide of his or her patient?

Tillman began by introducing us to qualitative research methodology, delineating the differences between epidemiology, quantitative studies and qualitative interviewing. Then she described the four types of research interviews: phenomenological, ethnographic, grounded theory, and the psychoanalytic research interview. Her first hypothesis was: 1) MDs are more likely to experience the suicide of a patient than social workers who are more likely than PhDs, since a higher volume of patients means greater exposure to risk, and MDs tend to see sicker patients; 2) less than half the attendees at a conference on suicide will have had a patient suicide and; 3) Clinicians with a completed suicide will report more subjective distress than those with attempted suicide. Her second hypothesis was: B) the gender of therapist and patient wouldn’t make a difference regarding attempted or completed suicide.

She received 74 surveys, and the vast majority of clinicians had been in practice over four years and was highly trained. Twenty-one percent were psychoanalysts, 42% psychodynamic, 5% cognitive-behavioral. On average they saw 15.5 patients per week, and there were five patients in analysis. We were asked on a scale of 1 to 6, how worried were we about the possibility of having a patient suicide. The most frequent response by far was 2. We also answered 2 on average in rating our reluctance to take on a patient with a past history of a serious suicide attempt. Almost all of us said we had had very little training regarding how much formal education we had received on the effects of suicide on clinicians. In our experience, 22 had a patient attempt suicide and 29 had a patient complete a suicide. We were asked how aware had we been that the patient was in a suicide crisis,
and what methods the patients had used. Then we were surveyed on our own symptoms – sleep disturbance, nightmares, feelings of guilt, regret and shame, trouble in our own family relationships, our worries about lawsuits and damage to our reputations, worry about loss of referrals, and whether we had crying jags, all this comparing the suicide attempts and completed suicides. Did we become physically ill, lose interest in being a therapist, did we become numb, angry at the patient or his/her family, did we lose self-esteem; did we become depressed or anxious? Then we were asked about the actual sequelae of the suicide.

In the midst of this, we were all jolted by the hospital alarm – a loud, screaming noise, flashing lights and the redundant announcement of a particular code. It was random theater that echoed with our feelings at those times we were considering in our survey. Additionally, an important person in our community had recently committed suicide. There was no way we could know who among us had come to the conference in an effort to deal with their raw grief. And we were seated in a fixed-row theater. There were no break-out rooms and thus no possibility for us to break up into groups of eight where we would have felt more comfortable in discussing our own painful clinical or personal experiences. While this was disappointing, the day itself was very helpful. We all gained considerable clarity and strength.

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**The Task Force on Future Directions Begins to Wrap-Up Its Projects**

*by David L. Lopez, M.D.*

The Task Force for Future Directions is celebrating its accomplishments of the last year and a half and realizing with pride that the hard work and ingenious ideas of its members have paid off handsomely. The Presidential Initiative of Joan Tolchin put this Task Force for Future Directions together in May of 2008 as a cornerstone of her presidential agenda for her 2008-2010 term. It has been Co-Chaired since the beginning by Clarice Kestenbaum and me and has as members prestigious senior Academy leaders Jules Bemporad, Gene Beresin, Richard Brockman, Jim Edwards, Buddy Glucksman, Doug Ingram, Tom Kalman, Hae Kim, and Mark Novick. David Forrest, Tim Lacy and Charles Nemeroff have been consultants to this task force. The charge for the Task Force was to put into action a plan to transform the Academy into a vital organization that would attract younger psychiatrists. As the end of Joan Tolchin’s presidency is approaching, the groundwork for this transformation has almost been completed.

Before Joan Tolchin’s presidency, the Academy went through a very complicated and lengthy process in which consultants from the William Alanson White Institute interviewed numerous Academy members and then presented a comprehensive report to our Executive Council. One of the concrete recommendations from this consultation was that the Academy needed to strengthen its ties to the American Psychiatric Association. In addition, the consultants advised that the Academy become more attractive to younger colleagues. The Task Force for Future Directions was created with the charge of looking at different areas of the Academy, working closely with several Academy Committees, and promoting projects that would implement these findings.

One of the first responsibilities of the Task Force was to search for the historical photographs and documents of the Academy. Buddy Glucksman, Jim Edwards and I did this. The idea behind this project was to be able to show, in a technologically advanced way, the history of the Academy to our younger members. This group went to the Central Office and found historical documents from the Academy’s most important events. These history buffs also found some of the best preserved documents at the Oskar Diethelm Library at the Payne Whitney Cornell Medical Center building in Manhattan. Many of these pictures and documents can be seen at www.psychodynamicpsychiatry.org.

As a result of the vigorous and constant work of this Task Force, the Academy has been able to increase its membership significantly through creative and straightforward projects. The booth that our President, Joan Tolchin, coordinated during the Washington DC and San Francisco APA meetings brought into the Academy about 5% of its current membership. The booth was strategically placed at the Exhibit Hall of the APA Annual Meeting, achieved in part thanks to the help of Academy member and former APA President, Carolyn Robinowitz. It allowed members of the Academy to interact directly with potential members, and to present individually our philosophy and approach to treatment. It also was a way to broadcast our mission and vision for psychodynamic psychiatry in American Psychiatry.

In October of 2008, the Task Force for Future Directions was able to coordinate, together with the Website and Electronic Communications Committee, the construction of a new state-of-the-art website. We have been able to do so with one of the most prestigious web designers in the country, eTapestry. Our previous website had been constructed, as a hobby, by a late member of the Academy, Joe Weissberg. It served its function superbly for 9 years, until technology advanced to the point of making it seem obsolete. Thanks to this initiative, the Academy has been able to keep up with the pace of electronic progress as we continue the legacy of excellence set in place by ex-President Weissberg.

The most difficult aspect of the website design process was to choose the pictures that would accompany the website. The Committee studied more that 200 pictures and presented two to the Executive Council which turned them down. I decided to bring my Nikon SLR to our San Francisco Meeting and asked
our website designer to improve them with state of the art Photoshop enhancements. The Committee finally unanimously agreed to use four pictures which show attendees at our San Francisco meeting.

The future directions that this Task Force has set in place are promising for our Academy. They have set the foundation for an exciting future and our ability to promote psychodynamic psychiatry among our psychiatric community. It has brought us into the XXI Century with outstanding initiatives that we hope can be now used wisely by the incoming administration. I personally want to thank my Co-Chair, Clarice, for setting the tone, bringing her experience, and a very humane but structured manner of organizing complex tasks. I also want to thank our members for brilliant and insatiable work that has brought us great rewards; and I want to thank our President, Joan Tolchin, for actively working with us in the different subgroups of the Task Force and providing us with her visionary leadership.

**OPINION**

*Systems Integration Reform in Mental Health*

by Carolyn Howell, M.D.

Between April 2007 and February 2008, several horrific events were reported in the media. In each of these cases, a homicide, suicide, or both occurred. They each also have in common a connection to multiple agencies. However, there was no collaboration among these agencies, such that proactive measures could have been taken in their lives, and/or the lives of their victims. Seung Hui Cho was the student at Virginia Tech who on April 16, 2007 went on a shooting rampage committing the deadliest school shooting in U.S. history and what has come to be known as the Virginia Tech massacre (Virginia Tech Review Panel [VTRP], 2007). After killing 32 people and wounding 25 others, he committed suicide. Cho was diagnosed with selective mutism in the eighth grade. His parents sought treatment for him through medication and therapy. He was later diagnosed with Major Depressive Disorder and Social Anxiety Disorder. He was prescribed Paxil for one year. An Individualized Education Plan was developed for Cho in January of 2001 while in high school. He was placed in special education under the classification “emotional disturbance.” He was excused from oral presentations and participation in class conversation and received speech therapy. He continued to receive mental health therapy until his junior year when Cho rejected further therapy.

Cho’s interventions in middle and high school resulted in his improved adjustment and emotional status (VTRP, 2007). However, this did not continue in college. Considered forbidden by federal law to share (without Cho’s permission) any record of disability or treatment, Westfield High School officials disclosed none of Cho’s speech and anxiety related problems to Virginia Tech. Nor did Virginia Tech ever inquire about a previous history of mental illness or special education needs. Although the Family Education Rights and Privacy Act (FERPA) and the American Disabilities Act generally allow secondary schools to disclose educational records (including special education records) to a university, federal disability law prohibits universities from making what is known as a “preadmission inquiry” about an applicant’s disability status. After admission, however, universities may make inquiries on a confidential basis as to disabilities that may require accommodation (VTRP, 2007).

On December 13, 2005 (two months before the incident), Cho was found “mentally ill and in need of hospitalization” by the New River Valley Community Service Board (Schulte & Jenkins, The Washington Post, May 7, 2007). Even though he denied suicidal ideation and denied symptoms of a thought disorder, he was suspected of being an imminent danger to himself or others. A temporary detention order was obtained at St. Albans medical center pending a commitment hearing before the Montgomery County, Virginia district court. On December 14th Cho was released from the mental health facility after Virginia Special Justice Paul Barnett ordered Cho to undergo mental health treatment on an outpatient basis, with a directive for him to follow all recommended treatments. Cho never complied with the order of mandatory mental health treatment as an outpatient. Also, neither the court, nor New River Valley CSB exercised oversight of Cho’s case to determine his compliance with the order for outpatient treatment. Virginia law actually requires Community Service Boards to “recommend a specific course of treatment and programs” for mental health patients and monitor the person’s compliance (Stewart, VTRP, 2007). If a person fails to comply with a court order to seek mental health treatment as an outpatient, that person can be brought back before the court. If still in crisis, that person can then be committed to a psychiatric institution for up to 180 days. Cho was never summoned to court to explain his noncompliance.

Cho stalked at least three coeds on campus. In two of the incidents, the girls called police and they responded to Cho’s dorm room. He was not charged with a crime, but he was referred to the Cook Counseling Center. Health care professionals at Cook Counseling Center never treated him. Cho’s parents were not made aware of his involuntary commitment and other events that happened in the fall of 2005 (VTRP, 2007).

Under federal law, Cho should have been prohibited from buying a gun after a Virginia court declared him to be a danger to himself in late 2005 and sent him for psychiatric treatment. Federal law prohibits anyone who has been “adjudicated as a mental defective,” as well as those who have been involuntarily committed to a mental health facility, from buying a gun (VTRP, 2007). The special justice’s order in late 2005 that directed Mr. Cho to seek outpatient treatment and declared him to be mentally ill and an imminent danger to himself fits the federal criteria and should have immediately disqualified him. Mr. Cho’s ability to buy two guns despite his history has brought new attention to the adequacy of background checks that scrutinize potential gun buyers. And since federal gun laws depend on states for
enforcement, the failure of Virginia to flag Mr. Cho highlights the often incomplete information provided by states to federal authorities.

Currently, only 22 states submit any mental health records to the federal National Instant Criminal Background Check System (Luo, New York Times, April 21, 2007). Representative Carolyn McCarthy, Democrat of New York, has been pushing a bill to require states to automate their criminal history records so computer databases used to conduct background checks on gun buyers are more complete. The bill would also require states to submit their mental health records to their background check systems and give them money to allow them to do so. The bill has twice passed the House only to stall in the Senate.

Banita Jacks is a thirty-three year old woman charged with murder after she was found January 10, 2008 in her DC home with the decomposing bodies of her four daughters (Alexander & Dvorak, The Washington Post, January 16, 2008). She initially told investigators that the children were possessed by demons and died in their sleep (Klein, The Washington Post, January 11, 2008). Her children were in and out of the public school system. On December 6, 2005 Jacks applied for housing assistance, listing a Mr. Fogle as her spouse and an address on 3rd St., NW, DC. For a week, though, the family apparently had no home. Jacks, Fogle and the four girls moved into the D.C. General Hospital’s hypothermia shelter Dec 14th and stayed for four months. While there, the couple applied for public assistance and enrolled the older kids in DC public schools. In March of 2007, her children were pulled out of school. Jacks told authorities she was home-schooling, but officials did not verify that (Alexander, The Washington Post, January 11, 2008). Once a child is truant for nine days, a report should be sent to Child and Family Services according to Sharlynn Bobo, then director of Child and Family Services. This reflects a need to report and enforce school truancy as well as home-schooling policies.

Social service agencies had contact with the family. School social worker, Kathy Lopes, voiced concerns to DC police and social workers with the DC Child and Family Services Agency (Alexander & Dvorak, ibid). She said that the girls were being held “hostage,” that she believed “abuse and neglect” was occurring and that the mother apparently suffered from mental illnes. Within 16 days of Ms. Lopes’ second call, Child and Family Services closed the case without ever seeing the children or making contact with any family members. Metropolitan police had contact with the family. During a visit to the home, Jacks was “very difficult” with police and a social worker (Morse & Dugan, The Washington Post, January 13, 2008).

In July ’06, three months after the family left the shelter, a nurse at George Washington Hospital phoned the city’s Child and Family Services agency and spoke with the hotline call-taker (Morse & Dugan, ibid). Fogle, a patient diagnosed with nasal cancer, had checked himself out, and the nurse was concerned that Fogle and Jacks had substance abuse problems. Jacks’ history of substance abuse was later confirmed. (She admitted this to a Pretrial Services Agency.) The nurse told the call-taker that the family was living in a van. Fogle died Feb 19, 2007. A month later, Jacks showed up at Meridian to withdraw the girls saying she was going to home school them. Fogle’s death devastated Jacks, and it appeared to have accelerated her alleged homicidal descent. Five DC government agencies had contact with Jacks while she and her daughters lived a chaotic existence in the city.

But the agencies failed to aggressively follow up.

Steven Kazmierczak killed six people including himself on the campus of Northern Illinois University, February 14, 2008 (Lydersen & Vargas, The Washington Post, February 16, 2008). He had a history of mental illness, yet purchased firearms and ammunition. Interestingly, Kazmierczak purchased two Glock 33-round magazines that would allow his pistol to carry many more than the standard number of bullets from the same website as the Virginia Tech shooter.

In each of these cases, the perpetrators had contacts with multiple systems, including human services, mental health, the judiciary system or law enforcement, the educational system and gun stores. Cho was successful in obtain guns and ammunition after a background check (legally required) failed to cross systems having vital risk factor information. Kazmierczak obtained his weapon accessories from the same website dealer as Cho.

If multiple agency involvement is a common problem, what is the solution? What if we had coordinated systems of care, instead of isolated individual agencies? Shared databases could exist such that data could be aggregated to reflect the consensus of professionals in an integrated system as to circumstances collectively considered to be high risk. There could be multiple points of entry into a collaborative system.

Only minor adjustments to existing privacy laws would need to be implemented, such that basic privacy rights are safeguarded while protecting more fully the safety and welfare of individuals. For example, certain case exigencies established through collaborative planning would qualify for additional exemptions from privacy rights/laws (children, known drug use, danger to self and others is already an exemption).

There are coordinated systems that already exist that can be used as a framework to build upon. Several agencies are increasingly supporting comprehensive continuums of care and services in their policies, procedures, technology and assistance to states, including the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Substance Abuse and Mental Health Services Administration (SAMHSA), and U.S. Depart of Education. The Veteran’s Administration is considered to be one of the best integrated health care information systems in the nation. They utilize an electronic health record with a clinical reminder system. Several private organizations have prioritized funding to promote systems integration, such as the Annie E. Casey Foundation and the Robert Wood Johnson Foundation.
The central group represented in the schematic is the core collaborative group called the Crisis Intervention Team (CIT). It represents the nexus/intersection of critical individual and family system information within individual agencies. Representatives from each agency would analyze case information identified through systems integration technology (integrated data bases programmed to red flag cases based upon CIT’s already determined critical risk factors). Collaborative decisions are made concerning risk factors and needed interventions based on the analysis. This process involves integration of information generated at the agency levels and is enabled by already determined multiple risk factor analysis.

The CIT has already engaged in consensus building toward identifying a unified list of cross connecting critical factors potentially emanating from individual agencies that would require CIT action. Collaborative decisions are made based on individual case circumstances and recent applicable empirical findings. An evidenced based risk factor instrument could be developed, e.g., a scale for suicide/homicide/familicide risk, and plausible interventions would be made based on risk factors as identified by the CIT. Such an instrument can be of assistance in both identification of treatment needs and outcome based evaluation – e.g., through pre/post measures offering baselines for determination of relative change and achievement of case objectives.

Based on case circumstances, a particular agency or agencies within the collaborative may need to carry out action plan determined by the CIT; e.g., patient with an Axis I disorder has fallen off the treatment wagon (Mental Health System/Treatment Facility), was recently arrested for aggressive behaviors (Judicial System), and has significant family system stressor(s) (Human Services/Child & Family Services). Given this scenario, the CIT’s action plan would include the primary involvement of the Mental Health and Human Services agency members.

The case management team is a separate team/arm developed by and responsible to collaborative agencies. It can be part of the infrastructure of the CIT, and its role involves ongoing scrutiny of interagency databases to identify at-risk cases. For example, the court order for Cho’s outpatient treatment after being submitted to the community service board from the court would be a red flag in the integrated database and the case management team would notice this because of their continued scrutiny of the information in the shared system. Workers would need relevant areas of expertise and high level clearances for access to sensitive information. Data information specialists with expertise in cross system/integrated data base technology would be required. An additional role of the case management team is to present to CIT identified cases/circumstances as derived from the information system which has been programmed to cross connect individual agency data according to the CIT’s already determined critical risk factors.

Collaborative systems are enabled by information technology. Therefore, a critical component of this integrated system involves individual agency overhaul of their data technology system to equalize information technology status among agencies involved. Such agencies would include the Department of Human Services, Mental Health System (core service agencies, mobile crisis teams, DC ACCESS, etc.), hospitals, the judiciary or law enforcement system, the educational system and gun stores.

Federal privacy laws designed to protect sensitive information about individuals seem in many instances to protect a person’s rights to harm themselves and/or others, and needs to be changed. We as mental health officials are so worried about following those laws that we often withhold information that can be legally shared with others. We are now moving into a new era, which calls for a new national dialogue about how individual privacy rights are weighed against public safety. For example, even the doctors treating Cho’s mental illness didn’t necessarily have all of the facts about him. Many people became aware of Cho’s difficulties including students, parents, resident assistants, teachers, administrators, the Tech police department and counselors. But, as Virginia Governor Timothy Kaine said, “there was not an effective mechanism for compiling information and taking action, either to intervene in an effective way, or even to contact Cho’s family” (Schulte and Jenkins, ibid).

Some anticipated challenges to this proposed system include:

- **Unequal databases** – everything from rooms full of stacked files, to highly advanced computer-based systems (like the VA system and other national and state programs)
- **Funding streams**, which can be isolated and contribute to turf issues. We need assurances against territorializing to minimize turf issues and to prevent an identified core agency from overshadowing collaborative efforts
- **Consensus building** – a consensus has to be established among agency members of the collaborative integration team to identify unified critical care needs (stemming from what is considered risk factors within individual agencies) – agreement is needed concerning collective risk factors

These and other cases collectively command the attention of governmental agencies and officials. There is increased attention placed on remedies/proactive solutions, including funding. Highly evolved information sharing systems now exist and collaborative information systems can be built from heterogeneous devices. With advances in information technology, increased specializations necessarily follow – this leads to a fragmented system, hindering unified services. Governmental agencies, politicians and policy-makers are already focusing their attention on integrated systems. It is therefore an opportune time to develop strategies to establish a coordinated system of care to be proactive in the lives of the mentally ill.

Dr. Howell was a third year psychiatric resident at the George Washington University Medical Center in Washington, D.C. when she submitted this paper. Her email address is cjhowell77@hotmail.com.
Remembering Freud: My Own Genuine Quasi-Memoir
by Roy R. Grinker, Jr., M.D.

My father (who I will subsequently refer to as Grinker)’s analysis with Freud was quite “orthodox,” focusing more on the transference issues, although (Ruit-inbeek, H. M., ed., 1973, Freud as We Knew Him, Wayne State Univ. Press, Detroit, pp. 180-185) Freud hardly behaved in the “surgeon’s mode.” Not only did he look up every place-name on his maps, but when Grinker “came through” with a good piece of analytic work, Freud would pound on his chair-arms, pound on the head of the couch, and congratulate his patient, with a spray of spittle, because of his palatal prosthesis and surgically-missing portion of his tongue, which made being right somewhat of an ordeal for the reclining patient. Whether my father wiped his face off or not I never knew, and never thought to ask (Grinker, 1940). This response to critical material was similar to Frances Hannett’s: she would sit behind the patient, knitting, and when something important was said, the patient knew it because the click of the needles would cease.

I remember that our apartment had a butcher shop on the street level, and an illegal printing press in the basement, which I watched for hours squatting on the pavement, peeking down through the open windows. Later, of course, it was closed down. But it was dismantled in such an unremarkable way that it did not seem to be an important event. My mother told me to first grade, and the principal said he would give me two weeks to learn to keep up with the class of all German-speaking Viennese children. My mother told him that was impossible, and that he was being totally unreasonable. He stood firm, however. Amazingly, I did it, and used to poke fun at my parents for their poor pronunciations. (When I was flunking premed Ger German in college, my teacher asked me why I was so bad in the language, but had a perfect Viennese accent – at that time then, I had no answer).

School was very different in Vienna. In first grade there was no organized or disorganized play. We sat at desks like little soldiers, wrote with pen and ink, had our mid-morning roll and jam, that we brought with us in little wicker baskets hung around out necks, (the brief-cases were strapped to our backs, full of books and homework papers).

One of the more traumatic moments of my life occurred in Vienna - Fraulein tip-toed in to the room where my sister and I slept to show off her charges to a friend. I woke with a startle and started crying. She was so angry (and obviously now humiliated), that she squeezed my transitional object, a thick rubber blow-up Popeye doll, and ruptured it permanently with her long red fingernails, thus instilling in me a life-long aversion to red nail-polish. At least, it was Popeye’s neck, and not mine. At seven, I was free to go to the Ring Strasse and St. Stephen’s church to play. One day, I excitedly ran home to tell my mother of a parade she should come to see with me. She recognized they were brown-shirt-Nazis, and within hours we fled the city, to Baden-am-Wien, where we felt completely safe, even though by map it was only 15 miles away. We stayed three weeks at the Pension of Herr and Frau Auhlich, a lovely grandparent-type couple. They had a beautiful garden, and the municipal swimming pool was directly across the street. After three weeks, we returned to safety in Vienna.

Upon our return, my friend Rudi showed me the shell-holes in the walls of his government-housing high-rise, and the barrel in which he hid in the basement during the shelling. There were still rolls of barbed wire in the streets. After that life seemed to return to normal, at least to my seven-year-old eyes. We went to school every day, with our uniforms, came home, did our homework, and snacked. My favorite food of all-time was Kupfel, which Liesl made every day and hid from me. The aroma was and is still divine. My first task was to discover the hiding place of the cookies which were always but in obscure and different places. It was great fun. Once, Liesl and my sister put a box of tea on top of a slightly-ajar door. When I opened it, it fell on my head. Everyone laughed at me. I shrieked in terror, and then made them repeat the same trick over and over again, until I was able to laugh too. This was clearly my first recollection of repetition in the service of mastery.

In July, 1934, Engelbert Dollfuss, the Chancellor of Austria, was killed by Austrian Nazis in an abortive coup (Gay, 1988). The Austrian republic survived as an independent nation for four more years. By this time, Hitler had shot most of his German co-conspirators, whom he suspected as rivals. (Then came Hitler and his troops to Vienna, in 1938, but we were safely back in Chicago long before then.) In 1934, we returned to and lived in Baden-am-Wien for six months, while my father commuted to his analysis in Vienna. One of Grinker’s concerns was that he would CHANGE TOO MUCH. Freud replied, “Don’t worry, Dr. Grinker. Your friends in Chicago will still recognize you” (personal communication).

One day, as we were driving in Vienna from Baden-am-Wien, my father asked me what kind of work I hoped to do for a living. I replied, “Papa, why should I work? I’ll just write out American Express checks – like you do!”

During the period of analysis, he took me along for one of his appointments. Freud petted me on the head, and said “Nice boy!” And that was the end of my personal tete-a-tete with the Herr Professor Doktor. When I asked my father what he was talking about with Freud, he said, “I am telling the Professor what a bad boy you are!” I replied, “Oh, no!, you are telling him what a bad boy YOU are.”

When the analysis was over, we went to London, and Grinker worked at Neurology and brain-cutting at Guy’s Hospital. We had a tutor who came to the house daily, apparently because it was less expensive than going to a “public” (private) school. In 1935, we returned to the United States on the S.S. Manhattan. The Manhattan was later a troop-ship during World War II. (The S.S. Champlain was sunk by Nazi torpedoes – this was the ship
we took to Europe.)

We met a young college student, Franz Ippisch, who served as a guide on various motor excursions. He was handsome and charming, flirting openly with my mother, or so my father thought. But they liked each other. In 1937, he wrote to us, asking us to guarantee to support him as an impecunious immigrant, which we did. He came to the U.S., then went to Guatemala, where his educational career as a chemical engineer stood him in good stead. He developed a bunch of rare grasses, which produced vital oils. For this he became a popular figure in Guatemala, and a multi-millionaire to boot. He was forever grateful and kept in touch yearly.

My father often and fondly quoted Freud as saying, “Dr. Grinker, your analysis has been one of the last great pleasures of my life.” This may have been Freud’s standard parting, but Grinker took it most seriously, and never forgot it. This mood was a far cry from what he met on his return. The University of Chicago was as anti-analysis and anti-psychiatry as ever, and going to work for Grinker was a daily ordeal to be endured (personal communication).

In 1937, Michael Reese Hospital in Chicago offered him a job as Chief of Psychiatry, to run the department as he saw fit. He went to see Alan Gregg, who had financed the entire expedition to Vienna for the benefit of the University of Chicago Medical School. Gregg was most sympathetic, and told Grinker that he should see himself as a “Johnny Appleseed” and spread the seeds of psychiatry and psychoanalysis wherever they might take hold. Gregg told him to go to Reese with his blessing (personal communication). At the same time, Grinker became a candidate at the Chicago Institute, and graduated with Certificate #27. In the course of his career, he had three analyses: Freud he liked, but felt he was more interested in proving his theories than in Grinker’s character change. The second, Franz Alexander he felt was most concerned in proving himself right. The third, he felt, did the most for him: this analyst was only interested in him, and his character and his neuroses, whatever they were. He liked all three immensely, was able to develop both positive and negative transferences to them, but clearly felt that of the tree, Freud was the least effective (personal communication). It must be remembered though, that Grinker’s analysis with Freud took place at the time of the earliest development of ego-id psychology, and there was no such thing yet as “working through.” Grinker did not have the time for that, and Freud had not the theory for that: that remained for his daughter to develop.

By 1950 he had built an 80-bed free-standing psychiatric hospital, and a large out-patient clinic, with 120 people on his staff, 115 of whom were either analysts or analytic candidates, and 15-18 residents at all times. He had successfully created a training institute, training psychiatrists with a “psychoanalytic frame.” As a graduate of that institution, I can testify that “P AND PI,” as it was called, (now the Singer Pavillion), was a ferment of excitement, learning, and scientific activities, as well as biological research (15 members). Residents came early and stayed late. My father published many books and papers, gave many speeches, created great animosity, portraying himself as an “intellectual gad-fly,” stinging the flanks of Organized Psychoanalysis and Psychiatry. No one had neutral feelings toward him. He was one of the founders of the Academy of Psychoanalysis and Psychiatry, which in its charter expressly devoted itself to scientific endeavors, and NO politics. This made Grinker often quite disliked, but he did manage to help foster the development of many men of distinction, including 19 other Chairmen of Departments of Psychiatry in the U.S.

Thus ends my “genuine-quasi” memoir. It consists of what I have read, what I was told or heard, and also of what I myself saw and experienced. Just as Chicago had its 1911-12 historical island, my mind has a six-eight-age island of clear and vivid memories, that hopefully, can “flesh” out the appropriate formality of the other contributors. It is my hope that in “fleshing out” Grinker, I have also been able to “flesh out” at least to some extent Sigmund Freud. Freud himself was worried that “we would deify him and deny him the human privilege of error.” (Grinker, 1940) I think we have kept the good and slowly deleted that which was inaccurate or not useful from Freud’s classical scientific work. It is no exaggeration to say that Marx, Darwin, Einstein and Freud have changed our understanding of people and of the world forever.

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See article on pg. 8 for more details
The Relevance of Evolutionary Theory to Psychoanalysis: A 2009 Anniversary

by Marco Bacciagaluppi, M.D.

In this article I take the opportunity of two Darwin centennials in 2009 (200 years from his birth in 1809 and 150 years from the publication of *The Origin of Species* in 1859) and of a Bowlby anniversary (40 years from the publication of *Attachment*, the first volume of his trilogy on attachment theory, in 1969) to discuss the relevance of evolutionary theory to psychoanalysis. A systematic examination of the explicit and implicit evolutionary premises contained in the various psychoanalytic models has been carried out by Slavin and Kriegman (The Adaptive Design of the Human Psyche, Guilford Press, New York 1992). In what follows I shall discuss Freud, a predecessor of Bowlby, and Arieti, a peer of Bowlby and of special interest to Academy readers—more briefly. I shall then discuss Bowlby at greater length.

Freud

At the end of Lecture XVIII of the Introductory Lectures on Psycho-Analysis (SE, Vol. 16, pp. 284-285) Freud states that the self-love of men received three major blows at the hands of science: one was the work of Copernicus, the second of Darwin, and the third of psychoanalysis. It is understandable that Freud, after the icy reception of his 1896 paper on hysteria and after changing his mind on the seduction theory in 1897, should now be proud to place psychoanalysis alongside Darwin, who was by then, after much opposition, an avowed authority. Darwin regarded evolution as taking place by natural selection acting on variation. He did not at the time have a clear notion of the origin of variation. This notion was only possible after Mendel discovered the basic laws of genetics in 1866. Even then the importance of this discovery was not recognized and had to await the rediscovery of Mendel’s laws in 1900. In the light of this discovery, the variation on which natural selection acts is the result of random mutation of genes.

Notwithstanding paying lip service to Darwin, Freud never really subscribed to this view. Ernest Jones (The Life and Work of Sigmund Freud, Vol. 3, Chapter 10) states that Freud remained to the end of his life a stubborn follower of Lamarck, namely a believer in the inheritance of acquired characteristics. Modern genetics does not provide any conceivable mechanism for Lamarckian inheritance. The phenotype (the product of the interaction of the genotype with the environment) adapts to its surroundings, but this adaptation does not become hereditary, i.e. is not transmitted to the genotype, and from there, through the gametes (in a multicellular and sexual organism), to the offspring. If, however, the organism is the carrier of a favorable mutant gene it has more chances of surviving and therefore of transmitting that gene to the offspring.

Arieti

Unlike Freud, Arieti stands firmly in the Darwinian tradition. In a commemoration of Silvano Arieti which my wife and I published in 1981, the year of his death (Bacciagaluppi, M. and Bacciagaluppi Mazza, M, In memoria di Silvano Arieti, Psicoterapia e scienze umane, Nuova Serie 4, 168-172) we wrote (my translation): “One of the aspects of Arieti’s work which most deserve to be developed is possibly the evolutionary approach. All his work is firmly rooted in evolutionary theory. As regards cognitive mechanisms, for instance, he suggests that the ontogenetic development from image to paleosymbol to symbol also reflects a phylogenetic evolution.” We concluded: “In our opinion, all these insights could converge into an ethological theory of normal and pathological behavior in man.”

In a later paper (Bacciagaluppi, M., 1999, Evolutionary aspects of Silvano Arieti’s work, Journal of the American Academy of Psychoanalysis, 27(4), 575-581) I wrote that Arieti, with The Intrapsychic Self (Basic Books, 1967) “had written a synthesis in which he studied both the ontogenetic and the phylogenetic evolution of cognition and emotions, their reciprocal relationships, their psychopathological transformations, and their expression in creativity.” The origin of Arieti’s evolutionary approach is clear in The Intrapsychic Self, where he repeatedly cites the ethological works of Tinbergen and Lorenz published in the 1950s.

Arieti’s evolutionary inquiry into cognitive mechanisms reaches its peak in a very important section of The Intrapsychic Self titled The Biological Origin of Knowledge and the Mesocosmic Reality. He writes: “Our whole interpretation of nature is imposed on us by the biological origin of our cognition. Moreover, it would seem that the psyche brings to awareness what was already implied in the living matter” (p. 196; italics in the original). He states that life exists in the mesocosm, a world of middle dimensions, as distinguished from the microcosm (a world of subatomic dimensions) and the macrocosm (a world larger than solar systems). “But life exists in the mesocosm…The categories represent what we have acquired from mesocosmic reality through a process of evolutionary adjustment.” To conclude: “The order of cognition derives from the order of the mesocosm” (pp. 197-198).

Bowlby

While Arieti was reading Tinbergen and Lorenz in the 1950s, Bowlby was doing the same on the other side of the Atlantic. On p. xviii of *Attachment* (Bowlby, J., 1969, *Attachment*, New York, Basic Books) he writes. “In 1951, at a sensitive phase in my thinking about problems of separation, Julian Huxley fanned a germinal interest in ethology and introduced me to the just published classics of Konrad Lorenz and Niko Tinbergen.” The evolutionary input was thus the same, but these two authors developed it in different directions. It may be useful to pursue the comparison between them.

As I say in the paper mentioned earlier (Bacciagaluppi, 1999), “In an essay on his intellectual development published three years before his death (Arieti, S., 1978, in Witenberg, E.G., Interpersonal Psychoanalysis, Gardner Press, New York), Arieti claims that…especially in the teaching of Frieda Fromm-Reichmann…he learned that the human species requires solid and lasting interpersonal relations. Arieti applied this principle in his therapy, without making it an object of further research.”
Instead, he devoted himself to the subject of cognition.

Bowlby also started from a clinical experience, the observation of the reaction of very small children separated from their mothers because of hospitalization. For him this experience also raised a fundamental question of a relational kind: What was the nature of the child’s bond to its mother? Unlike Arieti, Bowlby considered this question the fundamental aim of his research. The answer that Bowlby draws from this (reading ethology) is that “the baby’s attachment to the mother is an innate behavior, selected in the course of evolution because of its survival value.”

The survival value largely consists in the defense from predators. Attachment is part of a wider pattern, which Bowlby (Bowlby, J., 1988, A Secure Base, New York, Basic Books) defines as a secure base from which to explore. This wider pattern thus includes two basic needs: at first, that for attachment, and later, the need for autonomy. This is the subject of the first volume of his trilogy (Bowlby, 1969, op. cit.). In the reaction of children separated from their mothers there is a succession of three phases: protest (anxiety and anger), then, if separation is prolonged, despair sets in, and finally detachment. The first phase is the subject of the second volume of the trilogy (Bowlby, 1973, Separation, New York, Basic Books). The second and third phases are the subject of the third volume (Bowlby, 1980, Loss, New York, Basic Books).

Within this conceptual framework Mary Ainsworth observed the behavior of children at one year of age in an experimental setting termed the Strange Situation. The style of attachment of the children was related to observations of the interactions with the mothers in the home in the previous months. Three types of attachment were described: one was secure, two others, resistant and avoidant, were termed insecure. Finally, Mary Main described a fourth type of attachment, of great clinical importance, termed disorganized, when the mother was unavailable due to a loss. This fourth type may be the antecedent of borderline pathology. All this work led in turn to an impressive amount of empirical research by many other authors.

Arieti’s evolutionary approach included a much wider range than Bowlby’s and could have led to an equal or even greater amount of specific research, yet he is now rarely mentioned in the literature. Maybe Arieti’s work was carried out, to some degree, in isolation, and this explains his lack of followers.

There is a surprising antecedent of Bowlby’s interest in evolution and ethology. In 1939, alarmed by the prospect of war, Bowlby and his co-author Evan Durbin wrote a book on large-scale violence (Durbin, E.F.M. and Bowlby, J., 1939, Personal Aggressiveness and War, London, Routledge & Kegan Paul). Much of the theoretical background is still Freudian, but the authors also come up with a surprising anticipation of an ethological model. They report the observations of Zuckermann on a community of baboons kept in captivity in London Zoo. The unnatural conditions of overcrowding and the impossibility of separating led to fierce fights in which many animals were killed (op. cit., p. 55). In this book the authors speak of “transformed aggressiveness.” In his later work Bowlby distinguished between functional and dysfunctional anger, or between the anger of hope and the anger of despair. This may be an ethological model for human fighting. Fromm (Fromm E., 1973, The Anatomy of Human Destructiveness, New York, Fawcett Crest) makes a similar distinction between “benign” and “malignant” aggression, or between defensive and destructive aggressiveness. He too makes use of Zuckermann’s model to point out that malignant aggression arises in unnatural living conditions (op. cit., pp. 126-127). Fromm comments bitterly: “‘Civilized’ man has always lived in the ‘Zoo’” (op. cit., p. 126).

The Darwin biography

At the end of his life Bowlby addressed Darwin directly by writing his biography (Bowlby, J., Charles Darwin, London etc., Hutchinson). This is a little-known work, the last book he wrote. It appeared in 1990, the year he died. In writing this book Bowlby made explicit a link which had previously been mediated by the ethologists and was already implicit in his prewar book. The book is very scholarly, with family trees, photographs, notes, bibliography and so on. The main focus is not on Darwin’s scientific achievement but on the ill-health which afflicted him for most of his life and consisted chiefly in gastric pains and palpitations.

It is now widely accepted that Darwin’s ailments were psychosomatic. Starting from this premise, Bowlby sets out to understand the origin of these complaints. Drawing on his own work he states that “stressful life events, including bereavements, play a major role in causing emotional disturbance and disorder” (p. 2). I shall here give a brief sketch of the most meaningful events in Darwin’s life. He had an invalid mother, who died when Charles was eight. He was left with an “intimidating father” who at 16 sent him to Edinburgh to follow in his own footsteps and study medicine. Charles disappointed his father by interrupting his studies. The father then sent him to Cambridge to study for the Anglican church. At Cambridge Charles was lucky enough to be befriended by Henslow, the Professor of Botany, who introduced him to scientific interests and later found Darwin a position as naturalist on board the Beagle in its trip round the world. In Bowlby’s view the most important stressful event for Darwin was the mother’s early death, aggravated by the family tradition of never mentioning it. It was alleviated by the presence of two older sisters but further aggravated by the presence of the authoritarian father. This was offset by the encounter with Henslow, an alternative father, who instead of imposing his own views encouraged the flowering of Darwin’s talents.

At the outset of the book Bowlby shows he considers Darwin his patient and approaches his treatment with confidence. “I see no reason why Darwin would have been an especially difficult patient” (p. 14). He gives evidence of his medical background by outlining a therapeutic plan which includes very advanced approaches such as the study of family dynamics and transgenerational transmission.

I venture to give my own reading of this book. By applying his own frame of reference, which he had elaborated with Darwin’s help, to Darwin’s health problems, Bowlby is showing deep gratitude to Darwin for having provided him with such a powerful conceptual framework. Darwin’s ill-health elicited a parental caregiving attitude (here I, in turn, am applying Bowlby’s terminology), in return for Darwin’s gift to him.

Finally, I want to make explicit my own involvement with the authors I have discussed. I have found a powerful frame of reference in Bowlby. A paper on self-analysis which I gave recently at the Eleventh Joint Meeting between the AAPDP and my association (OPIFER) is entirely based on attachment theory. Further back, I was a student of Silvano Arieti at New York Medical College in 1963-64, and later translated most of
In describing his relationship with the poet Rainer Maria Rilke, Freud used the term “no lasting bond can be forged with him.” Freud borrowed this term from Schiller’s poem Das Lied von Der Glocke. I first translated and read this poem at age seventeen. Dealing with the adolescent issues of death, impermanence and separation, I found it deeply meaningful. Unwerth describes how in this poem by Schiller one is reminded of life’s essential, contradictory significance. The bell (Der Glocke) heralds the transience of life and the inevitability of death at the end of the “changeful game.” “I celebrate the living/I mourn the dead/I break the lightening.” All of this is an illuminating metaphor for the functions of mourning. Unwerth notes that this represents “the emblem of all human striving against the inevitable decline and extinction we face, individually and as a race….the knowledge won only by the experience of loss and the intimation that death alone conveys….the artist shoulders both the burden of creation and the even heavier knowledge of the transient fate of that creation - and yet takes it up anyway.” (Unwerth, M., 2005).

Unwerth’s book Freud’s Requiem deals with the relationship between Freud, Rainer Maria Rilke and Lou Andreas-Salome, the poet’s former lover and eternal muse. (Ibid) Rilke (1875-1926) also searched the human condition but never quite reached a satisfactory balance. The contents of Freud’s On Transience relate to a conversation of these three people in a hotel lobby in Munich during the Fourth International psychoanalytical Congress in 1913. (Freud, S., 1916) Freud viewed Rilke’s refusal to mourn - to acknowledge the inevitability of loss - as resulting in him running from human relationships. This, then, is the paradigm of the dilemma of mourning. The giving up of internalized objects carries the risk of there being no internalized object. Clinging to such objects is the result of the most primitive of all fears, the fear of psychic annihilation - the product of no object at all. It is most important to understand this. Rilke’s difficulty may have had something to do with the fact that he was a “replacement child” taking on the identity of a ghost and being two living beings. He refused to mourn, meaning to acknowledge the inevitability of loss. My rather scabrous translation of “stone coffins” highlights his “joy” as the stone coffins of ancient Rome, used by later farmers for irrigation, have excited butterflies flying out of them. “Euch, die

his books into Italian. Still further back, when I was taking a postgraduate course in genetics and evolutionary theory, I read The Origin of Species and reported on it. My article is an expression of gratitude to two fathers and a grandfather for their precious gifts.

To synthesize. The relationship between caregiver and receiver (child or patient) is not simply linear, i.e. the caregiver gives care and the receiver receives it. Rather, the relationship (as is the rule in all biological systems) is circular: caregiving elicits gratitude, which in turn impels caregiving.

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**Freud and Rilke**

_by Ronald Turco, M.D._

In describing his relationship with the poet Rainer Maria Rilke, Freud used the term “no lasting bond can be forged with him.” Freud borrowed this term from Schiller’s poem Das Lied von Der Glocke. I first translated and read this poem at age seventeen. Dealing with the adolescent issues of death, impermanence and separation, I found it deeply meaningful. Unwerth describes how in this poem by Schiller one is reminded of life’s essential, contradictory significance. The bell (Der Glocke) heralds the transience of life and the inevitability of death at the end of the “changeful game.” “I celebrate the living/I mourn the dead/I break the lightening.” All of this is an illuminating metaphor for the functions of mourning. Unwerth notes that this represents “the emblem of all human striving against the inevitable decline and extinction we face, individually and as a race….the knowledge won only by the experience of loss and the intimation that death alone conveys….the artist shoulders both the burden of creation and the even heavier knowledge of the transient fate of that creation - and yet takes it up anyway.” (Unwerth, M., 2005).

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ihr nie mwin Gefuhl verliesst…” In contrast Rilke always felt there was something sinister in him. (Bly, R., 1981) In August of 1914 he wrote a small group of poems welcoming the “war god.” Similarly, his friend Magda von Hattingberg heard Rilke read some of his passages and told him she found hostility to life in them. Rilke blamed some of his coldness on his mother. His dedication to art became obsessionial. He did not go to his daughter’s wedding for fear of losing his concentration. (Ibid)

As Unwerth has noted, nearly all of the dreams reported in The Interpretation of Dreams are Freud’s own and taken together they form a “portrait of his preoccupation with his own mortality and with the losses he had known in the first half of his life: patients, friends, and especially his father, whose death in 1896 led him into depression and to the self analysis that produced psychoanalysis.” (Freud, S., 1900)(Unwerth, M. 2005) Some have said that his book on dreams is a book of death and mourning. The evolution of this analysis led to the conceptualization that mourning involves a kind of killing of the loved person by the detachment, and the “guilt” over this murder endows mourning with its exquisite agony and explains why so many refuse to mourn. “In keeping the dead alive within ourselves, through grief, we also keep the hate and guilt alive, which we now turn on ourselves.” (Ibid)

Rilke died in 1926 as a result of leukemia. He wrote his own epitaph. “Oh rose, you say two things at once, the desire to be no one’s sleep under so many poems (author’s translation).” This searching and ambivalence is in contrast to Freud, the realist. In both Mourning and Melancholia (Freud, S., 1917) and On Transience (Freud, S., 1916), Freud describes the transformation of grief into a new memory of the departed and the uneasy truce that is arrived at by the living and the dead. Freud had the courage to face these issues. He saw beauty even in his dogs… “providing the beauty of an existence complete in itself.” (Grezemkovsky, 2002) “Dogs love their friends and bite their enemies, in contrast to men who are incapable of pure love and must at all times mix love and hate in their object relations.” (Ibid).(Roazin, P., 1975)( Glucksman, M., 2005).

Vamik Volkan has expanded on this in the analysis of guilt and loss in his work on the short term psychoanalytic treatment of unresolved grief. (Volkан, V., 1968) (Volkán, V., 1969, 1970, 1972), (Turco, R., 1981, 1982), (Van der Hart, O., Brown, P, Turco, R. 1991) By such techniques as visualizing the corpse and visiting the grave of the departed the reality of the loss is introduced during a gradual analysis of feelings and the significance of the linking objects with the deceased. (Volkán, V., 1972) The ultimate lesson of mourning is the recreation within
I hesitate to say anything additional after hearing such a thorough and enlightening talk from our speaker without running the risk of being irrelevant, anti-climactic or just plain wrong. So I will confine myself to a personal experience as personal experiences cannot be right or wrong – they merely add to the complexity of what we all do everyday as therapists.

I was 26 years old when I entered psychiatry residency. In my first month, on my first rotation in the first year of my residency, one of my patients committed suicide. Let’s call her Fay. She was a 76 year-old woman who battled schizophrenia for almost all of her life. A frail-looking, mild-mannered woman, she looked “normal” to me and after spending a few days in the inpatient unit for hallucinations, Fay was moved on to the partial hospital program of the same hospital. My interactions with Fay were brief and limited, confined to the necessities of completing what I thought was needed to be a good intern - writing good progress notes, making sure I knew all the medications she was taking and appearing competent to my resident and my attending during morning rounds. During the family meeting where Fay’s children broached the idea of a nursing home for her as an option after discharge, I was more concerned with what was the proper thing to say rather than pondering the implications of this meeting for my patient.

That afternoon, Fay went to her studio apartment one last time, locked the doors, took the elevator to the rooftop terrace and jumped. In her purse was a suicide note in which she indicated that none of her children or her doctors, including me, understood her. Fay wrote that a nursing home would be unacceptable and she picked death as a better option.

In the ensuing days, my attending, let’s call him Morris, also concomitantly the program director of the residency I was in, became enwrapped in the now predictable risk management strategies, meeting with the hospital lawyers and administrators to prevent a lawsuit. In the end, Fay’s family did not sue. They looked at the hospital as an institution that had always been there for them in previous crises and, in fact, they expressed gratitude and thanks for all the work that was done.

A month passed and life moved on somehow. Morris then called me into his office and casually asked me how I was feeling. I was not fine of course but I said I was. I resented his Johnny-come-lately inquiries about how I was doing, a full month after the fact. There were moments when I felt like I failed and that perhaps I chose the wrong specialty, wondering out loud to myself whether there was still time to switch to internal medicine. Or pathology where you only dealt with dead bodies or tissues. Or anesthesia where the patients are asleep. Or radiology where you only looked at pictures. Any specialty where you were not expected to deal with live, quivering grief, misery and suffering. In short I was like the typical therapist described in today’s presentation, wracked with indefinable aggregate feelings of guilt, misery, doubt and loss.

The lie I told Morris was that I said I was fine. I thought that was what he wanted to hear. In those days, I only wanted to get on to the next node of my training without a fuss, thinking that saying the truth about how badly I was feeling would delay my progress. But deep down I resented him; it felt like his culpability unfairly washed on to me.

Years later, plus a couple more patients who completed suicide under my belt, I bumped into Morris at an APA meeting. I found myself having a kinder opinion of him as I chatted. But more so, I am now what he was then – an attending, with residents in my charge and I could very well see making the same mistake as he did then, not seeing to the upheaval in the young residents in my charge when something bad happens to their patients, being so enwrapped in the vicissitudes of possible lawsuits that I could see myself failing to look after the therapist.

Several things then come to mind regarding present literature on the effects of patient suicide on their therapists:

1. The fact is therapists are so used to taking care of other people that when it is them that need the care, the role becomes like

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an alien skin, uncomfortable and difficult to fit into. Like me when I was an intern, they may say they are fine merely as a way out of this discomfort when in fact they are not. One remaining challenge is to devise strategies by which we could crack this complex shell and access what truly is happening beyond possibly a façade of competence and stoicism.

2. Suffused with the armor of an authoritarian presence and theoretical knowledge about human distress, therapists often ignore or gloss over the fact that they do have a close relationship with their patients. When a patient commits suicide, it is only natural to grieve or go through the process of some form of mourning as we do with every person who dies who has some connection to us.

In this day and age it is becoming harder I think for therapists to ponder the nature, quality and intensity of their relationships with their patients because of the varying types of office visits that now occur. There are the once a week psychotherapy sessions, the brief psychotherapy sessions when visits are clustered in the beginning then eases off in the end. Then there are the medication visits, occurring very infrequently. This is not even mentioning the many exploded cross-relationships when one patient is seeing multiple therapists - is the guilt and the grief proportionately shared and therefore diluted, or is it compounded?

What is obvious is that in postmodern times, guilt over someone’s death is transmogrified in complex ways by the institutions to which the patient belonged in life – his or her family, the hospitals and of course, the therapist’s office. Guilt can morph into that bette noir that we all fear, the malpractice lawsuit. The malpractice lawsuit compounds grief and guilt into magnitudes several times the original. In addition, thrown in that toxic brew are the elements of blame, righteous indignation and the often carnivalesque encounters with lawyers and insurance adjusters. Reactions to death I think could be categorized into a binary – those reactions that bring people together and those that alienate them.

But I dare to sound cavalier in saying that malpractice lawsuits are part of the painful cost of living in our time, perhaps in the same category as traffic jams and the greenhouse effect - we wish that they would go away but they are here and we must endure in the best way we can. Obviously, despite this knowledge, lawsuits remain a significant source of distress and probably will continue to do so. What is important to think about is could there be ways by which we can protect therapists from an excessive level of stress when they are sued?

There is I believe a very important question that we need to pose in this conference – how can we help the therapists? What is the most effective way of not only lessening the distress but to protect against unhealthy cynicism and worse, a departure from the profession? In short, what are we doing for our colleagues?

In fact, another study by Hendlin, Haas et al in 2004 echo Jane Tillman’s findings, that the primary characteristics in the well of feelings within the therapist after a patient’s suicide are guilt and grief. These feelings are expectedly the same feelings that flood the relatives and friends of the dead patient. Dissecting their findings a bit more, the female therapists tend to be more distressed than the male therapists after a patient’s suicide. Over half of the therapists that were severely distressed were still in training, underscoring the factor of experience as perhaps protective of distress.

Let’s review what happens to a therapist when a patient commits suicide. The therapist probably calls his or her lawyer who will then advise not to talk to anyone about this issue. An immediate meeting will probably be arranged at the law office where the chart will be dissected ad infinitum looking for clues, for vague evidences of steps not taken, conversations glossed over, session that were missed, telephone calls not returned, medication side effects that were documented but not alleviated. All of these actions will further isolate the therapist contrary to the very thing that we advise almost everyone – “talk about it.”

It’s easy to see that we, as a community of practicing therapists, must address effective ways to help our own when faced with such a situation, to somehow break through this cordon sanitaire imposed around the therapist after a suicide couched by institutions in the postmodern lingo of risk management. The double risk is to somehow make it seem as if the right thing to do is to be stoic and silent, stances that could masquerade as competence and “being fine” when in fact, there is a welling of doubt and grief that have no outlet. It is amazing that after a medline search, there is no systematized method studied and published yet about what helps and what doesn’t help therapists faced with a patient’s suicide. Granted, psychotherapeutic data can never be truly comfortable with quantitative methods and by necessity, the contours of future research on this field would be narrative and non-parametric and that is perhaps part of the reason why there is little data on this issue – it is rather difficult to get published these days with non-parametric or statistically processed data. Even then, the need for effective ways to help clinicians remains.

As far as I know, my organization, the APA and its local branch, the Washington Psychiatric Society, do not have policies or practice guidelines regarding helping its members after a patient’s suicide. Walter Menninger published an article in 1991 in the Bulletin of the Menninger Clinic (55/2: 216 Patient Suicide and Its Impact on the Therapist). He urged clinicians to seek out those therapists whose patients committed suicide; in short, he urges for us not to wait until they ask for help. Menninger thinks that the most helpful attitude is to not reassure or criticize, but merely to listen.

What happens in the act of non-judgmental, non-reassuring process of talking and listening between two people? In that space, we put into language our fears and our guilt and somehow, as we know, putting these abstract contents of thought into language makes us feel better. Jacques Lacan famously declared that the unconscious is shaped like a language. We can only see the order and the logic of the human universe when our thoughts are translated into language because language is intrinsically a communication devise. We can manipulate our thoughts only by language and therefore we get a small sense of control and soon we are not as scared, as guilty or as pained by our grief over our dead patient. Because therapists use this affective and linguistic space, our colleagues are the best people to help us when we are in these circumstances.

Of course, we all know that people die despite our best efforts. This adage is not often comforting to therapists - it is in fact more likely than not that a therapist will lose a patient to suicide at one point in his or her career. Psychotherapy is not an infallible silver bullet against despair. Despite our best efforts, there are those ambiguous dark corners in the human psyche.
that could lean towards self-annihilation. Historically these dark, nihilistic corners have been theorized by Francis Bacon, Theodor Adorno all the way to Melanie Klein and Sigmund Freud. In George Minois’ work *History of Suicide, Voluntary Death in Western Culture*, he affirms that historically, suicide has always brought a sense of shame upon the family, and perhaps a mixture of other reactions including guilt, confusion and chaos. In 18th century France, at the height of the enlightenment, Voltaire declared that suicide must be considered a legitimate individual prerogative. But the physicians and alienists at that time blamed society and especially the clergy for the suicides claiming that intense moralistic judgments from the church led their patients to suicide. What I am trying to highlight is that the very dynamic within the aftermath of suicides that is the subject of today’s conference has always existed. And scant data on this process begs the question - is this another manifestation of our discomfort in admitting that our colleagues can be in distress to the point that they would need our help? Does this reinforce a delusion of toughness and invulnerability? And does this reinforce the idea that we are uncomfortable being helped because we have gotten so used to helping? Finally future research would hopefully address the nuances of what helps therapists and for those of us who are educating therapists, we must devise ways in planning our curriculum to address this issue.

The person that helped me most during the time when my patient committed suicide when I was a resident was another resident, another 26 year-old boy from Spain, who just knocked unexpectedly on my door that day that my patient Fay committed suicide. I could tell he was meant to be a psychiatrist – he instinctively knew what to do. He just sat there in my apartment. I don’t exactly remember what I said but more likely something oblique and inarticulate as only a 26 year-old psychiatric intern could manage. Afterwards, after our talk, I remember we ordered pizza and beer and I think we got drunk and were late coming to work the following day. The important thing was, despite the hangover, I felt much better. It’s amazing how these simple things could make a difference.

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**On the Necessity of Either Functionalism or Epiphenomenalism**  
*by Steven P. Lieske, M.D., Ph.D.*

It is hard to imagine a problem more fundamental to the practice of psychiatry than the relationship between mind and brain. Nonetheless, as Dr. Richard Chessick has pointed out in a recent issue of the *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, it is a striking truth in the contemporary study of the philosophy of mind that none of the commonly discussed positions accords well with the instinctive judgments of most people (forthcoming). Existing theories typically evoke reactions ranging from discomfort at best, to denunciations as implausible or obviously incorrect at worst. This has led some to embrace the so-called “mysterious” position, in effect stating that no present theory is adequate (Chessick, op. cit.). I will argue here that the mysterious position is itself inadequate, inasmuch as it is possible to conclude from currently existing information that either functionalism or epiphenomenalism must be true - despite both of them being intuitively uncomfortable.

Before proceeding any further, it is necessary at the outset to establish just what I mean by epiphenomenalism and by functionalism. Both terms refer to specific claims regarding the mind-body problem, but neither in my opinion picks out a single well-defined position. Epiphenomenalism is the doctrine that mental states lack causal efficacy. Thus, it maintains that the pain I feel when I stub my toe is not the cause of the actions that follow, despite the clear association that I perceive. It is important, I think, to differentiate between epiphenomenalism towards consciousness in its *subjective* (first-person) properties, and epiphenomenalism towards consciousness in its *objective* (third-person) properties. The philosopher David Chalmers drew a bright-line distinction between understanding the physical facts associated with consciousness - the so-called “easy problem” of consciousness - and understanding how those facts connect to our ineffable individual subjective experiences - the “hard problem” (”The Conscious Mind,” Oxford University Press, chapter 1, 1996). Epiphenomenalism towards *subjective* consciousness is a “hard problem” epiphenomenalism. It strikes me as a tenable, if uncomfortable, position: it would hold that the true cause of my actions after toe-stubbing can be found in the brain events associated with the pain, but that the *actual feeling of pain* is irrelevant. It is this kind of epiphenomenalism that I make reference to in this paper. In contrast, “easy problem” epiphenomenalism—arguing that the physical facts associated with consciousness are without causal relevance—is not in my opinion a tenable position. Numerous observations make it very clear that consciousness has significant effects on cognition, survival, reproduction, and so forth.

Functionalism is the doctrine that the key feature of any given mental state is the functional role that it plays - as opposed to, say, the specific activity of particular neurons, or any other lower-level description. Here, too, two varieties must be distinguished. According to the first, a functional description of a mental state is *all that there is* to the state in question. This is essentially an eliminativist position, holding that subjective experiences (“qualia”) simply do not exist. Although some philosophers do adhere to this position, others argue—in my
opinion convincingly—that this is implausible on its face (e.g., John Searle, “The Rediscovery of the Mind,” MIT Press, chapter 1, 1992). According to the second variety of functionalism, the functional description is merely how mental states are individuated from each other; qualia are not directly addressed. For relatively qualia-poor states such as beliefs and desires, the two varieties are nearly equivalent. For relatively qualia-laden states (perceptions, especially), the latter version of functionalism implies that the occurrence of a particular functional arrangement somehow gives rise to the quale in question. [It would seem that that “somehow gives rise” bears some relation both to the “fundamental physical property” theory of consciousness advanced by Chalmers (op. cit., chapter 8), and to the “nomological danglers” ridiculed by Herbert Feigl (“The ‘Mental’ and the ‘Physical’,” in H. Feigl et al (Eds.) Concepts, Theories and the Mind-Body Problem, Minnesota Studies in the Philosophy of Science, Vol. 2, 1958).] It is this latter variety of functionalism that I consider below.

Both epiphenomenalism and functionalism are widely discussed, but they have not in general been presented as bearing a relationship to each other. I will argue, however, that there is a tension between them, such that denying one requires endorsing the other. Consider the following rather simple thought experiment. Imagine that, at some point in the future, a group of scientists construct a detailed simulation of a human brain, which runs on an extremely fast supercomputer. This computer is so fast that the brain can be simulated in minute detail: the individual atoms that make up the molecules of which the brain is made, and all their interactions with each other, are simulated individually. This is done in the context of a physics that has been completely worked out and proven to be correct, and this system reproduces the (also well established) laws of physical and organic chemistry without error. Further, technology exists that allows a precise, detailed, atomic-level scan of an actual human brain, and the information obtained from that scan is used to provide the starting point for the simulation. Now, with appropriate inputs and outputs provided, the simulation will behave in a manner that is indistinguishable from an actual human brain: its initial simulated state is molecule-for-molecule identical to the actual state of the scanned brain, while its subsequent states will follow from that initial state in exactly the same manner as the original scanned brain would have done, provided the same inputs.

The question is this: is this system, or is it not, conscious? Thomas Nagel famously asked “What is it like to be a bat?” (Philosophical Review 83:435-450, 1974). I am asking a similar question: what, if anything, is it like to be the simulation? Certainly it would give every external appearance of being conscious. Ask questions, and the answers given by the simulation are just those that you would expect a person to give. It can describe a beautiful sunset in heartfelt tones, even commenting on the mystifying inefﬁability of the redness of red. It describes itself at times as happy or sad, or lonely, or angry. Now, whether or not it actually feels happy or sad, or anything at all, is precisely the question at hand. We can state with conﬁdence, however, that it would say that it does. After all, speech acts originate in the brain, and this is a perfect molecule-for-molecule simulation of a brain. Note, too, that this is not merely a surface similarity. This is not a computer program that fakes talking about conscious states by, say, storing an enormous database of conversational speech patterns, and generating responses statistically from its internal storehouse. Instead, there is a deep similarity, which extends all the way down to the atoms—simulated atoms in the computer, actual atoms in the human brain, but arranged and interacting in precisely the same way. [In some respects, this thought experiment bears similarity to a number of related proposals by various authors over the years. See, for example, Chalmers (op. cit., chapter 7) for a version in which individual neurons are replaced by silicon chips one at a time. To my knowledge, however, none of these have applied questions about simulations to the particular purpose that I do herein.]

So: is there anything in this simulated system that is conscious? It would appear that this is a question that admits of only two possible answers - either the simulation is conscious, or it is not. Consider first the claim that the simulation is not conscious. We have already established that all the objective signs of consciousness are present. There is no question we could ask of it, no test that we could do, that would show it to be a non-conscious entity. We have already stipulated that the internal states of the simulation evolve over time in precisely the same way that the internal states of a human brain would do. Thus, the absence of subjective consciousness in the simulation simply has no bearing, either on its behavior, or on the evolution of its internal states: both the non-conscious simulation and the conscious human being behave in precisely the same way, and furthermore - in light of the deep similarity mentioned above - they do so for precisely the same reasons. Thus we are forced to conclude that the presence or absence of subjective consciousness is without any causal relevance. This admission, of course, is the definition of epiphenomenalism.

Alternatively, consider the implications of asserting that the simulation does possess a subjective consciousness. The arrangement of the physical materials making up the computer is thoroughly unlike that in the brain. The only thing that is preserved is the information processing itself; there is nothing about the implementation of the processing that is remotely similar. This would seem to imply that we live in a universe in which the presence or absence of an apparently basic phenomenon - consciousness - is determined by a computational-level description of how a system functions, completely independent of any lower-level description - including even the material it is made of. The thought experiment assumed a supercomputer, but as others have pointed out, computers can be built of anything - silicon microchips, tinkertoys, or as Ned Block has suggested, the human population of China dialing telephones (“Troubles with Functionalism,” in C. W. Savage (Ed.), Perception and Cognition: Issues in the Foundations of Psychology, University of Minnesota Press, 1978). But none of that matters: as long as those tinkertoys are arranged in the right kind of way, then consciousness springs into being. This universe is one in which functionalism holds.

Thus, it seems that your response to the thought experiment puts you solidly into one of two camps. If you deny the simulation consciousness, then your theory of consciousness, whatever it is, commits you to epiphenomenalism; if you grant the simulation consciousness, then you believe in some version of functionalism. Both of these are uncomfortable positions, yet there seems to be no escape from the fact that either the simulation is conscious, or it is not. One may lack a clear intuition in regard to the thought experiment— it is certainly possible to say
that one simply doesn’t know if the simulation is conscious or not—but this does not avoid the dilemma. It is still the case that if the simulation is conscious, then functionalism holds, and if it is not, then epiphenomenalism holds; and again, whether we know the answer or not, it has to be one or the other. Likewise, it is very difficult to see how any future theory could escape both horns of the dilemma: however consciousness turns out to work, either the simulation has it, or it doesn’t.

There are (at least) two possible approaches that one might take to escape the dilemma, but I will argue that neither one succeeds. First, one might reject the entire thought experiment as impossible in principle: the laws of physics are such that it will never be possible for a computer simulation to mimic the evolution of human brain states, no matter how detailed. This is a bit of an odd position, inasmuch as it is not at all clear why this should be the case. Is there something unique about human brains that renders them impossible to simulate? Indeed, molecular-level simulations similar to this already exist, just at a much smaller scale. Simulating every single molecule of a human brain would require orders of magnitude more computational power than is available today, but this is a difference only of degree, not of kind. One could imagine beginning to write such a program today, if one desired.

One proposal that merits a specific mention in this context is the position advanced by Stuart Hameroff and Roger Penrose, according to which the solution to the mind-body problem will be found in a future version of quantum mechanics. According to this hypothesis, consciousness is associated with a specific hypothetical phenomenon known as “objective reduction,” in which superposed quantum states collapse to a single classical state in a manner that is simultaneously “deterministic” and “non-computable” (“Conscious Events As Orchestrated Space-Time Selections,” Journal of Consciousness Studies, 3:36-53, 1996). I must confess that it is unclear to me exactly what this means: “non-computable” certainly seems to suggest that a simulation would not capture the phenomenon, but how then is it deterministic? Regardless, the most compelling reason to reject this possibility is that there is simply no evidence that the evolution of brain states at a macroscopic level proceeds in a non-classical manner (see, for example, C. U. M. Smith, “The ‘Hard Problem’ and the quantum physicists. Part 2: Modern times,” Brain and Cognition, in press, doi:10.1016/j.bandc.2007.09.004. Smith). If quantum mechanics is not necessary to explain the objective phenomena, then even if it does explain the subjective phenomena we remain stuck on the epiphenomenalist horn of the dilemma.

The other possible approach to avoiding the dilemma is to argue that looking for consciousness within the simulation is to commit a category error: of course there is no actual consciousness; what there is, is simulated consciousness. According to this view, just like a simulation of a waterfall contains no actual turbulence, but does contain simulated turbulence, which accomplishes all the causal effects of the real turbulence in the real waterfall, so the brain simulation contains a simulated consciousness, which accomplishes all the causal effects of real consciousness in the real brain. There is an interesting discussion to be had, I think, regarding what differences might exist between “real” consciousness and “simulated” consciousness. I would argue, however, that there is no category error to be found here. Considering the turbulence example, this is a phenomenon that arises in a subset of moving fluids—to attribute actual turbulence to a computer whose parts include no moving fluids, or to the program running on that computer, whose parts are not even physical but informational in nature, would indeed be a category error. This situation is not the same. Consciousness is a phenomenon that arises in a subset of physical systems that collect information and respond to it; this description could apply to the computer running the simulation as easily as it could to you or me. Importantly, though, regardless of where one lands on this issue, this approach still does not succeed in avoiding the dilemma: there still remain only the two possible answers to the question of whether or not the simulation possesses a subjective consciousness. So, is it or is it not like something to be the simulation? If there is no (real) subjective consciousness, then subjective consciousness is irrelevant.

This, then, is the argument:

1. It appears to be possible, at least in principle, to create simulations that precisely mimic the functioning of human brains.
2. Such a simulation would share functional properties, but no lower-level properties, with actual brains.
3. Given such a simulation, it would have to either be conscious (experience a subjective aspect to its existence), or not.
4. If it is not conscious, then experiencing a subjective aspect is irrelevant to the functioning of human brains. Epiphenomenalism is true.
5. If it is conscious, then it is only the functional-level description of a system that contributes to determining the presence or absence of consciousness. Functionalism is true.

It must also be emphasized that although this suggests that there is a tension between denying functionalism and denying epiphenomenalism (such that one cannot coherently deny both), there is no such tension between endorsing both propositions. It is entirely possible to take the position that the simulation is conscious, and still also believe that subjective consciousness lacks causal efficacy, in both the simulation and in real life.

Dr. Lieske is a Research Fellow in the Department of Psychiatry at UCSF and the San Francisco VA. His email is SLieske@lppi.usf.edu.
LETTER TO THE EDITOR

Dear Dr. Perman,

I had mixed emotions and thoughts about Harvey Greenberg’s ignoble Letter-to-the-Editor in the Academy Forum Vol. 53 No.2 - Summer 2009. On the one hand, I was pleased to see such a strong though mean-spirited response to my article in the previous issue. I can’t recall such lively exchanges in our FORUM very often. I think by definition of the concept of a Forum, it is positive to have lively discussion of ideas! I am sad about and object to Greenberg’s glib ad hominem attack of my ideas as a foil for his polarized political rants!

It is clear to me that Dr. Greenberg had axes to grind that have origins far beyond my writings. I chose not to confront Greenberg’s political polemics and they are many. In addition, it is clear to me that he has not read in-depth my recent book, The Cult of Osama: Psychoanalyzing Bin Laden and His Magnetism for Muslim Youths. If he had read my book, he would not form and express such glib and shallow conclusions about my thinking. In fact, he would even find me in agreement with a few of his political opinions.

In the past I have found our colleague Dr. Greenberg to be more cordial, respectful, and fair-minded in our exchanges. I do plead guilty to one of his subtle accusations about me. From my childhood days in a poor family in Brooklyn, I, like my immigrant parents, have idealized our flawed but also humanistically majestic American Democracy. President Obama’s election says volumes to refute Greenberg’s cynicism about our changing and evolving American form of democracy. If Dr. Greenberg chooses to read my book carefully, he might be less inclined to be judgmental and shallow about my ideas!

Sincerely,
Peter A. Olsson MD, DLFAPA

BOOK REVIEWS

Psychodynamic Psychiatry and How I Met The Jungians
By Paul Fine, M.D.

Life is good, semi-retired in this mid-sized, Midwestern city during the last half of my seventh decade. My practice is diverse, hours comfortable, colleagues helpful, income adequate, paperwork manageable, and there is time to think. Yet, one has to balance against professional isolation and, as usual, I have lots of questions. Curiosity is intrinsic to the work.

Academy meetings are a helpful way to catch up on relevant research, compare notes with other settings, and renew psychoanalytic roots. This year the meeting was in San Francisco; the theme, “Wisdom and Beauty.” The bay area was scenic, the weather brisk, cultural opportunities available and deep thinkers abundant. In many ways it is the deeper questions about human nature that make psychiatry so interesting.

A high point of the meeting for me was to cross paths with Thomas B. Kirsch, M.D. and to review his book, The Jungians (Kirsch, Thomas. The Jungians: A Comparative and Historical Perspective. London: Routledge, 2000). The book traces psychoanalytical (Jungian) psychology from the early 1900’s up to the near-present. It is a story that parallels psychoanalytic history and is relevant to contemporary psychodynamic psychiatry.

I Met a Jungian

I met Thomas Kirsch in the course of a panel at the meeting. It was the third year of a workshop titled “Psychoanalytic Peer Supervision: Quandaries in Clinical Practice.” There were about twenty participants. Douglas Ingram, M.D. coordinated the workshop. Gerald P. Perman, M.D. and I were to give brief case presentations and Dr. Kirsch was designated lead discussant. I had heard he was a Jungian but didn’t know exactly what that meant. The case I presented was not psychoanalytic psychotherapy in the traditional sense. It was, I thought, an example of patients confounded by complications, conflicts and stress, yet able to benefit from a psychodynamic approach. The clinical quandary was how to focus on therapy in the face of multiple stressors and split relationships. The case is summarized here to illustrate how I came to appreciate Tom Kirsch and The Jungians.

A Case Study

“Donna Smith,” 47 years old, sought help for progressively severe anxiety and depression, worse since the death of her father three years previous. Lifelong atopic dermatitis compounded her misery. The youngest of eight siblings, she believed her mother had been “worn out” and that nuns virtually raised her in the course of frequent childhood hospitalizations. Donna possessed significant personal assets, including intelligence, artistic talent and charm. She had raised three children and put herself through college. Assertively identified with each of her mixed African, French, Jewish, and Native American heritages, she remained alienated from family.

Stressors at the time of referral were overwhelming and finances low. Her trusted dermatologist retired and a variety of medications prescribed by a succession of physicians were of limited help. One day Donna called in a panic, regressed and childlike while being physically evicted from her home.

As far as Medicaid was concerned, my role in Donna’s care was medication management, but she felt there was more. Years before, I had helped one of her young children overcome depression and she said she trusted me. To my mind there was a thin thread of therapeutic attachment that could be applied to her advantage.

With encouragement Donna was able to connect with a therapist in her community and pull herself into a better state, albeit while still almost homeless. At first she stayed with her college student son, their apartment subsidized by his scholarship. Now she lives at the shelter, rent-free in return for counseling other residents. Recently Donna re-engaged with regular medical care.
and hosts a local radio talk show about welfare survival.

**Thoughtful Support**

Looking back on the workshop, my presentation came toward the end of the session and there was little time for discussion. I had hoped the group would consider issues raised by the case such as multiple therapists, the presence or relative absence and type of transference, and prospects for mid-life personality change. But the participants seemed out of energy and silence was conspicuous. I wondered if the material had been too controversial, or the formulation flawed, the talk dull or the power point too slick? It was a situation that would daunt most discussants.

Thomas Kirsch rose to the task with wry good humor and a listening ear. He noted that the presentation exemplified analytically informed case management for pathology that was frequent in psychiatric practice. Kirsch expressed mild surprise about the presentation itself, having expected something more traditional. I was positively impressed, and did not feel unsupported.

A short time later, Tom Kirsch came over to ask my wife Sally (a therapist) and me how we had found the workshop, particularly the lack of response. He indicated that he didn’t enjoy the role of “token Jungian,” and said he had written a book, but after several years it had not been reviewed by the Academy. On inquiry we found a review was, in fact, scheduled for publication in the Academy Journal later in the year (Brookes, Crittenden. “A review of The Jungians.” The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry. 37:3, 2009). Still, I was curious about Dr. Kirsch’s work and suggested an additional review, this one in the Forum as a reflection on the San Francisco meeting.

When we got home there was a package in the mailbox. It contained a book which was inscribed with thanks for our support at the meeting. Only after reading *The Jungians* did I realize why Tom Kirsch may have felt frustrated by the workshop. The book narrates a story much richer than I had any idea and clearly the lack of response. He indicated that he didn’t enjoy the role of “token Jungian,” and said he had written a book, but after several years it had not been reviewed by the Academy. On inquiry we found a review was, in fact, scheduled for publication in the Academy Journal later in the year (Brookes, Crittenden. “A review of The Jungians.” The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry. 37:3, 2009). Still, I was curious about Dr. Kirsch’s work and suggested an additional review, this one in the Forum as a reflection on the San Francisco meeting.

When we got home there was a package in the mailbox. It contained a book which was inscribed with thanks for our support at the meeting. Only after reading *The Jungians* did I realize why Tom Kirsch may have felt frustrated by the workshop. The book narrates a story much richer than I had any idea and Kirsch’s role had often been central. Clearly, his base of knowledge was too rich to present syntonically as brief comments to a mixed audience about a complex situation. There was, however, much in his book that could be applied to the case and to psychodynamic psychiatry in general.

**Analytical Psychology**

It turns out that Thomas Kirsch is exceptionally qualified to chronicle the Jungian story. He is an analyst at the C.G. Jung Institute in San Francisco, lectures at the Department of Psychiatry at the Stanford Medical Center, and is a fellow in our Academy. He and his wife, Jean, also a Jungian analyst, reside and practice in Palo Alto, California.

Dr. Kirsch is a graduate of Reed College and the Yale University School of Medicine. He trained in Psychiatry at Stanford and has been active throughout his career at the Institute in San Francisco. Thomas Kirsch was vice president of the International Association for Analytical Psychology (IAAP) from 1977 to 1989, then president from 1989 to 1995. He traveled widely to all parts of the world during those years to facilitate Jungian groups and establish standards.

A unique aspect of Kirsch’s background is that both his mother and father were analysts who were analyzed by Carl Jung in Switzerland during the 1930s. Kirsch’s father, James, a German-Jewish psychiatrist, fled the Nazis to Palestine and England where Tom was born, and finally to Los Angeles. In 1942, James helped found the Society of Jungian Analysts of Southern California. Thomas’ mother, Hilde, is described as quietly supportive and actively appreciated by the Los Angeles Jungian community. She helped introduce therapeutic sand play and Jungian analysis for children.

Kirsch says he grew up in Los Angeles “with Jung, Hitler, the Holocaust and WWII as central themes in my upbringing...I met many of the founders of analytical psychology from different parts of the world...(and thought of them)...as part of my extended family...Many stayed in my parents’ house when visiting in Los Angeles...(Later) in San Francisco...I had the good fortune to meet Joseph Henderson who in turn has been my analyst, teacher, mentor, and dear friend.” The *Jungians* is dedicated to Joe Henderson.

**Interesting Reading**

Tom Kirsch told me that it took years to write *The Jungians*. It’s easy to see that it was a labor of love, 276 pages in paperback, with eight pages of vintage family-like photographs, 168 scholarly references, two pages meticulously acknowledging “input (from)... many people and organizations” and a list of abbreviations for 42 organizations discussed in the text.

Kirsch explains that the goal of the book is to describe analytical psychology “as a profession with regulations, processes and splits,” rather than a biography of Jung or exposition of theory. I think he succeeds. *The Jungians* is at the same time scholarly, inclusive, detailed, accurate, balanced and scrupulously diplomatic. Yet, as one would expect from a perceptive analyst, the book is alive with stories and sketches about memorable people and events. It is written in clear prose and was fun to read.

*The Jungians* begins in Switzerland where Carl Jung spent most of his life, influenced, Kirsch notes, by traditions of independence, democracy and openness to new ideas. He graduated from medical school in Basle, studied under Pierre Janet in Paris, and was chief physician at the University of Zurich psychiatric hospital under Eugen Bleuler.

Jung joined the group around Sigmund Freud in 1907. He was the first president of the International Psychoanalytic Association, edited the first psychoanalytic journal and introduced “the rite of a training analysis...(now) a standard feature of all depth psychology schools.”

By 1914 “Jung had reformulated major theories of the psyche, the collective unconscious, archetypes, individuation, and psychological types.” An analytical psychology association was formed in Zurich and a series of international conferences arranged. Martin Buber, Joseph Campbell, and Paul Tillich attended. It was at that time that Freud and Jung parted ways.

Most members of the initial generation of Jungian analysts were analyzed in alternating sessions by Jung and his assistant, Tony Wolff. Some, from abroad, returned home to start programs, notably in England, Germany and the United States. Centers in Italy, France, Israel, Canada, Australia, New Zealand, Latin America, Russia, Eastern Europe and East Asia followed over the years. Kirsch describes significant personalities, ideology, history and organization in detail for each center. To his credit, he does not avoid controversies. Rivalries, boundary violations,
Some History

Jung’s attitude toward Jews and National Socialism has been a subject of debate. He made statements in 1933 that purported to compare “racial characteristics” of Jews with Aryans and Chinese. Kirsch suggests that Jung was initially naive and “after 1934... (was) mocking the Germans,...and...amazed by how much Hitler could get away with.” In Berlin by 1939 a Nazi controlled “Goering Institute” took control of all psychotherapy. Jewish analysts were forced to emigrate or perish.

Even after the war the Zurich Analytical Psychology Club restricted Jewish attendance, but the quota was soon rescinded and an apology issued in 1993. Kirsch asserts that Jung’s attitude toward Judaism changed to clearly positive when “he discovered and experienced (Judaism’s) mystical elements.” German Jewish analysts who knew Jung well vouched safe that he was not personally anti-Semitic.

Kirsch recounts how analytical psychology was gradually reestablished in Germany which now has the largest Jungian society in the world. Jungians in England also were affected by World War II, particularly when communication with Zurich broke down. By 1961, at about the time of Jung’s death two factions were in place. One, the “developmental school,” headed by Michael Fordham, incorporated works by psychoanalysts such as Klein, Winnicott and Bion. The other “classical school” focused more exclusively on Jung’s writings. Eventually, not without some turmoil, they arrived at standards for accreditation, training and certification. Kirsch reports that there are now over 400 Jungian analysts in Britain and that “most practice some hybrid of analytical psychology and object relations psychoanalysis.”

Jungian history in the United States centers around New York, Los Angeles, and San Francisco. Kirsch traces each region from the early years of contact with Zurich to the growth of membership following the war, societal challenges in the 1960s, inter-regional standards during the 1980s and international activity following the fall of the Berlin wall in 1989.

Northern California has been a model for integrated training. The Jungian community in San Francisco was founded by Joseph Wheelright and Joseph Henderson, both American-born graduates of medical school in London. Kirsch tells us that their philosophy emphasizes the character of the individual analyst over academics, “openness of thought,” and disciplined personal boundaries. Ties with Stanford and the University of California have been maintained from the beginning and an institute was founded in 1964. Candidates currently arrange a confidential personal analysis and must have at least 100 hours of supervised analytical experience. Didactics include two years of core Jungian topics and two years of electives. Works by neoFreudian and developmentally oriented psychoanalysts such as Heinz Kohut and Erik Erikson are included. Evaluations occur yearly and an interregional board confers certification.

A Bit of Self Study

Tom Kirsch’s narrative did not delve into theory but technical terms were inevitable. At such times I sought definitions from an abridged collection of Jung’s works (De Laszlo, Violet S. v. Modern Library, New York. 1959), a more recent analytical psychology text (Jacob, Mario. Psychotherapy and Contemporary Infant Research: Basic Patterns of Emotional Exchange. Routledge. London 1999) and the dictionary. My efforts were rewarded with a fascinating glimpse of the Jungian worldview.

Some terms are now a part of everyday language, others more arcane. I listed a few to get a feel for the gestalt: Alchemy. Jung was interested in the medieval symbols of alchemy as an expression of the deep unconscious, an alchemy of psychological transformation rather than physical change. Animus connotes the inner feminine self of men. Anima is the inner masculine self of women. Archetypes are “the organs of the collective unconscious,...bipolar,...and experienced [as] innate patterns of behavior, ...[and] universal images...in all cultures.” The Collective Unconscious defines a matrix of deep psychic existence that all humans have in common. It can be accessed through dreams, myths and symbolic expression. Complex describes archetypal patterns such as mother, father, inferiority and hate complexes. Individuation in the Jungian sense is an adult process of maturation of the mind or spirit. Multiple Analysis is an analysis that alternates sessions with two analysts. Numinosum refers to awe that can be experienced from mystical insights, “god within us.” Personal Unconscious describes individually repressed life experience. Psychological Types for thinking, feeling, sensation and intuition include Extroverts and Introverts. Self refers to the full scope of a personality, conscious and personal unconscious and deep unconscious. Shadow is a metaphor for the dark side of the personal unconscious.

Fifty years ago there was a tendency in my psychiatric training to dismiss Jung as unscientific or anachronistic. It is interesting to see how well his ideas survived. Recent findings from systems biology, including the human genome project, functional brain imaging and neurotransmitter studies, are consistent with a theory of the human mind that, like Jung’s, is capable of innovation, symbolism, abstraction and creativity, genetically programmed, multi-focal, and largely unconscious. (See Hauser, M. Origin of the Mind. Scientific American, 301:3. Sept. 2009. pp 44-51.)

Psychodynamic Psychiatry

The Jungian experience appears remarkably relevant in the 21st century. Papers at the annual meeting expressed a need for trained therapists in situations such as the Chinese earthquakes, New Orleans flood and third world problems in south India. Typically they called for professionals with psychodynamic and relationship skills.

It seems to me that the essence of psychodynamic psychiatry is to apply insights from depth psychology with good timing in mundane situations where multiple psychiatric modalities are required. Jungians in common with other analytic traditions are receptive to unconscious thoughts and feelings, sensitive to transference, and know how to maintain appropriate boundaries. They also add special dimensions of cultural and spiritual awareness, rare and valuable in the modern world.

Back here in the Midwest, life goes on. Last week “Donna Smith,” the lady whose case I had presented at the panel in San Francisco, came for a session. She keeps appointments every month or so and continues to work with her psychotherapist. Thanks to my reading about analytical psychology I now think of her sessions as multiple supportive relationship therapy, a sort
of conceptual cousin to multiple analysis and very frequent in actual practice. I also am more aware of her individuation and insights as a sentient adult.

The trip we took to California last spring was to learn something about beauty and wisdom in clinical practice. Success came from an unanticipated direction, Thomas Kirsch’s book, The Jungians, which reads beautifully and contains much wisdom. The Jungians is highly recommended to anyone who practices psychodynamic psychiatry. Hopefully, analytical psychologists will continue to lend their unique perspective to the work of the Academy deeply into the future.

From Baghdad With Love
Lt. Colonel Jay Kopelman with Melinda Roth
The Lyons Press, Guilford, Connecticut, 2008, 195 pp., $14.95
Reviewed by Ronald Turco, M.D.

The kind of person who reads this book will likely not change their thinking or their behavior. That person will, however, receive reinforcement of what Buddhists might call respect for all creation.

This is not a book for children. In the midst of the battle for Falljah, Iraq, a group of marines, the Lava Dogs, rescue a puppy in the midst of sniper fire while storming a compound. Reluctantly the responsibility for this puppy is passed on to Lt. Col. Jay Kopelman. His attempts to get the dog out of Iraq are met with resistance by the military and the very obvious combat conditions. His descriptions of life in Iraq are vivid and direct.

This book is hauntingly evocative of the paradox we all face in our existence - life against death. (Turco, R. Academy Forum Vol. 53, No. 2 - Summer 2009. pp 15-17). Kopelman’s attempts to achieve his goal and rescue this puppy make for a suspenseful and engrossing story. General order A-1 does not allow for military veterinarians to vaccinate the animal. The Iraqi government has orders issued to shoot any stray dog. (By eating the dead bodies they spread disease.) Ultimately Anne Garrels, the NPR reporter, is enlisted in the cause. She becomes a heroine, risking her life in the “Red Zone” to secure the puppy’s safety. (She has been embedded with the marines, previously having served in Chechnya, Bosnia, Kosovo, Israel Saudi Arabia, Afghanistan, the former Soviet Union, Central America, Tiananmen Square, Pakistan and you name it.) An Iraqi man who doesn’t even like dogs is enlisted to help, and this man, “Sam,” is added to the hero’s list, risking his life as well.

The pages of this book are embedded with a strain of decency and respect not easily found in wartime stories. This is a book, not about war and destruction, but one about love, dedication, service and life. I salute the author for his bravery, I thank him for his service to our country, and I praise him for the humanity he brings to his readers. I recommend this book to anyone who likes animals or has relied on a pet in times of disillusionment and despair. I am richer for having read Kopelman’s narrative - the story of a man I feel I know.

Jealousy: True Stories of Love’s Favorite Decoy
By Macianne Blevis
Translated by Olivia Heal, Other Press, NY 2008, pp. 152
Reviewed by JoAnn Elizabeth Leavey, Ed.D.

In her book Jealousy Macianne Blevis shares with us ten of her case files. She refers to her patients as heroines and heroes and has determined through their psychoanalyses that they have been struck by a very difficult malady, jealousy.

Blevis explains at the outset that she has written this work not for psychiatric professionals but rather for the general reader. I found this to be interesting and helpful regarding how she framed her interpretation of the life situations and reactions within the ten case studies presented in her book.

Although the title suggests that this book is an analysis of jealousy, it is in fact much more complex. It includes such issues as narcissistic tendencies, personality disorders, mood disorders and antisocial themes present in some of the characters portrayed. However, as a psychiatric professional, Blevis has chosen to approach her ten patients as having “human conditions” rather than characterizing their emotional dilemmas as “disorders.” She very cleverly helps her patients and the reader by “normalizing” her patients’ jealous behaviors. By subsuming these behaviors under the rubric of a human condition, it in some ways makes them more accessible for others to understand and, more importantly, for analysts to guide their patients through a process of recovery.

Blevis concentrates and develops the concept of jealousy in her book. She defines the experience of jealousy as bound up in one’s identity, reverting to a time in childhood or adolescence when the person was left wanting the kind of erotic and loving responses that would have made him or her feel strong, autonomous and desirable. She goes on to see jealousy as a “delayed reaction, to a situation that left a person helpless and humiliated.” It is within this framework that Blevis moves through the case studies, each patient being treated as unique and respected within their own self-awakening in their understanding of the past and where each of their respective historical traumas occurred.

A constant theme within the book is the need for and ability of the therapist to immerse herself in the turmoil of the presented world of the patient in order to fully understand the jealous dilemma and pain and chaos associated with it. The therapist and patient do this by creating a therapeutic space in which both the patient and analyst sit. Through this space, she explains her use of self understanding and reaction to the patient’s narrative in each of the case studies to guide her therapeutic stance and feedback. In other words she appropriately uses the therapeutic space in which to use the necessary emerging transference and countertransference information to begin the healing process.

Blevis sees the work of the psychoanalyst as being able to assist the person experiencing jealousy within the created therapeutic space to pinpoint the fracture that occurred when he or she was deprived of “love’s sustenance” in order to stop seeing the offender as something or someone outside himself, rather seeing the fracture from within. Blevis seems to infer that once this happens the wrecked hopes and damaged trust can begin to heal. The person no longer needs to fill up his world with jealousy just so he can feel something rather than being left alone in despair and ruminating over a dreadful fate, chained to jealous reactions, being unable to love or hate, and finding himself with no way out.
Jealousy is portrayed as a way to fuel passion. The patient equates a calm relationship with "death." Blevis explains that though the drama may unfold in the person’s life as problematic, the person resists the therapist’s attempts to pull her out of her dilemma, since it is the feeling itself that has become so familiar. It is extraordinarily difficult for persons to release themselves from this raw emotion.

Blevis encourages the therapist to take up the opportunity to explore the current expression of jealousy to unveil the original trauma in childhood as the root cause of the emerging behaviors. She purports that once the jealous dilemma can be seen not as a "here and now" issue but rather as an historical event in childhood, this is the chance to assist the patient to shift his or her perspective. The shifted perspective is where the person is able to stop seeing people outside of himself as emotional rivals and begin to understand the inner process of what was hurt in the past. Through this new understanding the person can start letting go of the jealous behaviors. She does not see jealousy as a negative behavior; rather she sees it as a necessary behavior that brings attention to the root cause.

Blevis explains that the therapist must be willing to enter a world of passion and violence to carve out a place to be heard in order to "break jealousy's spell." The author believes that once relinquished, a jealousy-free existence allows for a "new lease" on life.

This short book reminds us to dig at the human condition with patients rather than be drawn to labeling conditions as disorders or abnormalities. It also reminds therapists to utilize their own reactions to the information being portrayed as an inner guide to understanding their patients. The book does not provide prescriptive advice nor generalized answers to the human condition of jealousy. It rightly professes not to and suggests that each person’s struggle is unique, existentially motivated and should be treated as such. In the end Blevis asks the reader to be informed as fellow humans versus treating analysts. The book then gives us the latitude to see the ten narratives presented with an existential focus.

I would recommend this book not as a great text to help understand "disorders" and their treatments, but rather to be used as a reminder that at the root of all emotional dilemmas is a human struggle, and these struggles are set in an existential framework rather than in a disordered existence. In this spirit Blevis gives us and our patients a perspective of hope and healing versus disorder and doom.

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A Psychoanalytic/Dynamic discussion of TWILIGHT by Summit Entertainment.
A Temple Hill Production in association with Maverick/Imprint.
Screenplay by Melissa Rosenberg;
Directed by Catherine Hardwicke. 2009
Reviewed by Cassandra M. Klyman, M.D., DLFAPA

Twilight, the movie, is based on the #1 NYT best-selling novel by Stephanie Myer with Bella Swan (Kristen Stewart) and Edward Cullen (Robert Pattison) as the romantic pair. The series of books and movie have become a new “cult” for early adolescent readers who have tired of Harry Potter. In Twilight, each protagonist has their own conflict - Edward, his inborn, genetic vampire instincts curbed by both his renegade but intact and functional family and suppressed by his love for Bella and she, with her father-hunger and sexual rivalry with her newly re-married mother who is about to re-locate her life around her husband.

As many teen-aged daughters of divorce who express wishes to live with their father, (to take care of them, to be a better wife than their mothers once were if only given the chance) Bella actually leaves Phoenix and moves to Forks, Washington to live with her police chief father and go to the local high school. He represents not only law-and-order but a protective and repressive parent who gives her pepper spray and reminds her of her curfew. He lives a solitary, celibate, bachelor’s life. He horses around with his male friends and speaks in monosyllables and doesn’t hover and allows her to call him “Charlie” (not “Dad” that would uphold the incest taboo). This is in contrast to Bella’s mother who seems like a “chatty Cathy” and who gushes about her fun-filled life with her new man and who wants to know about the boys Bella has met.

At school Bella is the attractive new-comer getting lots of attention from the boys. One is a conventional kid who immediately sets his eye on her as his prom date. Because he is so typically adolescent she easily passes him off to another girl. Another is an African-American who stereotypically is the bold, sexually aggressive male who dares to run up and plant a kiss on her and later loses control of his car and nearly crashes into her with his oversized phallic symbol. The third male, Edward Cullen, the hero protagonist, throws caution aside about his true identity and saves her. His whole flying, soaring, upright, phallic persona is enough to make a girl swoon and Bella masochistically surrenders. She seems almost willing to join the undead in order to be with Edward forever. He, older and wiser, protects her from herself.

But of course there are challenges to his resolve. In a suspenseful subplot there is a trio of unrepentant, bloodthirsty vampires who are ravaging the town and countryside. They kill Bella, on paper and on film, lets the 21 C girl know that girls can be as lusty as boys. And in an era where so many divorces
and remarriages occur it is not uncommon that a young teenage
dughter will not just experience the quiet, burning embers of
an established marriage, but the intensity of a newly discovered
love between one or another of her divorced, dating or remarried
parents. This additional stimulation can be exciting and inciting
to have some of this for oneself and makes it harder to delay
that gratification.

The author and the screenplay writer both emphasize stereo-
types - that the right female sexuality should be passive and
nearly-perilous. That the luscious-lipped, fur-caped, aggressive
female vampire is wicked and gets the audience rooting for her
to absolutely perish. The movie seems to reflect the “promise”
culture that advocates chasteness or at least Dr. Ruth’s mantra
of mutual masturbation and no activity like defloweration that
would draw blood. But who among us has not moaned “take
me, take me. Do with me what you desire?” The symbolic
orgasmic flight with Bella, clinging with her arms and legs
wrapped around Edward, is not so dissimilar to paired motor
cyclists roaring down Main Street in the springtime, or as Ed-
ward says, “and so the lion fell in love with the lamb.” We can
all enjoy this great epic romance. The Debussy music to the
surging chords as they lay on the grass gazing into each other’s
eyes, the sunlight above like a clothed Adam and Eve before
the discovery of carnal knowledge. At another time there is a
Biblical allusion to the Serpent as Edward flies with her into
the sunlight to show her his diamond-like, glistening skin, the
cold skin of a killer, and ejaculates “I’m a dangerous predator.”
However in contrast to the Garden of Eden, Bella does not eat
of the food the Cullens’ prepare - they drop the italiano salad
and go out to play.

Other gender issues aptly described and commented on is
the typical girl’s source of self-esteem. Edward says in wry
amusement “So you’re coming to my home and not worried that
you’ll be in a house of vampires but only that they may not like
you!” At the University of Michigan parents’ orientation it was
remarked that typically, when grades come out and are disap-
pointing, boys say “What a bad teacher” while the girls think,
“Oh, am I stupid.” Earlier when Edward says in bemusement “I
can read minds, but I can’t read yours,” Bella replies “Is there
something wrong with me?”

A word about the Indian theme. Bella’s old childhood friend,
Jacob, an American Indian who goes to school on the reserva-
tion, is passive-aggressive. He had to be paid $20.00 by his
father in order to warn Bella of the danger of the Cullens’. He
tells her of the Quileute legend and that these men descend
from wolves, but the Cullens are from an alien tribe who made
a pact not to hunt humans. We note that the film opens with a
deer being attacked; then the security guard is killed and then
the fisherman is devoured. In this way the uniqueness of, and
how the latter affect our relationships with other people.

In his first chapter on the initial assessment, Akhtar notes that
the lack of a solid beginning often undermines the entire subse-
quent treatment. He devotes three full pages to the first phone
call. In several vignettes he illustrates the kinds of meaningful
cues that patients can provide in their briefest of initial contacts.
For example, there is the patient unable to enter into a committed
relationship with a woman who brings his own magazine to the
initial interview reflecting his need to be overly self-sufficient.
Akhtar draws from his encyclopedic Broken Structures: Severe
Personality Disorders and their Treatment (1992) as he describes
how to assess the patient’s level of character organization and
evaluate for identity diffusion. He discusses how to assess the
patient’s motivation for treatment as well as the importance of
paying sufficient attention to reality factors. He follows Coltart
in assessing for psychological-mindedness.

In the second chapter Akhtar traces the development of the
concept of the divisions between the intrapsychic agencies of
the mind, boundaries that separate the self from the non-self,
and how the latter affect our relationships with other people.
He then discusses related psychopathologies and their cultural
variations. Akhtar takes up this topic at greater length in his
Immigration and Identity (1999). In his section on boundary
crossings and sexual boundary violations he relies heavily on
the work of Gabbard and Lester.

Money impacts all treatments and it is a topic about which
too little has been written. Akhtar reviews the literature on
the symbolic significance of money and discusses the impact
money has on the therapeutic frame, the transference and the
countertransference. After cataloguing the syndromes of chronic
miserliness, overspending, excessive generosity and gambling,
he presents a section on setting fees, billing and third-party in-
volveement. He gives advice on working with the phenomenally
wealthy as well as the indigent patient and offers suggestions
on how much pro bono work to do. His consistently excellent
clinical vignettes provide spice to his various recipes.

Psychotherapy has been defined as a series of bridges that are
repeatedly blown up and rebuilt. Disruptions are addressed in
the fourth chapter of Turning Points. After defining “disruptions”
Akhtar explores some of the factors that contribute to them:
unconscious guilt, regression in the face of encountering newly
conflictual issues, the need to destroy a helpful situation, retreat
due to separation anxiety, and empathic failures of the therapist.
Therapeutic interventions include creating and maintaining an
adequate holding environment, assuring safety, setting limits and
being responsive to the patient’s oscillating level of transference.
He offers guidelines on the use of psychotropic medication to
help manage crises that can precipitate disruptions.

In his final chapter Akhtar discusses suicide, the ultimate
disruption to treatment. Psychiatry has accumulated quite a bit
of epidemiologic and demographic factors related to suicide and
suicide risk and Akhtar summarizes these nicely. We learn that
“suicide rates and homicide rates are often inversely related” (p.
120) and “the peak time for suicide is on Sundays or around
major holidays” (p.121). In his discussion of the psychodynamic
underpinnings of suicide, he emphasizes the ambivalence of
those who contemplate suicide. He elaborates on Freud’s state-
ment about whether suicide results from “a disappointed libido”
or “whether the ego can renounce its self-preservation for its
own egoistic motives” (p.122). He suggests that we attempt to
hold and contain the patient’s turmoil and set limits while re-
taining an interpretive stance. He offers suggestions on the use
of medications with suicidal patients how to decide whether to
hospitalize. He discusses countertransference reactions that may
contribute to a patient deciding to suicide and finally the effects
on the therapist in the aftermath of a completed suicide.

Salman Akhtar has written a concise and masterful book on
several crucial aspects of psychodynamic psychotherapy. He is
a marvelous writer and the stamp of his authorship on this book
is no exception. Turning Points in Dynamic Psychotherapy is
a short book but one that is well worth its price. Akhtar suc-
cessfully summarizes a considerable amount of material about
some of the most challenging and important aspects of a psy-
chodynamic treatment. His vignettes sound fresh and real. I
agree with Twemlow’s encomium on the back cover: “I would
recommend this very easy to read book to experienced therapists
as well as beginners, and I would do so with a rare sense of
having read a classic.”

Why write for the Forum?
• Relaxed, casual atmosphere
• No formal peer review
• 2,500 word essays; brief, but long enough to develop
your idea
• Avid Academy readership
• Opportunity for a personal touch
• Chance to express your opinion and receive comments
from colleagues
• Enhance our sense of community and friendships

Some suggested topics might include:
• A case of Freud’s in light of further developments in
psychoanalysis
• A case report illustrative of a clinical area of interest to
you
• A work of art, music or literature that has been most
meaningful to you
• A description of your research activities
• Reflections on your particular area of practice
• Psychoanalysis as applied to the current national or world
political scene
• Reviews of books you have read or movies that have
made a strong impression on you
• Personal experiences or changes in your life that have
made a difference to your technique and practice of
psychotherapy and psychoanalysis

Suggestions for education in psychoanalysis and psycho-
dynamic psychotherapy. How to encourage it and what
and how to teach
• Your experiences in teaching and supervision that are
worth sharing
• Crises or turning points in psychodynamic therapy that
you have encountered and how you dealt with them

Freud said that we had an obligation to publish our
clinical and theoretical work to continue to propel our field
forward. This remains as true today as it has always been.
Informal as well as more formal journal communications
are part of that obligation. Exchange of ideas and sug-
gestions on an informal level has an important effect on
generating new directions and changes in our field. Please
also encourage your colleagues to write for the Forum –
send this appeal on to them.

THE ACADEMY FORUM NEEDS YOU!

Please contact me if you have questions. Thank you.

Cordial best wishes,

Jerry Perman
Academy Forum Editor
gperman@gmail.com