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Silvano Arieti Honored in Italy

By: David Arieti

My brother, Professor James A. Arieti, and I arrived in Pisa, Italy, on Wednesday, October 17, 2001, where we were met by Dr. Rita Bruschi, who had organized the ceremonies, and her husband Paolo. On Thursday, October 18, following a luncheon hosted by Professor G. Corsini at the Department of Neurology, many of my father's relatives, friends, colleagues, fellow citizens, along with members of the Jewish community, met at the plaza outside City Hall, from where we were taken to the street to be called the Largo S. Arieti, just a short walk from the Leaning Tower.

The Vice-Mayor of Pisa presided over a brief ceremony in which the street sign bearing the street's new name was unveiled. The group then moved to the Via San Andrea, outside the house where my father was born and where a plaque was placed. The plaque reads (in translation):

In this house, Silvano Arieti was born on June 28, 1914. Graduated in Medicine at Pisa, in 1938 he was forced to leave Italy because of the racial laws. In the United States he became the most famous psychiatrist of his times for his extraordinary contribution to the understanding of schizophrenia and depression. Scientist and humanist, he told and interpreted the savage Nazi massacre on San Andrea Street. He died in New York on August 7, 1981. The City of Pisa has placed this monument here on the twentieth anniversary of his death to perpetuate his memory.

After this ceremony the group moved to City Hall, where there were reminiscences by friends and colleagues and speeches by various government officials, the historian of Pisa, and my brother and myself. My brother and I were each presented with a commemorative plaque, and a reception followed.

The Burdens of Confidentiality

By: Douglas H. Ingram, MD

(The following is modified from the discussion of a presentation by Richard Harding, M.D., President of the American Psychiatric Association, to the American Academy of Psychoanalysis in New York, January 3, 2002)

Many of us who have followed the privacy issues in psychiatry and elsewhere have been rooting for Dr. Harding. He gained special recognition in our minds when we learned that he was serving on a special subcommittee of the Department of Health and Human Services National Committee on Vital and Health Statistics. That subcommittee was charged with issuing recommendations for implementing the so-called "administrative simplification" clause of the Health Insurance Portability and Accountability Act of 1996, known by its acronym, HIPAA.

I want to divide the "burdens" of confidentiality into three groups: first, the *forensic/technical*; second, the *epistemologic/academic*; and, third, the *clinical/ethical*. The first part of this brief essay concerns the forensic/technical burdens of confidentiality.

A bit of history — HIPAA was primarily aimed at solving the problem of employees with medical insurance coverage and medical conditions who were unable to move to new jobs without sacrificing their health coverage. They had "pre-existing conditions." Also, HIPAA stated that if Congress did not act to protect medical privacy by September 1999, the matter would move to the executive branch, and the Department of Health and Human Services should craft medical privacy protection by regulation. This provision resulted in what has been called the Final Rule. The Final Rule took effect on April 14, 2001 and many components of the health care profession, known as "covered entities," like ourselves, have until April 14, 2003 to comply. Larger

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entities have more time to come into compliance. A detailed clarification of the Final Rule is ongoing at this writing.

It's worth recognizing, too, that the mostly positive recommendations that emerged in support of patient privacy protection under the Clinton administration, those specified in the Final Rule, were retained by the new administration. To the surprise of many, the date by which these recommendations will become effective has not substantially been postponed — a plus in our minds for the Bush administration. However much Mr. Bush nullified, postponed, or diluted the laws and regulations of Mr. Clinton's last year in the White House, the strength of the privacy regulations was retained.

Confidentiality refers to the understanding between patient and physician that whatever is revealed to the physician will not be disclosed to anyone else. It is a right of the patient, and only the patient may relinquish it. At this point in our history, what we include in that term "confidentiality" must include broad issues of medical privacy. One of the major issues we face is knowing how much we are permitted to reveal to third-party payers, including managed care companies. According to the Final Rule, the answer is, only the "minimum necessary" for the purpose of enabling these companies to decide if they are willing to pay for service. Another way to understand the "minimum necessary" provision of the Final Rule is to translate it as the "maximum allowable" information we can give to insurers. On March 21, 2002, modifications were introduced that may substantially eliminate the need for written patient consent to allow providers to share health information for treatment and payment; the "minimum necessary" provision emerged largely unchanged.

Unfortunately, one of the increasingly heavy burdens of confidentiality are the many regulations and applicable state statutes we may be asked to learn. Thankfully, for the individual practitioner, this particular burden of confidentiality — knowing what is expected — is not likely to be as weighty as it first appears. What applies to each of us we will learn, and the rest of the regulatory miasma will become inconsequential to our actual immediate needs. Certainly, I agree with Dr. Harding that these guidelines are far preferable to managed care or insurance company demands for the entire treatment record. Nevertheless, although we need to support the guidelines, I believe they give away too much. Functional status, GAF scores, the use of psychiatric medications, and the like all too readily can come back and haunt our patients. Many of us simply do not believe that recording of such material electronically in massive databanks, regardless of safety measures, can be trusted. Life is long. We are concerned about changes in governments, laws, and regulations, Supreme Court interpretations, and intelligence operations — let alone criminal hacking or unqualified penetration of databanks by corporations or journalists. (Call me paranoid! No, don't!) The accessibility of electronic records, once you get beyond the passwords and firewalls, is worrisome. The unintended consequences of what we do today for the purpose of playing ball, even if we think it is hardball, with the managed care companies may be to compromise our patients and their trust in speaking to us about their pains. Our patients are not likely to appreciate just how they are being compromised, or the unintended consequences of what we do today may lead us to misrepresent clinical data in the interests of protecting our patients tomorrow. This is but one of the burdens of confidentiality, newly outfitted, as we move into 2002.

Another burden of confidentiality, or what may seem like a burden, is the likelihood that our psychiatric records will need to be modified from what many of us have been doing. The Final Rule follows the US Supreme Court 1996 Jaffee-Redmond ruling. In that ruling, Mary Lu Redmond, a police officer who had shot and killed a man involved in an altercation, received counseling from a licensed clinical social worker. The dead man's family sought the therapist's notes in litigation, and the therapist refused. The Supreme Court upheld the position, generally speaking, that psychotherapy notes should be considered in federal court as having protection similar to that of the attorney-client privilege. The Final Rule, seeking to incorporate this ruling, establishes that psychotherapy notes should be treated differently from the general medical record, including the psychiatric record. Though psychotherapy notes are to be considered part of the medical psychiatric record, they are to be kept separately and are held to a higher standard of protected privacy. Whereas patients might ask to inspect and copy their psychiatric record, they have no right to see "psychotherapy notes." Just what constitutes a good definition of "psychotherapy notes" is surprisingly difficult to achieve. Also, we cannot be sure just how secure these notes will ultimately be — that will await further court decisions. This may mean that many of us who

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both prescribe medication and also conduct psychotherapy and psychoanalysis — probably nearly all of us — will have what we might regard as a “bipartite” record for each patient, one part that includes diagnosis, medications, and related observations, and another part that tracks themes in therapy, life details, feelings, fantasies, transference and countertransference. We’ll see. The approach to “psychotherapy notes” may turn out very different from what we imagine now. Please keep in mind that this is a work in progress, and it may go off in a direction entirely different from what I have described. However it comes out, I feel confident that the American Psychiatric Association is sensitive to and aware of the issues we and our patients face and that we will be able to trust the guidelines that emerge in this respect. It is expected that the APA will provide us with what we need well in advance of the compliance date.

Let’s turn to the second group of burdens that confidentiality presents to us — the epistemologic/academic. We want to protect our patients’ privacy and our own, and yet we want to continue to describe clinical cases. We want to eat our cake and have it too. Unlike much of medicine, psychoanalysis and dynamic psychiatry draws substantially from case reports. To the extent those reports are identifiable to a patient who becomes aware of them and feels hurt as a consequence, there may be a basis for litigation. Informed consent is a puny defense for the psychoanalyst who asks his or her patient if writing up the case report for publication is acceptable. How can consent by a patient be properly informed when transference issues are prominent? What if deep disguise is used, instead? If we use deep disguise or disinformation, are we sacrificing mimetic accuracy, and hence how reliable is the case report scientifically? A no less prominent teacher of psychiatry than Glen Gabbard sometimes turns with good sense to the “Sopranos” to illustrate matters of psychotherapy. By so doing he avoids compromising patient privacy.

Increasingly, our psychoanalytic journals — including the *Journal* of the Academy — turn to literature, drama, and biography to illustrate psychodynamic principles and matters of technique. The International Committee of Medical Journal Editors is expected to recommend or even require researchers to secure informed consent from those patients about whom clinical material is to be published. The Council of Psychoanalytic Journal Editors, which includes the *Journal* of the Academy, is supporting a more reasoned approach. Blanket informed consent will not lessen the burden of confidentiality we must carry, as editors, publishers, or authors, when we seek to publish cases. We believe that some combination of deep disguise and other approaches may afford a means to sustain the clinical case vignette as a valid means of reporting clinical data in our scientific literature without breaching confidentiality. In the next section, which does involve a case vignette, some of this difficulty is encountered. How valid do you accept the vignette as clinical data?

The third group of burdens, which I am calling clinical/ethical, leads us to the question, When must confidentiality be breached? If we judge that a patient is dangerous to self or others, we need to place the value of life above the patient’s right to privacy. We need to warn the potential victim or otherwise take action to protect the public from a dangerous patient, the Tarasoff-type case. It was the immediacy of this question that brought home to me the burden of confidentiality.

In the case I will describe, and I assume this kind of case is not rare among us, a middle-aged married mother of adult children came for consultation because of frequent arguments with her son causing her severe anxiety. In her life, she had achieved satisfaction as a grade-school teacher and was deeply devoted to friends and family. She was a generous person and a leader in her community. Her relationship with her husband was one of deep and enduring love, erotically gratifying, a partnership and a friendship unencumbered by betrayal of even the most minor kind.

We met once and twice weekly. We explored her relationship with her son and, finding our work valuable, she decided to continue in analytic therapy even after her chief complaint was successfully treated. I was transferentially endowed with the powerful intelligence and force of will that were presumed present in the father she had lost in early childhood.

Meanwhile, my patient’s husband showed signs of mild depression, then deep depression. Hard neurological signs emerged. A brain tumor was diagnosed. Surgery was necessary. He was left with residual depression, memory loss, dementia, ataxia, and psychosis — a full-blown organic personality disorder. My patient’s

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devotion to her husband was unbounded, and it seemed that the storybook marriage would continue. Each day, she would return home from school and relieve the attendant. She endured nights punctuated by his thrashing about, his calling on her for a glass of water or to take him to the toilet, all matter of things — and all without signs of appreciation. In what seemed like therapeutic progress, she acknowledged being angry, especially at her husband's intense and primitive self-centeredness.

One day, in session, in a tearful sputtering rage, she erupted with how she had lost the chance to kill her husband, to let his wheelchair tumble down concrete stairs to the pavement below. She acknowledged that such thoughts were in her mind more and more, and she worried about whether she could withstand the impulse to act on them. She said that she knew that I cared greatly about confidentiality and that she didn't need to worry that I would intervene. She was aware of duty-to-warn statutes and believed that I would have nothing to do with them.

Decisively, unequivocally, I told her that she was mistaken. Regardless of what the statutes might say, I would not stand by if she represented a threat to her husband. She said she could not bear to see him suffer, and she could not bear the suffering he put her through. I said we need to see this as the beginning of a conversation, not the end of one. Leveraging the transference endowment that was still firmly in place, I insisted that she phone me at any time if she felt such impulses getting out of hand. She was to hire full-time help immediately, I stated, and seek residential placement. Furthermore, she was no longer to sleep in the same bedroom as her husband. She must phone me the next day to let me know the progress of these efforts. Additionally, I put forth an explicit contract: One, you will not kill him or neglect him. Two, if he dies and you stop coming, I will phone the district attorney. Three, if you kill him or allow him to die, I will insist that you turn yourself in, or I will turn you in. Four, you will call me if the feeling of hurting him becomes very strong in you.

Terrified of her homicidal rage, which I regarded as arising as a vindictive solution to a profound and continuing disruption of primitive attachment needs, she did as I directed. She was relieved to have such explicit direction and a clear sense of consequence. She engaged both her son and daughter to help and by that same night had round-the-clock help.

The burdens of confidentiality are many. The confidences with which we are entrusted rise to the level of what another kind of discourse would re-signify as a kind of sanctity. How we manage our patients' trust speaks loudly for who we each are as persons, and for how we understand the meaningfulness of our profession. Dr. Ingram is a Fellow and Former President of the American Academy of Psychoanalysis and a member of the APA Committee on Confidentiality

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Osama bin Laden, The Ultimate Malignant Pied Piper: Understanding Terror Cults

By: Peter A. Olsson, M.D.

America will never forget the horror, pain and trauma, in New York and Washington, DC, on September 11, 2001. The use of our own large civilian jet airliners with innocent civilians aboard as missiles of suicidal destruction represents a new domain of evil for terrorists. This new terrorist tool is added to the existing arsenal of symbolic assassination, kidnaping, torture, skyjacking with ransom demands, and bombs on planes, in embassies, or in crowded public places.

In a confoundedly paradoxical way, the world-wide instantaneous media coverage provides a modern stage for the terrorists' ghastly reality drama. Terror used for social and political control has existed since antiquity, but modern terrorism is among other things a sensational media event. Marshall McLuhan reminded us that, as an extension of ourselves, the media is the message. If terrorists had to pay for the television time to cover their events, they would pay many millions for what they get for free. Terrorists search for novel actions against

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unsuspecting victims, actions that they know are politically strategic, pragmatic, and symbolic in their scope. These are key features in the definition of terrorism.

The uncanny and the psychological impact of terrorism:

The shocking world-wide media event that the terrorist orchestrates has a powerful, uncanny impact on our psyche. The terror event has a hypnotic magnification effect on the victim and society. People who saw the World Trade towers hit by airliners often said, "It was surreal!" or "It looked like a Hollywood movie." In fact, good movie-makers exploit the same human experiences of the uncanny that a terrorist does. Where does this sense of magic power in our experience of the uncanny come from?

Freud(1919), in a lesser known but absorbing paper "The Uncanny", says:

Our analysis of instances of the uncanny has lead us back to the old, animistic conception of the universe. This was characterized by the idea that the world was peopled by the spirits of dead human beings; by the subject's narcissistic over-valuation of his own mental processes; by the belief in the omnipotence of thoughts and the technique of magic based on that belief; by the attribution to various outside persons and things of carefully graded magical powers, or mana; as well as by all creations with the help of which man, in the unrestricted narcissism of that stage of development, strove to fend off the manifest prohibitions of reality. (SE, Vol. 17, p. 240)

The intuitive or calculated impact of the terrorist's act is upon the tendency of us all to regress to magical, black and white, or primitive thinking under stress or shock. During the uncanny impact of the traumatic reality of a terrorist media event, we all regress psychologically. Our nervous systems and our minds become fragile and vulnerable. Osama bin Laden had issued vaguely threatening warnings months before his terrorist network's actions. These gave an uncanny, magical, grandiose, prophetic quality to his group's terrorist event. The shock, horror, and media coverage leave us vulnerable to reacting out of impulsive, black and white, superstitious, and magical thinking. We all should be glad that so far our leaders have not reacted hastily or impulsively.

The psychological birth of the terrorist:

What accounts for the psychological birth of a terrorist? A significant portion of a terrorist' motivation and identity begins in the early stage of mental development described by Freud above. Most psychoanalysts, following Erikson, agree that individual identity crystallizes formed during adolescence or young adulthood. Fornari regarded stranger anxiety at eight months as the original emergence of "The Other" as enemy or as a bad presence that the child tries to get rid of by looking away. Kohut located the formation of the core of self in the second year of life. The self, he thought, is crystallized by the onset of latency. Kohut extended Freud's ideas about the early formation of self-love or narcissism and described two poles of the early experience of self. The child, Kohut stressed, feels a sense of a grandiose-exhibitionistic self at times and at other times a resonance with the idealized parental imago or childhood hero. The self's smooth loving integration is facilitated by the responsive, empathic, confident participation by parents or their surrogates. Empathic parenting helps the child's early grandiose fantasies of power, ambition, and significance, and the idealized parental imagos are used to form realizable goals, values, and guiding social principles. These early crucial self-other experiences with parents or role models provide models in the mind for self-love, self esteem, and confident, responsible actions.

Kohut also described the early emergence of a group self along with and entwined with the developing individual self. In essence, representatives of self and our self-in-a group, are developmental and maturational processes. He said that the basic patterns of a group self account for the continuity and the cohesion of the group and determine its most important ambitions, ideals, and actions.

Volkan provides important clinical and theoretical linkages between the group self – the human need to have enemies and allies – and our potential to understand the destructive self of a terrorist. Volkan observed that children experience angry or destructive feelings or impulses as dangerous. These impulses are often displaced

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on to the external world or others, a process that results in a precursor of the individualized idea of enemy. The "someone else" on whom aggression is displaced becomes dangerous and may also become a suitable reservoir for unwanted features of the child's sense of self. Volkan goes on to describe how these individualized enemies blend in the long run with shared enemies, unresolved mourning, and "chosen traumas." Unmended residues of pain and suffering can accumulate and fester within a large group. Others have pointed out that in addition to self-other experiences with parents, other early influences exist that can be called "extensions of the self-experience." These self-extensions are the national geography or terrain, the flag, monuments, churches, temples, mosques, or synagogues, and political leader figures from outside the family. In times of deprivation, persecution, or crisis, charismatic leaders like a bin Laden serve as a personified extension of the self or the group-self of a nation's or a local community's identity formation.

The cohesive self formed in preadolescent years is vital for subsequent secure identity formation in one's cultural and community group. Culture heroes and anti-heroes have particularly important charismatic psychological impact on self and identity formation on young people in countries where parents and families are forced into humiliating refugee camps or other painful group exiles. Parents become devalued role models.

Said presents a poignant example in his book, *After the Last Sky: Palestinian Lives* (1986, Pantheon Books:New York).

When A.Z.' father was dying, he called his children, one of whom is married to my sister, into a room for a last family gathering. A frail, very old man, from Haifa, he had spent his last 34 years in Beirut in a state of agitated disbelief at the loss of his house and property. Now, he murmured to his children the final words of a penniless, helpless patriarch. "Hold on to the keys and the deed.", he told them, pointing to a battered suitcase near his bed, a repository of the family estate salvaged from Palestine when Haifa's Arabs were expelled. These intimate mementos of a past irrevocably lost circulate among us, like the geneologies and fables of a wandering singer of tales. Photographs, dresses, objects severed from their original locale, the rituals of speech and custom: much reproduced, enlarged, thematized, embroidered, and passed around, they are strands in the web of affiliations we Palestinians use to tie ourselves to our identity and to each other. (p. -)

Situations where parents are humiliated and devastated in plain view of their young children become breeding grounds for future terrorists. The narcissistic injury to the parent results in injury to the child's inner hero. The vulnerable child turns outward towards the extended self for heroes with which to identify. Charismatic rebel political heroes like bin Laden spuriously offer to lead the injured individual and group-self out of psychological exile.

Bin Laden himself is an outcast and disowned exile from his large family of Saudi millionaires. He healed his own disappointments, narcissistic injury, and rage by becoming the self-appointed savior, martyr, or older brother-messiah for his followers and admirers. Bin Laden's new role as terrorist leader also allows him to act out his inner narcissistic rage at his parents, his exiling home country, and Saudi Arabia's oil customer, ally, and "friend," America.

The terrorist leader becomes a legend in his own mind and a healing legend for the wounded group-self of those he thinks he rescues. Charisma in a leader echoes passive receptiveness to charismatic influence in followers. The leader-follower patterns of a terrorist leader and his followers are remarkably similar to what studies of apocalyptic cults like those of Jim Jones, David Koresh, and Shoko Asahara have revealed. The group death scenario gives the leader and the apocalyptic cult group a special, exciting, and dramatically triumphant defining myth. It becomes a source of "under-dog" heroism and paradoxical group-cohesion. The besieged group prepares earnestly and "courageously" for the end-game of triumph over evil. Evil is initially defined by the leader but gradually becomes co-authored within the group as their group salvation death myth. The co-dependent leader holds the group death myth over the heads of the followers to magnify the special domain of his power. The leader becomes needed for the dramatic group action being planned and experiences the

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ultimate "celebrity" and fantasized triumph over his deepest insecurity and terrifying, helpless, fear of aloneness.

For the co-dependent followers, the group death idea brings heightened meaning and excitement to their otherwise mundane lives. I have listened to hundreds of hours of recordings of Jim Jones' ranting free associations during his "White Night" jungle sermons in Guyana. I was fascinated with his followers' comments in the background of the recordings. These affirmations of group death reveal how the idealism, group excitement, and grandiosity energize the co-dependent bond between the active pathological narcissism of the leader and the passive narcissism of the followers. Group death myths for such causes are truly terrifying. The New York and Washington terrorist pilots' instruction and inspiration manuals reflect similar denials of death through ultimate devotion to "The Cause" of Allah, as interpreted by bin Laden.

We might eliminate many bin Ladens, not with bullets, missiles and tanks, but with empathy and psychodynamically informed processes in our State Department. Our economy, oil, prestige, and other elements of self-interest are important, but so is diplomacy that has empathy for our allies and potential enemies in the shrinking world neighborhood. We cannot walk away when the Cold War is over or when Russia "loses" in Afghanistan. Devastated communities, families, and wounded group-selves are ignored at our peril. Billions of military aid dollars to middle east "friends" may not be worth the enemy-accumulating consequences. We need to help devastated world communities find ways to help themselves rebuild their lives.

The personal life-pathways of terrorists:

Eric Shaw (1986, Political terrorists: An alternative to the psychopathology model, *International Journal of Law and Psychiatry* 8:359-68) reviewed sociological studies, extensive psychiatric histories, and clinical examinations of terrorists and concluded that very few terrorists meet threshold criteria for any formal psychiatric diagnosis. He did find a pattern of what he calls the "Personal Pathway Model." The components of the vocational path to being a terrorist involve (1)early socialization processes; (2)narcissistic injuries; (3)escalatory events, particularly confrontation with police; and(4)personal connections to terrorist group members. Shaw concludes that terrorists come from a selected population who are at risk because of suffering early damage to their self-esteem. These young men and very few women come from affluent and middle-to-upper-class families. Their terrorist activities are extreme extensions of their parents' liberal social philosophies. They often express frustration with the contradiction they perceive in their family's beliefs and their parents' lack of social action. Their families' political philosophies may sensitize these future terrorists to the economic and political tensions throughout the modern world. Future terrorists often have an incomplete education, and they have been unsuccessful in obtaining a desired traditional place in society. Unlike their parents, they cannot find jobs in their crowded and economically struggling home country. The education their parents have provided for them seems meaningless and hollow in light of the societal turmoil around them. Becker, in his Pulitzer prize-winning book *The Denial of Death* (1973, The Free Press of MacMillan Company:New York) supports the notion that human beings live in reaction to our fear of death, but more than death, man fears a life lived without significance. It is interesting that conflicts with police are cited by terrorists as having provoked them to more violent political activity. Jail time provides an occasion to meet and join members of terrorist groups. Shaw suggests that terrorist group membership provides a sense of potency, an intense and close interpersonal environment, social status, potential access to wealth, and a share in a grandiose social design.

The children of terror and terrorism:

Rona Fields(1977) in her cogent book, *Society Under Siege: A Psychology of Northern Ireland* (1977, Temple University Press: Philadelphia), has described psychological tests on and interviews with adult terrorists from Northern Ireland paramilitary organizations, The Palestinian Liberation Organization, and South African Terrorists. Fields found these people to be without formal psychological disorders. They do have a readiness to commit violence without remorse and no conflict about experiencing or expressing their anger. She characterizes these adult terrorists' anger as the epitome of righteous indignation.

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Fields has also studied the cognitive, affective, and moral development of children in Northern Ireland, the Middle East, and Africa who had grown up constantly witnessing violence in their environment. She used various objective psychological test instruments, and some of her early subjects tested as children were later re-tested as adult terrorist cell members. Fields found that children growing up around ongoing violence show a keen concern about right and wrong. However, children traumatized by violence seem to be stuck at the stage of moral development where they view right and wrong exclusively in terms of their identity group. This identification through a threatened minority group leads to a righteous indignation about perceived wrongs and justification for vendetta (identification with the aggressor). Fields(1986) concludes:

For working class children in Northern Ireland, Palestinian refugee camps, and youths in black townships in South Africa, there is a prevailing sense of helplessness not ameliorated through observations of parental efficacy. For them, there is neither hope nor expectation of their own evolution out of powerlessness and helplessness" (paper, The Psychological Profile of a Terrorist, presented at the American Psychological Association, Washington, D.C., 1986).

Fields also notes that both Protestant and Catholic youths in Northern Ireland have identical psychodynamic and moral development. These children are obsessed about right and wrong and show black and white thinking about the moral issues. They seem to have low anxiety about their anger and high curiosity about violent solutions. Their search for novel and adventurous outlets for their anger provides fertile soil for the conversion of the terrorized into the terrorist, in a pattern similar to the American social psychological pattern of the abused child often turning out to be an abusive parent.

Toward solutions:

Finding solutions to terrorism requires an in-depth understanding of the social psychology of how terrorism impacts us psychologically and where its social psychological roots reside. We must also understand how a knowledge of the psychology of politics can be creatively applied to international dialogue and world-wide changes in legal codes and effective sanctions.

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Heuristic Techniques for Teaching Psychodynamics

By: Scott C. Schwartz, M.D.

American Academy of Psychoanalysis - Toronto, Canada - May, 1998

No member of the American Academy of Psychoanalysis would deny that psychodynamics are an integral, elemental and essential aspect of working therapeutically with patients. Most would agree that, given the mind-body connection, a basic ability to understand and utilize psychodynamic notions might be of value to any physician, regardless of one's area of specialization. The concretization of all of medicine in the modern age of profit motives and biological solutions, despite a friendly nod to "bedside manner," creates an image of psychotherapy and psychoanalysis in particular, as old-fashioned hocus pocus and irrelevant. In a world that eschews process for the pure result, that quantifies human suffering, improvement or functionality on numerical scales, or that seeks blood levels to assess psychological growth, the challenge is to preserve the value of understanding, alliance, and relatedness in psychiatry and other fields of medicine. This challenge is particularly important in teaching medical students. The approach I will describe here has been used in continuously teaching groups of five to ten third-year medical students in a weekly, one-hour class over a six-week psychiatry rotation during the past sixteen years.

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Heuristic teaching, simply defined, refers to a strategy that allows the student to learn from experience, or “from the inside out.” The process of personal discovery enhances the learner’s ability to retain information and to synthesize and transfer the experience into other situations. For example, we can tell a person that mixing the colors of blue and red will produce purple, or we can provide them with a palate of primary colors and allow them to “discover” what happens when primary colors are mixed with each other. Active involvement in the learning process enriches and strengthens all experiences. The challenge for the teacher is to create a palate of knowledge and meaningful experiences for each student. The concept of heuristic teaching has much in common with therapy in that learning is based on understanding or utilizing one’s own (the student’s, that is) experience or perception. Since psychodynamics demystify the human experience, the use of experience and conflict would helpfully demystify psychodynamics, in addition to effectively demonstrating the value of awareness.

Two factors create major obstacles. First, the art of analytic interpretation is esoteric and cannot be reduced to a series of formulas. Secondly, there are many schools of thought within the field that emphasize distinct aspects of the human experience, and each of these is plagued with its own lingo. Words that have a particular meaning to one school have entirely different meanings to other schools and yet other implications outside the field of analysis. This situation creates confusion for medical students and increases their resistance to understanding. Therefore, technical jargon should be kept to a minimum or eliminated altogether, so that we can emphasize meaning over correct terminology.

My own analytic background is the work of Karen Horney, and her particular structuring of dynamics fits the clinical work that the students encounter in a large urban multicultural teaching hospital. Relevant concepts include the notions of an idealized image, constructiveness, inner dictates, neurotic claims, and entitlements. Conflict as a response to competition and parental-societal expectations is central to the professional and personal life of most students and is easily taught through their own experiences. Most medical students are barely out of their adolescence chronologically, and due to the immense amount of work required are often psychologically and socially in the midst of adolescent conflict. Classes can effectively focus on the anxiety of this stage of growth.

In my course, the first of the six sessions is designed to provide an educational and emotional background for the development of the theory. I am very involved in medieval art, and my office is full of photographs and posters of manuscript illustrations, somewhat unusual for East Harlem. I begin by discussing the immense effort expended by common people of the twelfth century on the building of magnificent cathedrals, such as Canterbury or Chartres, and how the presence and patronage of a caring force, in this case the Virgin Mary or the saints, can stimulate constructive energy in a time of plague, dissension, and bigotry. The shock value of an art-historical lecture connected with the power of purposefulness usually reduces the initial inherent resistance in students who might ordinarily expect some esoteric jargon-filled lecture. We then explore the political, social, artistic, exploratory, and theological changes in Europe in the century before Freud’s work to place it in the context of universality and the society for which it was created. Once again returning to educational memories of college, five years earlier, students draw on concepts that they had de-emphasized during their medical studies. In discussing the Freudian theory and its value, I utilize the concept of horror movies, most of which contain libidinal urges (aggression and sexuality) personified by a protagonist which functions orally (Rodan, Reptilicus, Mothra), anally (Green Slime, volcanoes, earthquakes) or phallically (“Elm Street’s” Freddie, Chucky the demonic doll, Jason from “Friday the 13th”). The libido confronts some oedipal object and is ultimately defeated by virginal genitality, which achieves maturity in the process. This approach places in context the ideas that are central to Freud and ubiquitous in this form of entertainment. We then seek the problematic areas of the classical theory such as its de-emphasis of female psychology, its view of symptom rather than character pathology, and its nonacceptance of constructive forces. I conclude the class by asking the students to name the qualities of a “good” patient. They have always mentioned honesty, cooperation, trust, reliability, resourcefulness and motivation, among others. They are able to see that these universal constructive forces are also present in friends, lovers, mentors, and all positive relations.

The second class opens with a restatement of these constructive forces, and how they are the beginning of self realization, were it not for the villain of two significant, culturally induced obstacles, competition and parental

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agendas, which interfere with healthy growth and establish the need to “get it right,” a concept every student is faced with constantly. I ask them how extreme competition for success interferes with trust, and they note how truly hard it is to have deeply trusting friendships during times of competition. This situation opens the door to unrelenting humiliation and potential worthlessness, concepts central to Horney’s view of basic anxiety, as well as defensive structures, such as self-effacement, expansiveness, or detachment, that appear and solidify in youth. I use a typical elementary classroom to illustrate the bully, the brown-nose, the kid passing notes, the one in the nurse’s office, etc. I then take up the idealized image as the ultimate protection against worthlessness and how it begins externally, for instance in movie heroes, and is gradually internalized. A portion of time is spent conceptualizing the meaning of “being cool,” so essential an idealization for adolescents. Since this concept is so variable, so illusory, so transient, and yet so ubiquitous, it represents a good way to grasp what can be a quite esoteric issue. Of course, the point of being “cool” ultimately falls apart, and at the end of the lecture I point out that to succeed at being accepted we can only be ourselves, so that the idealized image becomes more the enemy than the protection.

The third and fourth classes deal with two important idealizing processes, the “tyranny of the shoulds” and “neurotic claims” in Horneyan terms. I present a vignette depicting the task of writing a term paper, with all the emotional gyrations, that would make us inert, worried, guilty, and finally, how the actual expenditure of genuine efforts relieves the anxiety. We discuss the idealization of the “super student,” who “should” be able to do this without major effort. I point out that we create the despised self when we see more and more friends having completed the paper while we just cannot get moving. Similarly, we talk about being in a situation “under protest” and how we get no satisfaction from either being there or relinquishing it, such as being at a family gathering when we would prefer to be elsewhere. This has been the easiest concept for students to grasp, undoubtedly because of the amount of internal coercion they experience. Neurotic claims are illustrated by a case presentation of an angry borderline patient I treated years ago. While students easily see this patient’s abusive and entitled attitude toward his wife and to me, less obvious, but equally important, was my own need for “decency” and a greater receptiveness to the warmth I was giving to him. On a more subtle level, it also shows students that we are not magically gifted to handle every situation with calm compassion, but that we can have needs, frustrations, and countertransference just as they do.

In the fifth class we look at the way the neurotic process operates in love relationships. I have a long letter written by a former patient, a self-effacing woman in love with a detached and narcissistic man, in which she describes numerous feelings and responses by both of them around an unexpected pregnancy. Using the letter, the students first respond “as people,” often siding with the woman but often feeling frustrated by her inability to see his behavior. Then we look at the characteristics of her self-effacement, her inadequate awareness of anger, her tendency to glorify the man, and her tendency to use others to validate her position. We are also able to see the way that a therapist can look at associations to assess unconscious process. Students are usually aware of these trends in themselves and in friends and can incorporate these interactions into their learning.

The final class focuses on unconscious process through the use of qualifiers and disclaimers as a function of dismissiveness or ego protection. Qualifiers and disclaimers are common in everyday parlance, are generally unconscious, and validate the importance of interpersonal dynamics. Charged expressions, such as “obviously,” “don’t take this personally,” “I know what you mean,” or “I’m not sure, but...,” are analyzed from the standpoint of their psychological purpose and, their effect on the listener. Since most of these are pseudo-empathic responses, we finish by discussing what constitutes real empathy, stressing the importance of hearing the communication and responding in a way that most directly addresses the need at hand.

This curriculum was developed over a number of years to address the needs of students who unwittingly use psychodynamics all the time but are loath to learn esoterica. It may be said that I provide a simplistic view of an immensely deep issue. However, most medical students will not become psychiatrists, much less analysts, but they will interact with patients, colleagues and friends and will experience the responses discussed in the course. Secondly, the purpose of studying dynamics is not to complicate our lives but to clarify what we observe or experience. Using universal experiential events is a way to pass along the information.

I had one student insist he was there to learn the scientific basis of behavior and not to learn why he had adolescent insecurities. He left the class, never to return. With that one exception, medical students have

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expressed through their attendance, their participation, and their evaluations, the fact that heuristic teaching can usefully increase the value of psychiatry in their lives.

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