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Front Cover
Elizabeth Frischauf, M.D., is a practicing neuro-psychiatrist in Manhattan. In addition she makes ceramic art, mobiles and writes poetry. She came of age in that great artistic incubator, the Upper West Side of Manhattan, the daughter of refugee parents, influenced by both the cultural explosion that occurred in Vienna over a century ago and New York City sights, sounds and energy.

The bas-relief mask plaque titled “Oh, Humm” arose spontaneously when I threw down a slab of clay and the shape suggested a face. The features also suggested themselves, as the face became a personality who says, “Oh humm.” This way of creating is a key characteristic of my work, where my imagination and sense of play run freely in all directions.

Fall 2013 Issue - correction:
Dr. Blumenfield’s column had mistakenly mentioned that Dr. Leah Davidson was a Past President of the Academy of Psychoanalysis and Dynamic Psychiatry. Dr Davidson was a Past President of the William Alanson White Society.
Philomena - One of Several Films Defines the Issue

One of the top movies of 2013 is Philomena. This is the story of an elderly woman (played magnificently by Judy Dench) who as teenager had an out of wedlock child at a convent. The movie has several interesting themes, one of which is the incessant drive that a woman has to reconnect with a newborn child which she gave up at birth. The film is based on a true story documented in a non-fiction book.

This is also a recurrent theme in several movies that I have reviewed (FilmRap.net). The Kids Are All Right, which stars Annette Benning, Julianne Moore and Mark Ruffalo, is about two lesbian parents who are raising two teenage kids who were conceived by artificial insemination with the use of a sperm donor. The film raises the possibility of what might happen if one of the children decides to track down his or her biological father. Obviously this could happen to a heterosexual couple and is an increasing possibility as new medical techniques are more frequently used to conceive and carry a pregnancy. One of the screenwriters for this film has indicated that the script was based in part on some aspects of her life.

The movie People Like Us, with Chris Pine, Elizabeth Banks and Michelle Pfeiffer, is about a man who upon the death of his father discovers that he has a 30-year-old sister whom he never knew about. This changed his entire understanding of his family and his own identity. The screen writing team that wrote the story also indicated that they had first hand knowledge of these issues.

Stories We Tell is a documentary film by Sarah Polley. It is about the complicated journey she has gone through as she uncovered secrets about her own family, especially finding out that the man she thought was her father was really not her father. Two other very good films that I have seen in recent years that have dealt with various aspects of these themes have been Admission and Mother and Child.

Movies Mirror Real Life

These movies highlight situations that occur more often than most people realize. In situations where the man is in a relatively stable marriage, or is single and doesn’t want to get married, but is promiscuous and fathers a child, he is faced with a decision. He could acknowledge the child’s reality but chose to stay with his current relationship, or leave his original family if he is married (presumably with a divorce) and establish a family with his new child. His wife, if he was married, could make this decision for him by deciding that she would not want to live with him any more. (The second woman might not want him either.) It is possible that the father may not even know that he has created a child, as the mother of the child may not wish to tell him. The pregnant woman, of course, has to make this decision, as well as the decision whether to have the child or get an abortion.

There are also situations where a couple has a child but don’t establish a relationship and the man moves on. He then has a family at a later date and does not tell them he has fathered a child in the past. Still other variations are possible such as when a single woman becomes pregnant and gives the child up for adoption and then goes on to live her life and perhaps ultimately have a marriage and children but never mention her past history.

I am sure there are other scenarios including twins separated at birth, siblings separated at early age and not having full awareness of the other, etc. Even before the discovery of the unknown family member is made, the parent who knows the secret has the burden of keeping the secret and not being able to be truthful with people to whom they are very close, usually a spouse and children. This can lead to guilt or fantasies of what happened to the secret child. The child who only knows that his or her biological parent has abandoned him or her can never know the reason why and may incorporate fantasies involving

continued on page 4
President’s Message (continued from page 3)

his or her self-worth or even grandiose thoughts about being rescued by the birth parent. A story told to the child that the missing parent died will of course backfire when and if the parent appears someday and all must deal with this major piece of deception no matter how well-intentioned.

Self-Identity Founded on Life History as We Know it

Our ideas of self are founded on our life history as we know it, including early childhood experiences, memories, and fantasies that are influenced by all variations and the nuances of the major players who impacted our earlier life.

There are an unlimited number of circumstances that could lead to the discovery of the unknown family members. Once a previously unknown family member is identified, the child very often has a strong desire to know about the biological parent and also meet and relate to the siblings who usually would be half siblings, sharing one parent in common.

What is the meaning of having an awareness of the existence of a biological family member who has not influenced your life for many years? What makes connecting with that person so important? Is it because you share some genetic makeup in common or that you come from some common heritage that drives the need for establishing this relationship? Is there a need to fill a void of being alone that can be corrected by meeting someone who shares some part of you? In the case of the newly connected siblings, is it the desire to rectify the mistake of the parent(s) who were not able to construct a complete family for all their children?

Three Case Examples

I would like to present three real cases (disguised) to illustrate some of these issues. I was not the therapist for any of these people so I do not have other information about the psychodynamics.

#1. A successful attorney was married for the first time at age 35 to a 28-year woman. They had three children and a fairly close-knit family and he never had any extramarital relationships. He died at age 65 and 10 years later a 45-year man contacted the now 67-year-old widow and told the following story. This man lived in another city with his mother and he had been told that his biological father was a successful attorney with whom she had a close relationship and who had subsequently died. (In reality he left her after she became pregnant and he moved to another city.) She told her son the unusual last name of his father. He found the name easily on the Internet since he was fairly well known in his field. He never told his mother that he had information about his biological father. After his mother died, and he himself was married with an 18 year old son, he located the widow of his biological father and told her who he was. He asked permission to visit her and wanted to meet her now grown and married children and any other close family members. She agreed. She had known about her husband’s previous relationship prior to their marriage (but not about this child) and asked her children if they wanted to meet him. The eldest son was not interested but the other two agreed. An older sister of the deceased husband was not interested but her grown son was agreeable.

The younger married middle-aged children of the deceased attorney established a good relationship with the “new family member” and they would visit each other when they happened to be traveling cross country to each other’s cities for other family events. Eventually the oldest son of the deceased father found that he had certain hobbies in common with his half-brother, e.g. sports car racing and golf, and he would join in these family occasions and he began to relate to his half brother. The grandson of the older sister of the deceased man was able to help the son of the new family member get a job in the entertainment business. He and all of deceased attorney’s sibs and the widow now consider him part of their extended family. When asked why he sought out his other family, he said he felt he owed it to his son to try to give him the extended family that he never had.

#2. The new young wife of a well known sports figure died in childbirth but their infant son survived. The father was devastated and gave his son up for adoption to a distant cousin with whom he did not have any subsequent contact. The boy was brought up by two loving parents. When he was a teenager, he was told the name of his famous biological father who supposedly had no interest in seeing him. When this child was a grown man of 50 years, he was in a movie theater with his wife watching a documentary about his biological father who was a legendary sports icon.

At one point in the movie the former sports figure recounted that he felt bad that many years ago he had a son whom he never met after his wife died in childbirth and he wonders what happened to him. The grown son was stunned by the interest shown in him. He contacted the filmmaker and asked if he could contact the sports icon who now lived in another country. The filmmaker agreed to arrange an all-expense-paid reunion if he could film it. The father is now a grandfather as is the son, and, after an initial meeting, the two families subsequently kept in touch with and visited each other from time to time.

#3. A teenaged mother gave her out-of-wedlock daughter up for adoption. Her daughter was raised by two loving parents. When the daughter married and had children of her own, she decided to track down her biological mother. She hired a private detective who was able to find her mother living alone in another city and had no other children. The daughter made contact with her, introduced her to her family, visited periodically and brought her to various family events. The oldest granddaughter became particularly close to her.

These three cases are obviously the bare facts and should raise clinical questions about the psychodynamics that are at play. What is clear is the strong need on the part of at least one person to connect with a long lost biological relative and family. There appears also to be an acceptance and probably a strong need on the part of the other family member or members to accept this contact and to learn about the lost biological family member. I believe that this area is ripe for both survey research, case reports with clinical discussion of the theoretical implications and psychoanalytic theory on this subject.

Proposed Research Study

I would like to propose a research study to start this off which one or more of the readers may wish to organize. This would be a survey of the members of this Academy with the following questions: continued on page 5
President’s Message (continued from page 4)

1. If today you were contacted by the hospital where you were born and told that you were accidentally given to the wrong family, would you want to contact and meet your biological parents and or their families?
2. Explain your reason. What would your need be if you agreed to do this and were there any conflicts in considering this question?
3. Would you feel differently if the parents who raised you were alive or deceased? Explain.
4. How would you feel if one of your children were notified as above and subsequently made contact and established a relationship with his or her biological family?

I would hope that the self awareness and insight of the Academy members would provide a good start into understanding the questions which I tried to raise in this article. If anyone is interested in organizing this study let me know and I will put you in touch with others who are interested so a collaborative study might be developed. I will step aside from this project but will eagerly follow any developments.

Dr. Blumenfield is President of the American Academy of Psychoanalysis and Dynamic Psychiatry. He is The Sidney E. Frank Professor Emeritus of Psychiatry and Behavioral Sciences at New York Medical College. He currently lives and practices in Los Angeles where he writes a blog, PsychiatryTalk.com, and also reviews movies on a blog with his wife at FilmRap.net.

Academy Annual Meeting in New York City
May 1-3, 2014
Scott Schwartz, M.D., Meeting Co-Chair; Gerald P. Perman, M.D., Meeting Co-Chair

The 58th Annual Meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry will be held at the Crown Plaza Times Square Manhattan Hotel in New York City from Thursday, May 1 through Saturday, May 3, 2014. The theme of this year’s meeting is Psychoanalytic Psychotherapy: 75 Years After Freud and we have an exciting program that will place Freud’s seminal work within the context of history and creativity.

On Thursday evening the audience will be treated to a dramatic reading of George Bernard Shaw’s “Don Juan in Hell” and we will see how another genius viewed the evolution of the psyche. Knowledgeable readers will bring this classic play from Shaw’s “Man and Superman” to life, demonstrating some of the philosophical underpinnings of psychoanalytic thinking.

Richard D. Chessick, M.D., Ph.D. will be this year’s Keynote Speaker on the topic “What Hath Freud Wrought? Current Confusion and Controversies about the Practice of Psychoanalysis and Psychotherapy.” Long-time Academy Member, esteemed teacher and prolific author, Dr. Chessick will bring his deep erudition and razor-sharp explanatory capacities to his subject. Dr. Chessick is well-known for tackling knotty philosophical and psychoanalytic problems in accessible language and he expresses his opinions compellingly and forcefully. Expect a tour-de-force presentation that will engage the audience in lively discussion.

A special Plenary Session will be held on Friday in which Marianne H. Eckardt, M.D. will give us her “Memoirs of a Founding Analyst.” On Saturday, Academy President, Michael Blumenfield, M.D., will look into the future with his Presidential Address: “The Academy 75 Years from Today.”

Among the panels and workshops, we will have our annual psychopharmacology workshop, a panel on malpractice liability, a workshop on group psychotherapy, a workshop on the humanistic impulse in psychiatry, papers on autoerotic deaths and slot machine gamblers, a panel on the interface between medicine and psychodynamic psychiatry, a dream workshop, a panel on the therapeutic alliance and the suicidal patient, a panel on bipolar disorder and sexuality, a paper session on contemporary understanding of male homosexuality and working with older adults, a panel on trauma and psychodynamic psychiatry, and a look at the cultural aspects of South American tribes and other societies.

As a special addition, we have arranged a tour of the Morgan Library where a significant document of Freud will be placed on view. In addition to this exhibit, we will have a showing of original letters by psychiatric pioneers including Freud, Jung, Horney, Menninger, Reik, and others. It is rare to be able to examine at close distance such original material. A silent auction, similar to the successful event held at last year’s Annual Meeting in San Francisco, will be held at this meeting. At our annual resident’s luncheon (yes, Virginia, there is a free lunch! – for residents) psychiatric residents will have the opportunity to interact with our Keynote Speaker, Richard Chessick, M.D., Ph.D. and ask him whatever they’d like about psychodynamic psychiatry.

Of course, one of the major attractions of this New York meeting will be the opportunity to meet and interact with some of the leading scholars in the field of psychiatric treatment, to reunite with your friends and colleagues in the Academy, and to guide future leaders in our field by sharing with them the wisdom attained from Freud and his followers. We hope that every member of the Academy will attend our 58th Annual Meeting to learn and to help sustain the relevance and importance of psychoanalysis and psychodynamic psychiatry for yourselves, psychiatric trainees, and your patients.

Scott Schwartz, M.D. Meeting Co-Chair
Gerald P. Perman, M.D., Meeting Co-Chair
American Academy of Psychoanalysis and Dynamic Psychiatry

58th Annual Meeting
Psychodynamic Therapy 75 Years After Freud

May 1 - May 3, 2014
Crowne Plaza Times Square Manhattan
New York, New York

Message from the Program Co-Chairs
Scott C. Schwartz, M.D. and Gerald P. Perman, M.D.

Every single approach to psychiatric treatment is based on the momentous discovery by Freud that all behavior is organized around a logical and comprehensible configuration of mental process. As a result, the work of Freud has been placed in the pivotal achievements of all science. Though aspects of his work have needed modification and reassessment, his theory remains central to all treatment. On the 75th anniversary of his death, an opportunity faces us to review and amplify his contributions. The treatment of mental illness has taken many forms and approaches, but always with the core belief in the fundamental logic of the psyche, and the ever-deepening value of the therapeutic alliance.

Register Now!

Visit www.AAPDP.org for the Preliminary Program and online registration or contact the AAPDP Executive Office at info@AAPDP.org or 888-691-8281
Establishing an APA Psychotherapy Caucus: A Grass Roots Effort Succeeds
by Erik M. Plakun, M.D.

At its December 2013 meeting, the APA Board of Trustees approved the establishment of a Psychotherapy Caucus. The inaugural meeting of the Psychotherapy Caucus will occur at the 2014 APA annual meeting on Monday, May 5 from 2:00 - 4:00 p.m. in the Riverside Suite, 3rd Floor at the Sheraton New York Times Square Hotel.

The establishment of a Psychotherapy Caucus means that once again psychiatrists interested in psychotherapy have a place within the organizational structure of the APA. It is also a step in the direction of reducing the biologically reductionist stance of the field.

Over recent decades the place of psychotherapy in psychiatry has been on tenuous ground as psychiatry’s focus has shifted toward pharmacotherapy. In the late 1990s the ACGME Psychiatry Residency Review Committee (RRC) realized that, given the biological emphasis of psychiatric training and treatment, the field was in danger of losing psychotherapy as part of the identity, training and skill set of psychiatrists. Because of this, the RRC required that residency training include teaching several schools of psychotherapy to a measurable level of competence during residency. Training in supportive, cognitive behavioral and psychodynamic psychotherapy is now a mandated part of every residency curriculum.

Concurrently, the APA also recognized that psychotherapy was dwindling as part of the practice of psychiatrists, and established a Commission that later became a Committee on Psychotherapy by Psychiatrists (COPP) within the Components of the APA. Over the roughly dozen years of its existence, COPP promulgated evidence about the efficacy of psychotherapy and its association with brain change, organized psychotherapy related programs for the APA annual meeting and Institute on Psychiatric Services, developed the Y-model for teaching psychotherapy across schools in an integrated, evidence based way, produced several APA Position Statements and informational documents on psychotherapy that were adopted by the APA, and conducted a survey of psychotherapy practice patterns among US and Canadian psychiatrists.

Because of financial concerns, COPP was sunset in 2008 along with many other components of the American Psychiatric Association. Subsequent efforts to reinstate a committee on psychotherapy were unsuccessful.

In 2012, an Assembly Action Paper led to the creation of a Psychotherapy Task Force in the APA Assembly. The 12 member Task Force was chaired by Academy Assembly Liaison, Eric Plakun, who is Associate Medical Director of the Austen Riggs Center. Other members included Samar Habi, David Flynn and Elizabeth Weinberg, also from Austen Riggs, Paul Lieberman from Brown, Bart Blinder from the University of California at Irvine, Allison Cowan from Wright State University, Randon Welton from the VA system, Andrew Gerber from Columbia, Donna Sudak from Drexel, Eve Caligor from the NYU School of Medicine and Evan Leib, chief resident at Mount Sinai in New York.

As determined by the Action Paper that established it, and using no APA resources, the Task Force shepherded the completion of a revised position statement on psychotherapy by psychiatrists. The Task Force also realized that, if a top down APA committee on psychotherapy was not going to be formed, then it could use APA operational bylaws to develop a Psychotherapy Caucus from the grass roots up. Letters were gathered and mailed to APA president elect and MPS member Paul Summergrad, who took the request to the APA Board of Trustees, where a Psychotherapy Caucus was formally approved in December 2013.

It seems particularly auspicious that a Psychotherapy Caucus exists at this moment in time when, ironically, even as the evidence for the efficacy for psychotherapy grows, there is evidence that the provision of psychotherapy by psychiatrists is declining. In 2008 Mojtabai and Olfson reported that over the ten-year period from 1996 to 2005, the percentage of psychiatric office visits involving provision of psychotherapy declined from 44% to 29%. In 2010 results of a survey carried out by COPP and APIRE (led by COPP member J. Christopher Perry and Joyce West, Ph.D. of APIRE) were reported at the Institute for Psychiatric Services. This study found that from 2002 to 2010 there was a 20% decline in provision of therapy to patients by psychiatrists from 68% to 48% of office visits reported by 394 psychiatrists. Those providing therapy to their patients tended to be over 65, white, U.S. medical graduates, and half their patients were self-pay or privately insured. Obstacles to the provision of psychotherapy cited by psychiatrists included significant debt burden, lower compensation for psychotherapy compared to other services, and intrusive and time-consuming utilization review burdens. Concurrent with this decline, a growing body of evidence demonstrates that multiple kinds of psychotherapy are effective for a range of single disorders and complex comorbid disorders, while we have also learned that the efficacy of some medications has been overestimated by as much as a third, as in the case of anti-depressants (Turner et al 2008), and much of their effect is placebo effect (Kirsch et al 2008).

The Psychotherapy Caucus offers psychiatrists interested in psychotherapy an opportunity to communicate with one another, to network and transfer knowledge across generations and across the country, develop symposia and workshops on psychotherapy, and learn about emerging evidence of the efficacy of psychotherapy. Please join us in New York. Contact Eric Plakun at Eric.Plakun@AustenRiggs.net for further information.
The Centenary of Silvano Arieti, 1914-2014: A Tribute from a Pupil
by Marco Bacciagaluppi, MD

Silvano Arieti was an Italian Jew from Pisa. After receiving his medical degree in 1939, he left Italy, where racist laws were already being implemented, and emigrated to the United States. As he describes in the 1978 book edited by Earl Witenberg, *Interpersonal Psychoanalysis* (New Directions, New York, Gardner Press), he spent some formative years at Pilgrim’s State Hospital, New York, in close contact with schizophrenic patients. He then trained at the William Alanson White Institute, where he was chiefly influenced by Frieda Fromm-Reichmann. As a result of this experience, he became a great specialist in the psychotherapy of schizophrenia, and in 1955 wrote his classic, *Interpretation of Schizophrenia* (New York, Brunner), the second, expanded edition of which appeared in 1974 (New York, Basic Books). In 1959 he became the Editor of *The American Handbook of Psychiatry* (New York, Basic Books), the second, greatly expanded edition of which was published over a span of years in the Seventies and early eighties. The Italian translation of the first edition was for many years the standard textbook for Italian students of psychiatry.

I first met Silvano in 1962 when he came back for the first time to Italy to lecture. Then, in 1963-64, my first wife and I were his pupils at New York Medical College where he was Clinical Professor of Psychiatry. We were fellow-residents of Jules Bemporad, Silvano’s cousin and later co-author. Subsequently, after returning to Italy, we translated many of Silvano’s books into Italian (Silvano had retained his refined Tuscan accent, and actually spoke Italian better than ourselves, who were Northeners from Milan, but he wrote all his books in English). These were *The Intrapsychic Self* (New York, Basic Books, 1967), *Creativity, The Magic Synthesis* (New York, Basic Books, 1976), and *Severe and Mild Depression*, co-authored with Jules Bemporad (New York, Basic Books, 1978). We also revised the Italian translation of the second edition of *Interpretation of Schizophrenia*, that, in Silvano’s view, badly needed revision.

Silvano was thus primarily a great specialist in schizophrenia, although he also wrote on depression. He also developed an interest in ethology, and hence in evolutionary theory. He shared this interest with John Bowlby. In the early 1950’s, without knowledge of one another, while Arieti was reading the...
Althea — Remembrance and an Appreciation

She wove creativity into her astute clinical work and authentic writing.

Her love of a garden was only exceeded by the joy she found in family.

A keen mind that would not abide psychoanalytic or other sanctimony, will live on in the Power of the Being and Loving contained in her books.

Future generations of psychotherapy patients and their helpers are grateful.

Peter A. Olsson MD, December 25, 2013


Being and Loving: How to Achieve Intimacy with Another Person and Retain One's Own Identity, 2005, Jason Aronson of Rowman and Littlefield

So, these are part of the poem as well, because of how these two books of Althea’s were particularly inspiring to me. Althea was/is an elegant and impressive person. She reminded me of my favorite and best supervisor when I was a resident, Hilda Bruch.

ARTICLES

Madness, Real and Feigned
by Marco Bacciagaluppi, M.D.

As I approach old age (I turned 80 in October 2012) I go back to reading the classics. Since August 2012 I have read, or re-read, in that order, four plays by Shakespeare: King Lear, The Tempest, Henry V and Hamlet. This is just a sample, although significant, of Shakespeare’s vast production.

In reading Shakespeare I rely on Harold Bloom, Professor at Yale, who wrote Shakespeare. The Invention of the Human (New York: Riverhead Books, 1999).

On the other hand, given my training, this reading inevitably leads to associations with psychopathology. In these plays I was struck by a theme that should be of interest to Forum readers: that of madness, real or feigned. Both types of madness are present in King Lear (Lear is really mad, Edgar feigns madness) and in Hamlet (Hamlet feigns madness, and drives Ophelia to real madness and finally to death by drowning). In these plays,
feigned madness is instrumental and real madness is due to
relational trauma. Lear is driven mad by the ingratitude of his
daughters and Hamlet drives Ophelia mad first by his fierce
rejection (“Get thee to a nunnery”), then by killing her father
Polonius. Finally, there is a variation on this theme in
Henry V, when Mistress Quickly describes the death of Falstaff, where the
appropriate term may be “dotage,” or the more professional term
“dementia.” The ubiquitous presence of this subject in literature
reveals that it is a universal human condition.

Shakespeare is very artful and witty in depicting feigned
madness as a vehicle for biting irony. Here is Hamlet (Hamlet,
II, ii):

Polonius: Do you know me, my lord?
Hamlet: Excellent well. You are a fishmonger.
Polonius: Not I, my lord.
Hamlet: Then I would you were so honest a man.

Hamlet obviously enjoys it when Polonius obsequiously follows
Hamlet’s apparent hallucinations (Hamlet, III, ii):

Hamlet: Do you see yonder cloud that’s almost in shape of a
camel?
Polonius: By th’ mass and ‘tis – like a camel indeed.
Hamlet: Methinks it is like a weasel.
Polonius: It is backed like a weasel.
Hamlet: Or like a whale.
Polonius: Very like a whale.

At one point, Polonius glimpses the truth (Hamlet, II, ii):

Polonius: Though this be madness, yet there is method in’t.
Ophelia is most poignant as she sings in her madness: (Hamlet,
IV, v)

He is dead and gone, lady,
He is dead and gone,
At his head a grass-green turf,
At his heels a stone.

And here is Edgar, feigning to be Tom O’Bedlam. Lear, who
is really mad, takes him seriously (Lear, III, vi):

Edgar: The foul fiend haunts poor Tom in the voice of a
nightingale.
Lear: Thou robed man of justice, take thy place.

And here is Mistress Quickly, describing Falstaff in his
dotage, just before dying (Henry V, II, iii):

Hostess: After I saw him fumble with his sheets, and play
with flowers, and smile upon his fingers’ ends, I knew there
was but one way.
Also mad Ophelia plays with flowers: (Hamlet, IV, v):

Ophelia: There’s rosemary, that’s for remembrance – pray
you love, remember. And there is pansies, that’s for thoughts.

There’s a daisy. I would give you some violets, but they
withered all when my father died.

After this marvelous poetry, I now extend this theme to
another great author, Goethe, and to the realm of music. Harold
Bloom includes both Shakespeare and Goethe in another volume
(The Western Canon. The Books and School of the Ages.
New York: Harcourt Brace, 1994), in which Shakespeare
is placed at the very center of the Canon, and Goethe appears
chiefly because of Faust, Parts One and Two.

In the realm of music, Arrigo Boito was a distinguished
and aristocratic 19th-century Italian musician, who, in
contrast to Verdi, only composed two operas, Mefistofele and
Nerone, now rarely performed. His merit lies in having referred
to these two authors of the Canon. In Mefistofele he staged
both parts of Goethe’s Faust, thus revealing a much greater
intellectual sophistication in comparison with Gounod, who in
his Faust based himself only on Part One. Boito then provided
Verdi with the librettos of his two most mature works, Otello
and Falstaff, based on Shakespeare. An earlier opera by Verdi,
Macbeth, was also based on Shakespeare, but the two later
works are of an entirely different stature.

The theme of madness appears in Boito’s Mefistofele, when
Margherita, after having been seduced, made pregnant and
abandoned by Faust, is in jail for having drowned her baby.
She sings a beautiful and desolate aria, “L’altra notte in fondo
al mare” (“The other night, at the bottom of the sea”). This aria
recurred in a dream which I reported as an example of self-
analysis in a book of mine, Paradigms in Psychoanalysis. An
behavior may be viewed as an example of the trans-generational
transmission of trauma. After having been rejected, Margherita
in turn rejects her baby. What she had endured at the hands of
someone stronger, she then inflicts on someone weaker, indeed
on what she may have regarded as a part of her own self. In jail
she goes mad, like Ophelia. She believes that someone else has
drowned her baby, and that she is falsely accused. “Or per farmi
delirare, dicon ch’io l’abbia affogato” (“In order to make me
delusional they say I drowned it”). But with those very words
she proves that she is indeed delusional.

Maternal rejection, as exemplified by Margherita, is the
severest of all traumas, for which we should be on the lookout in
our patients. As I say in the discussion of my dream, if the baby
survives the rejection, it can only react by disorganization and
fragmentation, because biological evolution did not contemplate
a rejecting mother at birth. A relevant research is that by Mary
Main, the title of which is self-explanatory (Main & Hesse,
Parents’ unresolved traumatic experiences are related to infant
disorganization status. In: Greenberg, Cicchetti & Cummings,
Eds., Attachment in the Preschool Years. Theory, Research
More recent research (Moskowitz, Schaefer & Dorahy, Eds.,
Psychosis, Trauma, and Dissociation. Emerging Perspectives on
shows that there may be different developmental pathways
leading from early trauma, through dissociation, to either psychosis or severe non-psychotic conditions such as BPD (Borderline Personality Disorder).

From great literature I have returned to psychopathology. Dry scientific prose is useful to complement affect-laden poetry, just as during development the left hemisphere eventually complements the right hemisphere, but this is the dominant one at the beginning of life. Similarly, interpretations may be useful in therapy, but the main factor is the quality of the relationship.

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**Jungian Outlooks on the Psychotherapy of the Suicidal Patient**

*by John Beebe, M.D.*

One does not find in Jung’s writings a basic, elemental formulation of what drives suicidal ideation. He makes no assertion with the pith of Freud’s postulation that identification with the aggressor is an inevitable consequence of growing up. There is nothing as poetic as Freud’s understanding of how, in the course of mourning the loss of a loved one, the “shadow of the lost object falls upon the ego,” nor anything as ingenious as Freud’s suggestion that depression is anger turned against the self - formulations that have enabled generations of psychoanalytically trained psychotherapists to feel that they can at least understand suicide.

It is not the case, however, that Jung failed to offer ideas that can guide the analytically-oriented clinician faced with a patient in the grip of such elemental dynamics. In fact, I will make the claim that Jung is actually an eminently practical guide in such a situation, even though, no more than Freud, he never really answers the question as to why some patients are more susceptible than others to becoming frankly suicidal as a consequence of their intrapsychic misery.

Jung’s first major contribution to the psychotherapy of mental states in which suicide risk was present came with his appropriation, early in his career, of the theory of complexes that had already been developed for psychiatry in Berlin by Theodor Ziehen (Kerr, J., 1993, *A Most Dangerous Method: The Story of Jung, Freud, and Sabina Spielrein*. New York: Alfred A. Knopf). The basic idea was that anyone’s psychology can be massively affected by a “complex of feeling-toned ideas.”

Exploring this theory through use of the word association experiment that Ziehen had adopted from protocols developed by Sir Francis Galton in London, Jung, working with general psychiatry patients at Zurich’s Burghölzli Hospital at the turn of the twentieth century, was able to demonstrate the complexes present in a variety of psychopathological states and to open them up to depth psychological analysis.

Jung did not support the notion that suicidal complexes had the power to transform the self for the better. In 1951 he wrote to a correspondent described as being “47, in a state of nervous collapse and depression:”

The goal of life is the realization of the self. If you kill yourself you abolish that will of the self that guides you through life to that eventual goal….You ought to realize that suicide is murder, since after suicide there remains a corpse exactly as with any ordinary murder. Only it is yourself that has been killed. That is the reason why the Common Law punishes a man that tries to commit suicide, and it is psychologically true too (Jung, C., 1975, *C. G. Jung Letters*, vol. 2, Adler, G., ed. Princeton: Princeton University Press).

In addition to realizing just how destructive a suicidal complex can be, Jung recognized something as a psychiatrist that I consider fundamental to the treatment of any suicidal person, and that is that the person in the grip of a such a complex, “the suicidal patient[,] is often quite concrete, i.e., has only a weak ability to distinguish fantasy from action. . .” Therefore, “[t] he therapist must explain repeatedly that emotion is not to be naively acted upon” (Beebe, 1975). This point is central to a chapter I wrote forty years ago for a book on crisis intervention, in which I described the following case:

An intelligent divorced woman in her middle 50s, (suffering from what would nowadays be called single episode major depressive disorder,) entered psychotherapy after a suicide attempt brought on by her rage at an indecisive boyfriend. She called her therapist after a session in which she had begun to ventilate her long-suppressed anger at the man, whom she had previously mothered and forgiven. She said that she felt like killing him. The therapist said those feelings were important but that they belonged to the psychotherapy, and if she felt like acting on them, she should come in immediately. At the next psychotherapy session the therapist inquired about her homicidal concern, and she said “I’ve got it under control now.” She reported a dream she had the night after she spoke to the therapist. In it she was holding a knife. In front of her was a wall on which the word KILL was written. Gripping the knife tighter, she moved to the right and saw the word MURDER. She was so frightened she dropped the knife, and from this point impulsivity was not a problem (Rosenbaum, P. & Beebe, J., 1975, p. 57-58, *Psychiatric treatment: Crisis, clinic, and consultation*. New York: McGraw Hill).

This dream deals with the concreteness that had overtaken the mind of a patient with a suicidal complex, exposing as well its homicidal shadow, and gives us a glimpse of her psyche’s considerable ability to transform itself simply by realizing the heaviness of what she was getting into. It shows us the normally unobservable instant in which violent fantasy is reframed in an ethical and legal context and thereby rejected as the basis for literal action.

Jung had long recognized the ability of the psyche, left to its own devices, to compensate for its understandable tendency to want simply to end its suffering by turning, concretely, to suicide. In his 1907 monograph, “The Psychology of Dementia Praecox,” Jung reports that a patient

who was disgusted with life because of his misfortunes wanted to commit suicide by inhaling gas from an open
jet. He inhaled the gas vigorously for a few seconds, then suddenly felt an enormous hand grasp him by the chest and throw him to the floor, where he gradually recovered from his fright. The hallucination was so distinct that the next day he could still show me the place where the five fingers had gripped him (Jung, C., 1966, p. 148, “The Psychology of Dementia Praecox” in Collected Works, vol. 3. Princeton: Princeton University Press).

In the same monograph, Jung describes “a patient in the first stages of progressive paralysis [who] wanted in desperation to kill himself by jumping out of the window.” Jung reports, “he jumped onto the window-sill, but at that moment a tremendous light appeared in front of the window, hurling him back into the room” (ibid., p. 147).

These examples make clearer why Jung could allow himself to consider not intervening when he heard that someone had expressed a suicidal wish. Making an important addition to Freudian theory, he says, “not only can the unconscious ‘wish,’ it can also cancel its own wishes.” This insight, based on real experience with psychiatric patients who had reversed their own destructive impulses much for the better, not unlike the patient I treated early on, who dropped the knife in her dream, led Jung to postulate “the existence of an unconscious self-regulation” (Jung, C., 1966, p. 166, The Relations Between the Ego and the Unconscious in Collected Works, vol. 7. Princeton: Princeton University Press).

In Suicide and the Soul, however, James Hillman observes that suicide expresses not just the urge for transformation, but the urge for hasty transformation (Hillman, J., 1964, p. 73, Suicide and the Soul. London: Hodder & Stoughton). That being the case, Hillman warns the therapist against too hastily attempting to symbolize his or her way out of the dilemma created by the patient who wants to transform his or her life by literally ending it. Hillman urges both patience toward, and containment of, such emotion within the therapy to allow the patient to express completely the extent of the desire to bring the kind of life that has been to an end.

Certain root causes of the suicidal complex have been postulated by Jung’s followers. Several have identified extreme alienation of the ego from the Self as the source of both suicidal and homicidal tendencies. The ego that has shut itself off from the positive, self-renewing aspect of the unconscious may lose hope and become a “renegade,” forming an unholy alliance with the dark side of the Self (Baynes, H., 1949, 40 ff., Mythology of the Soul. London: Methuen & Co.).

An ego in the grip of this renegade tendency is “actually a deserter, a traitor” to what one Jungian analyst calls “the enterprise of consciousness” (Harding 1947, 242). This condition amounts to feeling doomed to fail in any project involving self-realization, because the only part of the Self that is being consciously realized is dark and destructive. Harding emphasizes the loss of energy that arises from this biased misunderstanding of the Self. Edinger focuses on the actual violence it sets in motion, citing as an archetypal example the story of Cain. Both Cain and his brother Abel, as children of Adam and Eve, make offerings to God, but for reasons that are not entirely clear God rejects Cain’s offering. Edinger understands Cain’s resultant murderous rage toward Abel as an expression of his suffering at finding himself so unfairly alienated from God. Edinger’s analogy of Cain to the uncomprehending conscious ego and God to the often unfathomable unconscious priorities of the Self, recognizes that these two centers of psychic agency can have vastly differing visions of what is appropriate (Edinger, E., 1973, p. 43-44, Ego and Archetype. Baltimore: Penguin Books). This is a Jungian understanding of the alienation that the sociologist Durkheim had named in 1897 as an essential precondition of suicide (Durkheim, E., 1897/1951, Suicide: A Study in Sociology. Glencoe, IL: The Free Press).

The contemporary Jungian analyst Polly Young-Eisendrath argues that it is the shame over the failures that result from such alienation that goes some patients toward suicide. Her approach, when this sort of despair takes over, is to counter-provoke her patients by asking them to question their assumption that death will provide an end and a release (Young-Eisendrath, P., 1996, p. 178-181, The Gifts of Suffering. Reading, MA: Addison-Wesley Publishing). Hayao Kawai, the first Japanese Jungian analyst, saw the suicidal impulse somewhat differently, as arising, in almost a Buddhist way, from the patient’s need to experience a spiritual death and rebirth to get out of the despairing impasse. He cites one patient who, having survived a suicide attempt, “later said, "Unless I had gone through being near death, I would not have been transformed”” (Kawai, H., 1996, p. 111, Buddhism and the Art of Psychotherapy. College Station: Texas A & M University Press).

Here the contributions of Jungian analyst David Rosen in his book, Transforming Depression, make a great deal of psychiatric sense (Rosen, D., 1993, Transforming Depression: A Jungian Approach Using the Creative Arts, New York: Putnam). He convincingly shows that the deepest desire of the suicidal person is not to kill the self but rather to kill that part of the ego that is not allowing the self to realize itself. This process he calls “egocide.”

The way I understand “egocide” is to grasp that there is always a purposiveness in even the merest suicidal thought. My view is that when suicidal feelings surface, something in the personality really does need to die. Sometimes this is an internal attitude, but not infrequently it is also an outer relationship, or as we might say psychoanalytically, an object relation that has been wrongly enacted in a literal way and is compromising the patient’s development - for instance, a love relationship that is essentially sadomasochistic. Or what needs to die may be an immature state of self that has been acting as if no further psychological development is necessary.

A problem for many of us as young adults is getting past the adolescent versions of ourselves, the eternal boy or girl who can transcend, but never quite face, reality. The young man or woman who imagines him or herself to be fully realized at twenty-five is likely to be unwilling to endure the shock that comes from discovering that one’s divine presentation cannot sustain itself when adult responsibilities surface. These godlike youths, the famous Jungian puer aeternus and puella aeterna (Von Franz, M-L., 1970, Puer Aeternus. New York: Spring Publications; Hillman, J., 1979, Puer Papers. Dallas: Spring Publications) are beautifully portrayed as charismatic brother and sister in Bertolucci’s film, The Dreamers, set in the Paris uprising of 1968. Bertolucci’s incestuous pair cannot even separate: they can only crack up. Watching their dissolution, we are not surprised when suicidal behavior emerges.
Here again Jungian analysts have tended not to move too quickly, and have been cautious about attempting to ground high-flying puers and puellas early in their contacts with them. Joseph Henderson described the dream of a young man of twenty-seven, still seeking a vocation, unmarried and subsidized by his family’s money and endless patience. He dreamt he was floating in a vast cave among cloudy shapes, which on closer inspection were the huge bodies of the Olympian gods as they drifted about in the atmosphere of their eternal divinity. [As a psychiatrist, Henderson] was relieved to hear him say that in the dream on recognizing these figures as the gods, he also recognized the inappropriateness of his position among them; in a state of panic [the patient] escaped by a stone ramp, which led him down to safety and the association of mere mortals.

Henderson warns:

Sometimes the danger of this kind of inflated isolation is clearly registered in a dream, and one has the task of trying to puncture the balloon upon which the patient is riding high. This may be dangerous, as it would be in reality if one took away such a support, no matter how flimsy. For this reason, von Franz points out how important it is for the therapist to fly along with the airborne hero and persuade him to come down of his own accord by gradual stages (Henderson, J., 1967, p. 29, Thresholds of Initiation. Middletown, CT: Wesleyan University Press).

Frequently, however, a therapist’s task is to get patients to expand, rather than abandon, their awareness of their gifts. Here is perhaps Jung’s most original contribution to the understanding of what the psychotherapy of the suicidal person requires: it is often an educative effort into the possibilities of the Self. In his book, Freud or Jung, the psychoanalyst Edward Glover derisively characterized Jungians as “eclectic psychologists who cannot refrain from instructing their charges” (Glover, E., 1991, Freud or Jung. Evanston, IL: Northwestern University Press).

Jung, however, did not hesitate in describing education as one of the most important parts of any therapeutic effort to produce real change. As he puts it, “the patient must be drawn out of himself into other paths, which is the true meaning of ‘education,’ and this can only be achieved by an educative will.” Jung adds, however, that education is a relatively late stage in psychotherapy. His first stage is catharsis. In the psychotherapy of a suicidal patient, full room must be made for the confession of suicidal feelings and all efforts made by the patient, conscious and unconscious, to enact them. The second stage of psychotherapy Jung calls elucidation. That is when the neurosis is explained to the patient and when all the dynamic reasons someone might have to fantasize suicide can be brought to light. The third stage is education, and it is based on Jung’s understanding “that no amount of confession and no amount of explaining can make the crooked plant grow straight, but that it must be trained upon the trellis of the norm by the gardener’s art” (Jung, C., 1966, p. 68, General problems of Psychotherapy, Collected Works, vol. 16. Princeton: Princeton University Press).

Naturally, Jungian psychotherapy does not stop with the education required to enable a patient to accept the largeness and peculiarity of his own self. A fourth stage follows that Jung calls transformation, the basis for a lasting change of attitude toward the life the person has been given to live. At the stage of therapy where the changed attitude starts to emerge, a psychotherapist is often required to recognize what has become original and new about the patient and to be affected by that in a way that will transform the therapist’s clinical practice in the future (Jung, C., 1966, p. 69-75, General Problems of Psychotherapy, Collected Works, vol. 16. Princeton: Princeton University Press).

For only if the therapist is also somewhere changed by the impact of the patient’s trajectory through psychotherapy will the patient really believe that the new life he or she manages to achieve amounts to something. It is not only the old mindset of the patient that must partly die to enable the suicidal aspect of the soul to realize its purpose; some aspect of the old mindset of the therapist has to go as well. The therapist must not reduce to psychopathology the challenges that led to the suicidal impasse and must be open to the possibility that the patient’s individuation will involve solutions outside of the therapist’s prior experience. Both therapist and patient, observing the emergence of the patient’s healthy uniqueness, may find themselves thinking, “I never imagined this sort of life could be valid!” That affirmation of what they have discovered together is the final step in overcoming the fear of life that has fueled the patient’s suicidal impulse all along.

The therapist who is willing to follow these Jungian precepts with a suicidal patient is led to the brink of an atheoretical position that is, at the same time, a deeply practical one. As Jung himself puts it:

In practical psychotherapy we strive to fit people for life, and we are not free to set up theories which do not concern our patients and may even injure them. Here we come to a question that is sometimes a matter of life and death - the question whether we base our explanations on “physis” or spirit. We must never forget that everything spiritual is illusion from the naturalistic standpoint, and often the spirit has to deny and overcome an insistent physical factor to exist at all. If I recognize only naturalistic values, and explain everything in physical terms, I shall depreciate, hinder, or even destroy the spiritual development of my patients. And if I hold exclusively to a spiritual interpretation, then I shall misunderstand and do violence to the natural man in his right to exist as a physical being. More than a few suicides in the course of psychotherapeutic treatment are to be laid at the door of such mistakes (Jung, C., 1960, “Basic Postulates of Analytical Psychology,” p. 351-352 in Collected Works, vol. 8. Princeton: Princeton University Press.).

I would add that just as our patients are neither merely physical nor merely spiritual, the complexes that inform their motivations and choices are not merely archetypal. Their texture and tone are shaped by personal history and development. For Jung, to apply a single rule or method to every suicidal patient...
in blindness to the patient’s individuality is the one thing that would be most likely to deaden the soul out of which the life force flows. It is when the therapy accurately mirrors the patient’s uniqueness that he or she is most likely to recall and reaffirm his or her reason for living.

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**Overdiagnosis of Bipolar Affective Disorder**

*By Greg Mahr, M.D.; Kate Hocquard, B.S., M.D.; (candidate), Siobhan Fitzpatrick, B.A., M.S.*


A particularly challenging diagnosis is that of bipolar affective disorder (BAD). Bipolar affective disorder is being diagnosed with increasing frequency, and has become increasingly controversial. In particular, the non-classical forms of bipolar illness, such as bipolar II, now show a prevalence of 5% in community samples (Benazzi, F., 2007, *Bipolar disorder—focus on bipolar II disorders and mixed depression*, The Lancet, 935-945). Some of this increase has to do with change in diagnostic criteria to allow for the more liberal use of the diagnosis; some also has to do with “diagnostic creep,” or the tendency of practitioners to overdiagnose bipolar illness in marginal cases (Youngstrum et al., 2010, *The bipolar spectrum: Myth or reality?*, Current Psychiatric Reports, 12(6):479-489).


Serious difficulties also arise in differentiating bipolar disorder (BD) from borderline personality disorder (BPD); complex technical considerations and distinctions are required for clinicians to successfully distinguish one from the other (Goldberg et al., 2008, *Overdiagnosis of bipolar disorder among substance use disorder inpatients with mood instability*, The Journal of Clinical Psychiatry, 69(11):1751-1757). Even broader definitions of bipolar illness have been proposed, such as “bipolar spectrum disorders” (Ghaemi et al., 2008, *Diagnostic guidelines for bipolar disorder: A summary of the international society for bipolar disorders diagnostic guidelines task force report*, Bipolar Disorders, 10:117-128). A new potential diagnostic category; ultra-rapidly cycling bipolar disorder has even been proposed.

Complex psychodynamic factors related to countertransference amplify this issue of “diagnostic creep” and the increasing medicalization of psychiatry. Pharmacological treatment is emotionally “easier” than psychotherapy, less frustrating and involves for the psychiatrist a natural identification with a traditional medical and paternal role. Another cause for this surge in the diagnosis of bipolar disorder may be financially driven; a 2011 article from the New York Times illustrates the plight of the current insurance reimbursement era, and the trending of psychiatry away from traditional therapy toward a pharmaceutical-predominant specialty, solely on the basis of financial profit (Gardiner, H., 2011, *March 5, Talk doesn’t pay, so psychiatry turns instead to drug therapy*, The New York Times).

Unfortunately, the overdiagnosis of bipolar affective disorder leads to overtreatment and the excessive use of medications with all of their concomitant side effects. Weight gain, liver problems, falls, diabetes mellitus, and kidney failure are all common side effects of treatments for bipolar affective disorder. When patients who are not bipolar are diagnosed as bipolar they become subject to increasingly complex medication regimens, because they are “treatment unresponsive.”

A common regimen in the community for a “bipolar” patient will include an antidepressant, probably augmented with bupropion, a mood stabilizer or two, an atypical antipsychotic for sleep and further mood stabilization, like quetiapine, and a benzodiazepine for anxiety. For good measure a stimulant is often part of the regimen as well, as the impulsivity and lack of response to mood stabilizers leads to a secondary diagnosis of attention deficit disorder.

The authors performed a very simple pilot study to assess how the diagnosis of bipolar affective disorder is used in the community. Patients who received a psychiatric consultation at the request of their hospital physician, and were labeled as bipolar affective in their evaluation report, were then further questioned about their bipolar symptoms to assess if they truly met criteria for bipolar illness. These semi-structured interviews were led by myself and included asking questions regarding the duration of manic or hypomanic symptoms and associations of substance abuse with mood symptoms. When patients’ descriptions of their symptoms did not meet DSM IV criteria for bipolar affective disorder, they were considered to have been diagnosed incorrectly.

Of the 107 patients were screened, 48 (44.85%) were felt to be...
inaccurately diagnosed as any type of bipolar disorder. Failure to meet the duration criteria for mania or hypomania was by the far the most common reason for diagnostic inaccuracy (40 of 48). The second most common reason was substance abuse (6 of 38). Information gathered in the patient interviews yielded that most patients felt very strongly that they were bipolar, even when they did not meet criteria. Most patients were given their psychiatric diagnosis by a psychiatrist (98/107), a small minority were diagnosed by their primary care physician. The DSM does allow for the diagnosis of Bipolar Disorder NOS, which does not include a duration criterion, so those 48 patients might have all been Bipolar NOS. But then we have the troubling result that most of bipolar diagnoses are in fact diagnoses of Bipolar NOS. The NOS category is meant to be rare and uncommon, for the odd case that doesn’t fit criteria well. It is not meant to be the most common subtype of illness.

The results of this simple pilot study suggest that bipolar affective disorder may be frequently overdiagnosed in the community. The design of the study was only sensitive to overdiagnosis, but overdiagnosis occurred frequently. Some limitations to this study include interviewer bias, which can be a product of simplicity and clinical nature of the study design, and the fact that the interviewer is not blinded to the diagnosis or outcome of the evaluation. In an ideal and more formal study design, the interviewer might have been blinded to the purpose of the study and might have used a structured interview format like the SCID. This potential concern is mitigated by the fact that patients tended not to fake “healthy”, but rather tended to try very hard to convince the interviewer that they were indeed bipolar.

The diagnostic category of Bipolar NOS creates a special problem. This diagnostic category has very loose criteria, making it very difficult to distinguish bipolar NOS patients from those in the population that are moody and irritable but not mentally ill. While some small minority of the patients identified in the study as inaccurately diagnosed might be legitimately considered to have the NOS subtype; this does not alter the conclusion that a high rate of overdiagnosis of bipolar illness occurs in this community sample.

The presence of such a high frequency of diagnostic errors raises several important questions: 1) How are diagnostic decisions made?, 2) How are diagnostic errors made?, and 3) Why are diagnostic errors made?

The most important cause of diagnostic error is premature closure (Eva et al., 2010, Swapping horses midstream: factors related to physicians’ changing their minds about a diagnosis, Academic Medicine, 85(7):1112-1117). Physicians have great difficulty revising their original diagnoses. Clinically, this phenomenon leads to the overdiagnosis and treatment of bipolar illness. The initial diagnostic error creates increasingly complex treatment conundrums. For instance, the patient with a personality disorder misdiagnosed as bipolar will likely fail their initial pharmacological trial. Instead of revisiting the diagnosis, the inaccurate diagnostician subjects the patient to increasingly complex and dangerous combination therapies; soon the patient is on a mood stabilizer or two, an antipsychotic, and an antidepressant and an adjunctive antidepressant, with maybe a stimulant and a benzodiazepine for good measure.

Premature closure can be described as a form of diagnostic overconfidence. Physicians underappreciate the likelihood that their diagnoses are wrong, and this tendency has also been described as an important source of medical error (Berner, E. & Graber, M., 2008, Overconfidence as a cause of diagnostic error in medicine, The American Journal of Medicine, 121(5):2-23). This phenomenon may be more common than previously believed; one recent case-review study looked at the incidence of what is described as “suboptimal cognitive acts”, including errors of diagnosis, in a sample of 247 cases of patients who were treated for a chief complaint of dyspnea. In 13.8% of all cases reviewed, a diagnostic error was found to have occurred, and in 11.3% of all cases, the patient was harmed. The majority of these errors was due to the simple fact that the physicians were not even aware of their improper diagnoses, and had failed to revisit other options (Zwaan et al., 2012, Relating faults in diagnostic reasoning with diagnostic errors and patient harm, Academia Medicine, 87(2):149-156). If a significant percentage of dyspnea diagnoses may be incorrect - which have concrete lab and image findings to support suspected causes - it is not hard to believe that psychiatric diagnoses, which utilize significantly more subjective and self-report based information, might potentially be even less accurate.

A 2011 study found that, over the course of a five-year study, the average accuracy in correctly identifying five common psychiatric diagnoses upon initial consultation—depressive disorders, substance use disorders, delirium, anxiety disorders and psychotic disorders—was only 41.5% (Su et al., 2011, Change in accuracy of recognizing psychiatric disorders by non-psychiatric physicians: Five-year data from a psychiatric consultation-liaison service, Psychiatry and Clinical Neurosciences, 65(7):618-623). Therefore, it is clear to see the difficulty in correctly diagnosing psychiatric illnesses, and the critical importance of frequently revisiting and reassessing the initial diagnosis.

Facetiously, the authors propose a simple solution to the problem of the overdiagnosis of bipolar illness: Axis VI. In addition to the traditional five axes, the authors suggest an Axis VI, which would represent diagnostician’s estimate of the accuracy of their diagnosis, proposed on a scale of 1 to 100. A classic presentation of a patient with schizophrenia with a sufficient psychiatric history, delusions and auditory hallucinations, may be diagnosed with a certainty of 90%; the poor individual with sadness and temper outbursts might have a 30% reliable diagnosis of bipolar illness. Humility would be mandated and premature closure would be discouraged. When one notes a low certainty on Axis IV, one might be less inclined to add the fifth psychopharmacological agent.

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Most psychiatrists in community mental health settings are thought to function as medication management specialists with little interest in understanding patients and their problems in any significant depth. Even their diagnostic abilities are called into question if they do not slavishly follow the latest vogue in the general psychiatric literature or believe that the DSM IV is not an infallible collection of formulae. Our contention is community mental health psychiatrists cannot avoid engaging in depth-oriented interactions because of the nature of the clinical encounter. We can recall only a handful of patients who did not require more than a prescription embedded in a friendly, if superficial, chat.

Most patients meet us with magical expectations about medications, so successful have the advertising campaigns of the pharmaceutical companies been, armed with their seemingly infallible “gospel according to double blind controlled trials,” meta-analyses and so on. Patients subsequently discuss their medications with their non-psychiatric therapists and counselors who then make recommendations to the psychiatrist.

It is incumbent on these psychiatrists to develop the skills to provide what is not being sufficiently provided by others - a deeper exploration of emotional issues and conflicts, and self-deficits, given the time and other constraints in a community mental health center setting. Treatment with psychotropic medication presents opportune moments that can lead to this deeper therapeutic exploration and this can provide dividends later during times of crisis and decompensation.

The use of medication had once been considered undesirable in psychodynamic psychotherapy because of the concern that it would reinforce defenses against anxiety and emotional expression, and this argument may still be tenable in the case of healthier patients. Medication may strengthen avoidance of the healthy confrontation of problematic situations. However even many psychoanalysts today are treating sicker and more difficult patients, such as those with severe traumata and damaged selves, where the exploration of all but the most superficial matters may be difficult, if not impossible, without resort to medications and other self-strengthening measures (Donovan, S. J. & Roose, S. P., 1995. *Medication Use During Psychoanalysis: A Survey*. Journal of Clinical Psychiatry, 56, 177-178).

Psychoactive medications can be employed with two psychodynamic goals in mind: (1) to promote the exploration of problems, emotions, and the options for actions and confrontation of painful and challenging internal and external realities, and (2) to reinforce avoidance and passivity, and magical thinking, hoping for a degree of improved adjustment, if not contentment. Obviously, the latter alternative is not a healthy one in most situations, but must be accepted in the case of severely ill individuals, or in states of transient severe, psychotic-level regressions in reality testing and affectively volatile states, and so forth.

But how can one integrate the two modes of intervention to reinforce defenses to a certain extent with medication but not completely close off exploration? How can the two be titrated to have a mutually synergistic effect? When taking an SSRI, individuals have reported becoming less sensitive to environmental input with an increase in energy levels. The self can feel strong enough to confront inner and outer realities and can diminish its reliance on draining and enfeebling defenses (Novick, A. M., 2012, *Antidepressant Psychopharmacology and the Social Brain*. Psychiatry 74(1), p. 72-86 ). We believe that, with reduction in primitive levels of anxieties, states of disruption of the self, and decreased narcissistic vulnerability, ego function is fortified under the aegis of a stronger sense of self. The medication may be performing the function of a self object a la Kohut. However, excessive idealization breeds magical expectations that can lead to re-enactments of traumatic experiences and the turning of the ideal object into the persecutory or “bad” object. This can happen when an initial seemingly good response to medication fades, leading to frequent medication changes and recurrent disappointment.

An observation that we have frequently made over the years in our work with individuals suffering mainly from depression and anxiety in the context of structural disorders such as borderline personality is that the use of antidepressants can lead to irritability or increased awareness of anger that hitherto the patient either somatized, or introjected leading to refractory symptoms, or that were expressed in passive-aggressive or breakthrough aggressive actions. An example of the latter would be the severely traumatized patient who carries a great deal of hurt, resentment and aggression that, unable to be dealt with or expressed in a constructive manner, is experienced symptomatically or discharged though destructive behavior.

The following vignettes are presented to illustrate how one might proceed by seizing the opportunity that presents itself, for example when a patient reports a reaction to a medication or to a change in dosage. Details have been altered to ensure confidentiality.

**Case 1** Years ago, a man came to see one of us with the express purpose of getting us to agree to stop his lithium. His primary physician was reluctant to do this and made the referral. He was a wiry, asthenic, hyperthymic, self-assured character and he seemed to provide reliable information. He reported infrequent, minor and brief mood episodes that were years apart. He asserted that he would resume his lithium when he felt an episode approaching. At the same time, however, he conveyed the opposite state of mind, and gave us a sense of foreboding if we
were to support his decision. It seemed as if he had succeeded via projective identification in getting the doctor to experience his intense anxiety and to doubt the wisdom of following the course of action he was contemplating. The psychiatrist decided to obtain more data.

This man had recently moved to the area and reported no other major changes or ongoing conflicts in his life. Details regarding his last episode of illness threw some light on the role of the medication, not to mention that of his wife, in his self-regulation. He had been doing well off the lithium for more than a year. Then separation stress struck (Masterson, J. F. (2000). The Personality Disorders. Zeig, Tucker & Co., Inc., Phoenix, AZ). His wife had to be away for some months and he found himself increasingly immobilized with diffuse anxiety and he was unable to manage the most mundane tasks. In the midst of this affect storm, he was able to think about seeing his physician and getting back on his medication. Soon after starting the lithium he regained his sense of competence, did what needed to be done, and probably averted a full-blown episode.

The contact with his doctor probably played a significant role in forestalling further fragmentation. He did not find it difficult to acknowledge dependence on, and idealization of, the medication. Because of schizoid personality features, he had difficulty thinking about and tolerating the crucial part that others played in maintaining his psychic equilibrium. This equilibrium rests on, or has a reciprocal interaction with, the patient's neurophysiological substrate.

Case 2 The Screaming Bladder

In a community mental health setting, most patients seem to carry multiple traumatic scars, if not open wounds, exhibiting severely damaged self-structures. For these reasons, they often have a difficult time with the notion of communicating inner, particularly emotional, states. They are prone to be alexithymic and concrete, with an unsettling (to the psychiatrist) proclivity toward recitation of external difficulties and symptoms, embracing the idea of a chemical imbalance with a vengeance, in favor of any sense of an emotional imbalance or of agency. They seem to be phobic about thinking about inner states and the connections between these states and their external occurrences and symptoms. It is as though the whole business of thinking is located in the psychiatrist’s mind, the patient’s role reduced to that of producing a repetitious monologue of all her troubles and symptoms. The expectation seems to be that the psychiatrist will come up with a medication to “fix” “the problem.”

A woman in her 50’s was such a patient, entrapped in a prison of victimhood and passivity, with great expectations about psychiatric medications. It was not that she was not a genuine victim of childhood traumas and deprivations. However, potent blocking any possibility of change was her refusal to think about some capacity of ownership of her history and problems. So the cycle of endless recitation and repetition of symptoms and trials of antidepressants and other medications, with partial and transient effects, continued until a small breakthrough allowed her to begin to form a connection between her symptoms and her emotions.

During a sleep study, she had an episode of incontinence. It appeared that she had been feeling angry with the staff, for questioning her and hooking her up to the many instruments. She wanted to scream at them and leave. However, good sense prevailed and she stayed, but decided NOT TO SAY ANYTHING. Without much conscious thought, the psychiatrist told her that that she had let her body do the talking and that her bladder had screamed, hinting at the aggression. This made immense sense to her and, without prompting, she described other situations, where her emotions had been expressed via her “body doing the work” of self-expression. This helped the patient move into a more depressive position as she was able to begin to connect to her inner world and face the pain of thinking and feeling. It will be recalled that in the paranoid-schizoid position, the notions of agency and responsibility are disavowed and located in the external world.

Following this session, that can be described as a significant emotional experience (Sudberry, J., & Winstanley, I., 1998. Applying Psychodynamic Insights in Brief Psychodynamic Counseling 4.3, p.373), there was an appreciable deepening of the relationship and, in contrast to the lackadaisical response to psychotropics previously, there was a more sustained and meaningful response.

Case 3 A woman in her 50’s recently lost her husband, a loss that, like many previous losses, had remained unmourned. Chronically depressed with diffuse anxiety and a tendency to somatize, she had failed to respond appreciably to multiple medication regimens, including augmentation strategies.

In one clinic appointment, she reported a worsening of her distress level. With much encouragement and confrontation, and against much resistance, she reported that she had felt abandoned by her son who had sided with his wife rather than with her in some far-from-serious disagreement. She felt deeply wounded when her son had not given much thought about the impact of his behavior on her. She wanted him to live up to her unspoken expectations but had been unable to express these in words. She responded to the comment that her need for her son’s empathic responsiveness had been intensified due to her husband’s death with a degree of animation and brightness of demeanor which had not been previously observed. She also had an improved response to her medications.

Case 4 “Boxed in.” Do unto the doctor...

A patient with chronic schizophrenia in his 30’s was rebellious and argumentative and chronically non-adherent to his medication regimen. He had been to multiple psychiatrists before he made his way to our clinic door. He was difficult from the beginning as he refused to complete some routine symptom checklists. He responded to confrontation about this with resistance and dismissive comments. He finally confined that he experienced filling out a form as impingong on his autonomy and that complying with routine requirements was humiliating. He felt as if he “always” had to submit to others’ needs.

The psychiatrist told him that it seemed as though he wanted help, but he did not want to make it possible for the doctor to do his job by providing the necessary information to help him. He said with some liveliness and even interest “that’s exactly how I feel, boxed in.” The psychiatrist told him that he seemed to be doing to the doctor what others had done to him. He was able briefly to connect to his needy side and he became fearful, i.e., showing hints of depressive position functioning. However, this could not be tolerated for long and paranoid-schizoid functioning soon returned. Nevertheless, this brief interlude of healthy dependency allowed for a deeper understanding, a
more empathic response and continued treatment in the face of contumacious power struggles.

Case 5 A “selected fact” (Bion, W. R., 1963, Elements of Psychoanalysis. London Heinemann) immured in oblivion?

A woman in her 60’s came to the interview with her spouse. She had been chronically depressed since the 1980’s with only slight relief afforded by antidepressants and various augmentation regimens. She had lost her mother shortly before the onset of her depression - clearly an unmourned loss. When this was pointed out, along with the need for therapy to help her mourn, both the patient and her husband were relieved and surprised. It was astonishing to them that no one had previously made this connection and it made sense to them. It is of course possible that this had been brought up before, but that the patient had not been ready to accept it.

Lest it be thought that we believe that this kind of work, which has to be shoehorned into a brief psychiatric medication management session, is accepted by all our patients and without much difficulty, we add the following vignette.

Case 6 “Disability, not treatment”

A middle aged man, schizoid in his orientation, had always prided himself on being “the rock” in his family, the one who took care of everyone but who did not need anyone himself. He had been suffering from chronic depression and anxiety and he was reluctant to talk about his difficulties. He believed that he just needed a psychiatrist to validate his psychiatric disability. He wished this could have been arranged without his having to spend time with a psychiatrist in person and having to answer pointless questions that were an intrusion into his life. Apart from the irritation and resentment in his demeanor, he showed little affect. The needy, devalued and useless aspects of the self were deposited into the psychiatrist, but who needed a modicum of cooperation and receptivity to do his job. Some sadness and vulnerability became observable after the physician pointed out the contradiction in the way he presented his case: namely, as someone who is psychiatrically disabled and yet does not need a psychiatrist. After some rapport initially seemed to develop, this man did not return to the clinic. Perhaps he found treatment that would have included more than medication management too painful or even humiliating.

Discussion

At our community mental health center we seldom have the luxury of more than 15 to 25 minutes for medication management and whatever else we can do in this short time. With most patients, however, we find it impossible to avoid some therapeutic engagement; indeed, patients will often force it upon the psychiatrist. It is as if patients believe that some of their needs can only be addressed in a psychiatrist’s office, even when the patient has a non-M.D. therapist. We have the impression that these patients and their therapists frequently discuss medications, but when troubling symptoms or painful feelings emerge, they are given the suggestion that their medications need to be adjusted or changed. We believe that patients find it preferable to complain about medications not working than to discuss ambivalent feelings about their therapists and psychiatrists, or focusing on painful life situations. Or they may use the cover of the therapist to express their own misgivings about the psychiatrist.

We often hear patients devaluing therapy with the complaint that their “real” issues have yet to be brought out, that their therapist is too passive and inactive, and that the sessions consist of “just chatting” about things. Other patients staunchly refuse referral to a therapist; or if they do not openly refuse referral, sabotage the attempt by not showing up for their appointments. Or if they do show up, they say that they have nothing to talk about, or “I am only here because the doctor said I had to come,” etc.

There are many situations in which the psychiatrist has to provide as much of the psychotherapy as possible. We believe that it is possible to do so even within visits that are designed to be used for medication management only. The psychiatrist is in the unique position to interweave the psychotherapy with medication management. This can be done relatively effortlessly for certain conditions, such as agoraphobia, using the principles of exposure. However, for the more complex and more common conditions, the use of analytic concepts and ideas, such as countertransference, projective identification, enactments, Bion’s ideas regarding containment, the coexistence of the psychotic and non-psychotic parts of the self, can be more broadly applied and are useful and gratifying because of their deepening effect on the work. In addition, applying these ideas to patients’ expectations of, and reactions to, various drugs, as well as to the effects of medications not only on neurochemicals, but also on people’s habitual defenses, affects and vulnerabilities, may open up avenues of helping patients integrate their compartmentalized lives and their splits between their psyche and their soma.

We hope to further develop and expand these ideas about the applicability of psychoanalytic notions in the day-to-day work by clinic psychiatrists on a more conscious and planned basis with the goal of achieving, not an ideal but a “good enough” blend between medication and psychotherapy (Nakajima, S., 2012. Seishinryoho to Yakubutsuryoho no hodoyoi Blend. Nakayama Shoten, Tokyo, Japan).

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Supervision of Psychotherapy: East and West
by Leah Davidson, MD


In the area of transcultural psychiatry and psychoanalysis, learning to understand the application of our therapeutic skills in cultural contexts other than our own is currently bringing us closer to what Harry Stack Sullivan termed “a psychiatry of peoples” (Sullivan, 1953, p. 367). These new applications necessarily involve an increase in the frequency of contacts with therapists from other countries both here and abroad, by those of us involved in the teaching and supervision of psychotherapy and psychoanalysis.

This trend has always been present. Many analysts who themselves originally came from Europe in the initial phase of American psychoanalytic history returned to lecture or teach elsewhere and to develop knowledge of skills not available locally. Erich Fromm’s last years, for example, were spent both in Mexico and Switzerland, where he was active as analyst, supervisor, and teacher.

In the United States, the influx of foreign psychiatric residents in the 1960s sharpened the focus on the interchange of psychodynamic and psychoanalytic knowledge between Eastern, mostly Asiatic, students and American supervisors (Chen, 1981).

Major cognitive cultural differences in approaches to mental illness and human development became apparent to supervisors and residents at this time. At first, these seemed insurmountable. Unfamiliarity with these differences or failure to take them into consideration in favor of a standard teaching approach (e.g., over investment in one particular theoretical position) often led in such contexts to stalemates in the transmission of knowledge, with disappointments on both sides. Eager expectations were then abandoned, and often the patients were the greatest sufferers, since their therapists then turned to somatic therapies with minimal or no psychotherapeutic care. In this position, they were also supported by the return to the “medical model” in the middle 1970s on the part of the American psychiatric establishment. (Davidson, 1982).

Despite these difficulties, however, the trend towards foreign students learning psychoanalysis survives and remains a strong one. Many psychoanalytic candidates at analytic schools in New York and other parts of the United States are now Hispanic. Some are black, and recently quite a few have been Indian, Filipino, Japanese, Chinese, or Korean.

In this paper, I would like to consider some of the cross-cultural and transcultural difficulties in teaching and learning as they manifested themselves during a three-week stay in Osaka and Hiroshima, Japan, in the summer of 1980. The presenters were the advanced students and teaching staff of two groups, both medical doctors and psychologists. We met daily for presentations and workshops of about 10 hours’ duration. There were written histories of presented material both in English and in Japanese, and simultaneous translation was available.

Our first difficulty was at once apparent. In the West, argument presentation and exposition follow a formal, logical, one-point-at-a-time pattern leading to a conclusion. In the East many facts are set out laterally for an authority to choose the correct combination of factors. I believe all human beings think this way, both “laterally” and “vertically,” but differ culturally as to the predominant mode. The factors determining this predominance are highly complex and have to do with social mores and obligations. Since I was a “sansei,” i.e., a Zen-like teacher of whom I was being treated accordingly. This position of sansei also became apparent in the deference accorded me at social occasions. It was difficult to cut through this to reach the informality my mind required in order to be comfortable enough to evoke what I had come to impart. I managed this only because I was living with a Japanese friend of many years, who guided me subtly into transitional states of mind, bridging my cultural personality diffusion.

In the East, there is an emphasis upon what has been called an egoless state. People are seen as interdependent, and as defined by their actions toward and with others. They are transcendental, restrained, sublimatory, and impulsive in their feelings. Character and personality are not stressed as concepts. Lateral thinking is the norm, and vertical thinking is used only privately as an expression of autonomy (De Bono, 1979).

Cognition in the West and East is vastly different in its aesthetic discrimination. Lafcadio Hearn has written on Western and Japanese symbolism as follows: “An ideograph does not make upon the Japanese brain any impression similar to that created in the Occidental brain by a letter or a combination of letters - dull, inanimate symbols of vocal sounds. To the Japanese an ideograph is a vivid picture: it lives, it speaks; it gesticulates. And the whole space of a Japanese street is full of such living character-figures that cry out of eyes, words that smile or grimace like faces.” (1971, p. 401)

From the minute one lands in Tokyo or Osaka, one has this feeling of familiarity, or recognition, and then one of immediate unfamiliarity; this feeling of both the logical simplicity and the complexity of a culture is reflected also in the many words for the same feeling (e.g., love). The sensitivity of Japanese aesthetics and the Japanese way of life stretches one’s own imagination beyond the usual cultural limits of one’s norm.

Living “Japanese” style for a Westerner is a constant rearrangement of posture and gesture. As a Westerner, I felt like an elephant in a teashop all the time. People were gentle, thoughtful, and playful with me but also politely directive as with a newly enculturated child. I got a good idea from this of what it might be like to grow up Japanese.
How different from my own techniques of introducing students from Japan to American culture! I was harsh, “pushy,” “judgmental,” and “overassertive” by comparison. I remembered the students talking about the size of my rooms and taking photographs of my home to send back to Japan.

Now I was here with two tiny bags living cozily in a postage-stamp-sized bedroom and apartment, adjusting the other way. I began to realize that cross-cultural transition is indeed an emotional and physical “Gulliver’s Travels,” and to appreciate from inside exactly what it was that all my supervisees had to struggle with in America.

Japan is currently undergoing a period of cultural transition. This transition was certainly reflected in all of the case material presented to me at two different centers in Japan. Of a total of approximately five case presentations of long-term work, three of the patients presented were male and two female. The following two clinical vignettes, especially the dream material, illustrate some of the common identity and individuation problems in Japanese patients at the present time.

The first patient presented to me was a 35-year-old businessman who had developed an ulcer in the context of angry feelings toward an autocratic boss. The therapist was a man of the same age who was himself very traditional. He presented the patient to me defensively, saying, “This patient left after six months and you will say he needed more treatment, but I do not think so because patients in Japan are like this and different from American patients.”

Here is the dream of the patient given to the therapist in their last session: “I go into a subway toilet. It is so full of feces that there is no room for me to deposit my urine. I leave frustrated.” I suggested that the patient left because he felt unable to burden the therapist with his aggressive and envious feelings towards authorities. In addition, he felt that the therapist (symbolized as an underground toilet) already had received all his other patients’ destructive feelings (the feces). My interpretation of this dream helped the therapist change his mind about the need for further therapy.

He also agreed that he himself had a need to become more flexible and that this might facilitate the education of patients so that they agree to stay in longer-term treatment. Perhaps the problem of differentiation of aggression from assertion is one for consideration throughout the Orient, especially since a fear of expressing aggression toward the therapist seems to play a major role in the discontinuation of treatment at six months.

If assertion were seen as separate from aggression, which at present it often is not in Japan, then it might become a culturally sanctioned mode, which aggression currently is not. It seems to me that this differentiation might be a key one in helping patients to tolerate long-term treatment in the Orient.

Actually, the handling of aggression by therapists in America is based on this differentiation in a similar manner (a point my Japanese students did not fully understand), and the goal of therapy is frequently to enhance assertion while allowing the verbal expression of anger in order to diffuse it. I am suggesting that self-assertion with an Oriental therapist might be more comfortable for patient and therapist than overt discussions of anger or confrontations about it. Statements such as “I think, I feel,” and so on, if accepted, can help bridge the delicate road to expressing angry feelings, eventually.

In the second example, patient and therapist had been working together for two years at the time of the dream. The patient was a 22-year-old student who had been suffering from anorexia nervosa since the age of 18. This symptom was in remission at the time of the dream. The therapist was a gifted and flexible young female psychiatrist whom the patient had at this time been using very well as a role model. Both patient and therapist were making good adjustments in the cross-cultural transition going on in Japan.

The dream was as follows: “I am making dinner for my friends. I put on the table all the things I like: hamburgers, potato chips, ice cream, etc. Then I notice in the middle of the table a beautiful traditional rice bowl (association— you know that I do not like to eat rice with my family). It is all right with me because I realize that you can help yourself to as much or as little of the rice as you wish. I am very happy with the table, but then all of a sudden my father appears and I feel that’s too bad; now everything is spoiled.”

This dream seems to me to speak for every young patient in Japan. The rice bowl from which one can take what one wishes symbolizes the strong roots of the culture and the democratic modification. The American food is obviously the acceptance of modern ways and assimilation of new patterns. Both sorts of food represent the patient, her therapist, and her friends - the group who live and think as she does. The traditional father, as in the case of the male patient previously mentioned, is the problem. In this case, the family was extremely old-fashioned, beyond the usual modern Japanese limits, and felt ashamed of her need to be in psychotherapy.

The second dream also symbolizes for me some of the same struggles between the two cultures as are manifested by Japanese students working in clinics in America. As an illustration: one supervisee had established a good rapport with his assigned male Jewish patient, despite initial hesitation on the part of the patient because the therapist was Japanese. At this point, the patient expressed a wish to increase the number of sessions per week. The supervisee, in true Japanese fashion, responded with “I will have to ask the clinic.” At the next session, the patient once again expressed his desire for an American therapist because he felt uncomfortable with a Japanese doctor. Here, what had created the problem was the therapist’s anxiety about his formal arrangements. This had prevented him from hearing the positive transference aspects of the patient’s suggestion. Japanese female supervisees who come to the United States, on the other hand, felt very uncomfortable with American male patients and the patient’s overtly expressed eroticism towards the therapist. They tended to avoid such male patients, preferring to work with females and children.

In all supervisees, there was a problem with using the supervisor as a role model in an imitative rather than an integrated way. As a long-term supervisor, I had to be careful to make sure that the understanding was indeed dynamic and not just superficially correct.

Female supervisees also expressed a fear that they would
become too American because of their involvement with American patients and supervisors. They feared problems on reentry into Japan, where they might be regarded as too aggressive on their return. This fear showed up in supervision as reluctance to be too firm in setting limits or as a fear of interpretation or suggestion to the patient where necessary.

Some feelings are not experienced by Orientals as appropriate or ego-syntonic, in the same way as in the West. There is a vast difference in the social contexts in which feelings of guilt, shame, anger, or sexuality may be discussed in our two hemispheres.

Helping a supervisee keep his or her cultural identity while undergoing a “westernizing identity diffusion” is thus best done through the stressing of transcultural human similarities with examples from both cultures. At best, the supervisor is also someone who knows the differences between what is specific in a culture and important to pinpoint and what is universal. To give a simplistic example, a smile in Japan is often a sign of deference and politeness, while in America a smile is usually a sign of friendliness.

Do patients benefit or lose out because of cross-cultural influences?

The cross-cultural match produces less passivity on both sides because both parties have to work harder for understanding. This in itself is therapeutic, because it leads to the profound understanding that we are one another’s resources, no matter how different. In Sullivan’s “one genus postulate” terms, “we are all more simply human than otherwise” (Roland, 1983).

In the Orient, the primary symptoms seem to be depression in women and an increase in the prevalence of ulcers and heart attacks in men. These have been directly attributed to cultural transitional changes and “westernization.” Helping patients become more autonomous, effective people within the context of their culture is especially important in transitional periods. The therapist can thus be a useful person in meeting the stresses and challenges of history. When changing traditional identities can be understood and accepted as compatible with one’s roots, and when new desires to grow and change are actualized, free of guilt toward one’s family, health and happiness can improve.

On the negative side, we have a real danger that an avant-garde therapist may, in his or her zeal try to educate the patient out of the culture so that the patient becomes too “autonomous” and cannot adjust at all. This may lead to permanent emigration or cultural dislocation.

Misapplication of theories in a formal, shallow manner can also create negative transference, non-communication, and dropping out of treatment. The patient may sometimes also be too traditionalist to give up folk healing, for example, or other traditional approaches. If the therapist is unable or unwilling to work this way (i.e., to enter the patient’s system and allow this for a time), he or she may lose the patient for good and may blame the “foreign approaches” for the failure.

It has often been stated that travel broadens the mind. It is certainly true that psychoanalytic conservatism has been considerably shaken and challenged in its basic assumptions by confrontations with cultural differences, inexplicable by any other means than cross-cultural interpersonal processes. We owe a debt of gratitude to those of our colleagues from non-English-speaking cultures who came to our shores to interact with us and, in turn, invite us to come to their countries and work with them. As a result, all of us, and our patients, have become enriched in every aspect of our personal and working lives.

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**Freud and His Dogs — Love, Separation, Loss and Healing**

*by Ronald Turco, MD, AAPDP Past President*

Latin proverb: “One loyal friend is worth ten thousand relatives.”

Our relationships, animal and human, are the essence of life and the embodiment of our connection with the mystery of life, creation and love. There are a few, hopefully very few, cardboard people who coast through life devoid of what Freud called the ability to “form a lasting bond.” *Bark* is a magazine for dog people – those under the influence of canine charms and mysteries. The Spring 2002 issue published an article “Freud Sang to His Dogs.” The article is historically accurate, and although Freud did not exactly sing to his dogs, he did hum to his Chow Jo-fi. Most psychoanalysts know about Freud’s experiences and love for Chows as Freud viewed dogs generally “…as providing the beauty of an existence complete in itself”…and that dogs are absent of ambivalence. As Freud noted: “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.” (2002, *Bark*, Grezemovsky, U., *Freud Sang to His Dogs*) (1916, Freud S., S.E. Vol. XIV).

A decade before the Freud family acquired its first dog, one finds in a paper on technique: “Observations on Transference-Love: Further Recommendations on The Technique of Psychoanalysis” (1915, S.E.) a remarkable canine analogy adapted by Freud. Thus his dogs circulated both textually and extratextually. Freud was already predisposed toward dogs before he acquired his first Chow. In reference to Freud’s patient, the “Wolf Man,” one might say: “where wolves were, dogs shall be.”

Anyone familiar with the biographical details of Sigmund Freud’s life would acknowledge that he was a dog lover - the
stuff of psychoanalytic legend. This was likely a sublimation of his very great fondness for young children which could no longer be gratified in his advanced age. Freud’s dogs circulated in the daily life of the household and it would be a mistake to separate the affectionate attention given to these animals in the emotional life of the family from Freud’s analytic practice and theoretical work.

There are many references to his dogs and to other dogs in his letters, diary and theoretical texts. Anna Freud procured an Alsatian dog, Wolf, to accompany her on walks through the forest of the Semmering and, as a result, Freud took an interest in observing canine ways, eventually developing strong emotional attachments to Chow Chow dogs. Wolf bit Ernest Jones and Freud explained he had to punish her for that, but reluctantly, “for he, Jones, deserved it” and there is no ambivalence in a dog’s object relations. Wolf spent ten years with the family and Freud referred to him as the “old gentleman,” thus the presence of an Alsatian, a breed which makes an ideal police dog, in a household identified as Jewish. Some authors note that the dog was acquired to protect Anna - one of the many visible vehicles of the persecution of Jewish citizens in Austria and elsewhere. Freud also noted that Wolf had almost replaced the lost Heinerle, his grandson, son of his daughter Sophie, who died in 1923 at four years old. Wolf lived with the Freud family longer than any of their succession of dogs and was a longtime companion with whom Freud could momentarily retreat from the complexities of adulthood. Wolf solaced Freud and he could spoil him since the dog was a grandchild of sorts whom he would not discipline in the manner of a parent.

Aside from Marie Bonaparte’s dog, Topsy, there were three Chows in Freud’s life. (Chows developed in Mongolia about 4000 years ago and were later introduced into China where they were referred to as “puffy-lion dogs.”) Dorothy Burlingham, who was becoming intimate with the family, presented Freud with his first Chow, Lun Yu (or Lun Yug). Freud was 70 years old at the time. After fifteen months, the dog broke loose in the railway station at Salzburg and after three days was found run over on the railroad track. (1929) Freud remarked that the pain he felt resembled that experienced after the loss of a child (recall Heinerle).

It took Freud seven months to deal with this grief until Lun Yu was replaced by Jo-fi who was Freud’s constant favorite and inseparable companion for seven years and attended all of his therapy sessions. Some authors noted that Jo-fi means beauty in Hebrew - thus a Jewish dog. Jo-fi was nonjudgmental. Freud found that children in particular were more willing to open up to painful experiences when Jo-fi was present. This was a clear example of pet-assisted therapy and there is evidence that Freud encouraged the use of dogs in a variety of therapeutic situations. Thus he may also have been the father of “Animal-Assisted Therapy.”

What Freud regarded as Jo-fi’s effect on patients benefited him personally. He believed that dogs possess the qualities that humans often lack. They express their feelings directly, are incapable of deception and remain loyal. He developed what he regarded as a “lasting bond” with his dogs. Freud noted that this quality was absent in some human beings, notably Ranier Rilke (1916, Freud, S., “On Transcience” S.E. Vol. XIV), (1975, Roazin, “Freud and his Followers.” New York).

Frequent references to Jo-fi appear in his diary, letters and family memorabilia, as Jo-fi was with the family from March 1930 to January 1937.

Myron Glucksman, in his paper, The Dog’s Role in the Analyst’s Consulting Room, notes that his dog, Joe, provided him with a companion that was available for self-soothing and narcissistic reinforcement. He writes: “The work of therapy can be demanding, frustrating, and emotionally depleting. Joe’s usefulness in the therapeutic process outweighs his liabilities” (2005 Glucksman, M., The Am. J. of Psychoanalysis and Dynamic Psychiatry).

When visiting Berlin and Jo-fi was in the kennel, Freud mournfully wrote his wife: “Is anyone visiting Jo-fi? I miss her a great deal.” Jo-fi was said to be able to sense the end of an analytic hour by seconds and to judge the progress of an analysis and the character of the analysand sometimes to their dismay. Contrary to rumor, Jo-fi did not actually do the therapeutic analysis or write up the case reports. The dog’s presence acted as a calming influence on patients. The steady canine presence in the face of what a human might experience as painful or embarrassing material provided containment and a safe place of reassurance. Perhaps more importantly, Jo-fi was able to comfort Freud as he underwent a painful series of operations on his mouth. The first signs of oral cancer were detected in 1923. He wrote Marie Bonaparte: “I wish you could have seen with me what sympathy Jo-fi shows me during these hellish days, as if she understood everything.” On Freud’s birthday, Anna Freud would tie a poem around Jo-fi’s neck, slap her flank and have her bring it in.

Glucksman elaborates on the therapeutic role of dogs in the consulting room: the psychodynamic role with regard to the therapeutic alliance, promoting feelings of security and safety and allowing patients to communicate disturbed feelings and fantasies rather than directly to the therapist.

Freud’s relationship with the psychoanalyst Marie Bonaparte overlapped on the basis of Jo-fi’s puppies named Tatoun after the Bonaparte’s dog Tatoun. Tatoun gave birth to Teauri or Topsi, the subject of Marie Bonaparte’s book. Marie Bonaparte had written “Topsy: The Story of a Golden-Haired Chow,” illustrated by photographs taken by her daughter between March 1935 and June 1936, a book that Freud and Anna were translating from French to German and completed in 1938. Her Chow, Topsy, had developed a lymphosarcoma on the right side of her oral cavity and Marie Bonaparte bypassed the veterinarians and sought help from a private physician at the Curie Institute. Thus, Topsy was the first dog to receive experimental radiation therapy that was eventually curative.

Freud was convalescing from his own painful therapy that included some of the same treatments Topsy had received. The parallels between Freud’s illness and the dog’s are striking. Freud loved the book as both he and Topsi were afflicted with tumors on the right
sides of their mouths. “In Topsy Freud could look from a distance at his own failing life, free of the angst involved in contemplating his own mortality.” Travelling along with Topsy through this ailment provided Freud with a vehicle by which to explore his own fears and mortality. “Topsy lives in a world free of human concerns about the past and the future enjoying life and not burdened by the fear of death - she has no intimation of when time will cease to be.” In a short passage near the end of Topsy, the princess writes and Freud translated: “That is why Topsy, whose happiness is confined to narrow limits each day, is wiser than I; she who simply inhales the scented June air whilst I strive laboriously to trace vain signs on this paper” (1940, Bonaparte, M.).

Bonaparte cogently compares the human sense of the finitude of life with that of Topsy, her dog, and the core of our existential dilemma. This very serious book deals with separation, loss and death. She reflects on her own mortality and the seasonal blooming and buzzing confusion of life in contrast to the inevitability of Topsy’s death, regardless of the effects of treatment, as she contemplates her own mortality acknowledging that she too will perish in time: “My hair is growing gray,” the painful prospect of aging and dying perhaps from cancer. She will, however spare Topsy the “burial mania” that effects humans and arrange a burial to which she, herself, is not entitled, free of the “terrible customs” of the vault, sarcophagus, preparation of the corpse etc. – thus, not exiled in death from the garden in which Topsy roamed about.

At the end of the book, Bonaparte is able to take credit for having saved her pet, working through her fear that her canine interests may be turned against her as evidence of frivolity in a time of international crisis. What is unsolvable, however, is Topsy’s impossible task of barring death from Bonaparte’s (and our) room. Topsy is not just a story of a golden-haired chow, but a psychoanalytic tale from which the lives and works of Freud and Bonaparte, herself an excellent psychoanalyst, unravel and the ligature of caninity which bound them together is laid bare.

Freud worked on the translation during the Nazi invasion of Austria (March 1938), the climate of fear, and Freud without any analysands, house-bound (ultimately under house arrest), lonely, ill and uncertain about his family’s future. This translation, according to Anna Freud, repaid Freud’s own dogs for their years of companionship. Freud was able to distract himself from the strain of events around him as well. Nor did he overlook the parallels between his illness, that of Topsy and Bonaparte’s father. This discourse transcends anecdotal status and opens questions of technical, ethical, theoretical and emotional concerns.

Both Topsy and Freud suffered from tumors on the right side of the oral cavity which made chewing difficult, and both were treated with palliative surgery, Roentgen rays and radium. Bonaparte was haunted by the memory of her father who died of metastatic cancer, and her daughter who suffered from a tubercular cyst in her right thigh necessitating x-ray treatments. Topsy was both a charm against illness and a sign of it. Topsy won her battle against cancer, with this focus giving Freud the wish that he might yet recover and, at the very least, giving Freud and the Bonaparte’s the ability to acknowledge the nature of their suffering and yet keep some distance.

Freud wrote to Bonaparte stating: “I love it; it is so moving and real and true…it really gives the real reasons for the remarkable fact that one can love an animal like Topsy (or my Jo-fi) so deeply: affection without any ambivalence, the simplicity of life free from the conflicts of civilization that are so hard to endure, the beauty of an existence complete in itself…a feeling of close relationship, of undeniably belonging together. Often when I stroke Jo-fi I find myself humming a melody which…I can recognize as the (Octavio) aria from Don Juan: A bond of friendship binds us both, etc.” Freud then discusses the wish for rest from the suffering, at age 80 ½, further life would bring on (S.E., Vol. 3, p. 509).

On January 11, 1937, Freud suffered the loss of Jo-fi following surgery for ovarian cysts. To novelist Arnold Zweig, he expressed intense sorrow: “Apart from any mourning, it is very unreal, and one wonders when one will get used to it. But, of course, one cannot easily get over seven years of intimacy” (2002, Green. S. “The Guardian: Freud’s Dream Companions”). Freud felt he could not get on without a dog and took back from Dorothy Burlingham another Chow called Lun which he had to transfer to her years before because of Jo-fi’s jealousy. Lun helped assuage Freud’s pain over the loss of Jofi, who, according to Freud, was more tender than Jo-fi.

After noting “I can heartily recommend the Gestapo to anyone,” Freud left for Paris, and then London, all with the help of Marie Bonaparte’s financial assistance of 31,000 Reichmarks ($500,000.00) and that of the substantial influence of Ambassador William Bullitt. Freud was terminally ill with cancer by this time. Lun had to be quarantined for six months because of the strict British regulations against rabies. Although quite ill, Freud visited her four days after his arrival in London and on several other occasions in what he called the “animal asylum,” until they were re-united. During his visits he played with her and talked with her using all sorts of little terms to Freud, was more tender than Jo-fi.

Eventually, the unpleasant odor from Feud’s wound resulted in his Chow, Lun, shrinking and cowering into the far corner of the room, a heartrendering experience, as biographer Ernest Jones has noted. She was put off by the stench - the odor of death. This revealed to Freud the state he was in, getting very weak, gazing at the flowers in the garden and reading Balzac’s La Peau de Chagrin. He commented wryly: “That is just the book for me. It deals with starvation.”

On September 21, 1939, Freud the realist to the end, asked Dr. Shur to end the torture that no longer had any sense and, on September 23, 1939, he died and was cremated. Marie Bonaparte provided the Grecian urn for his ashes.

My experience with equestrian-assisted therapy involves post-combat veterans suffering from PTSD, as well as children with a variety of emotional as well as physical difficulties. The movement of the animal, in this case a horse, facilitates a redistribution of muscular energy and promotes a sense of mastery and accomplishment. This has also been my experience with blind children who may otherwise see themselves as having little direct influence or control over their surroundings.
communication. (2005, Roth. B. Psychoanalytic Review). Pets apprehend and respond to gesture, verbal emotional tone, expressions of emotion, and sense the presence of separation, death and loss.” This is consistent with my definition of horseback riding which is the kinesthetic communication between human and horse. Roth noted that Freud’s acquisition of Chows was consistent with his need for companionship. A compensatory emotionally resonating relationship with an animal may offer an alternative to depressive reactions. An animal-child nonverbal dialogue supplying a warming relationship with a pet may refuel a basic wish for object contact and supply the basic characteristics of a transitional object.

Consultation room therapy is not the only way animals are therapeutic. In his book, Until Tuesday (2011, Montalvan, L.C., Until Tuesday, Hyperion, N.Y.) Luis Carlos Montalvan describes his deteriorating life following two tours of duty in Iraq and his subsequent alienation from others. That is, until Tuesday when a service dog entered his life. “It has been a long road, filled mostly with downs, from there to Tuesday. The truth is I was lucky. I was lucky to find Tuesday…..” His book is a poignant exposition of the role of animals in the healing process and the importance of animals in human survival when suffering from Post Traumatic Stress Syndrome. His story is told in a sensitive and emotional fashion without embellishment and clichés. This book is a paradigm of those soldiers returning home with PTSD. War, violence and proximity to sudden death inflict psychological wounds that need to be addressed. He eventually completed two Masters Degrees from Columbia University.

A different venue for consideration of the role of animals is provided by Tom Devincenis (Dr. Tom) whose book, “Tails of the City - Confessions of a Manhattan Pet Vet”, highlights the psychodynamics of pet ownership without labels. Stories in this book describe, in heartwarming fashion, an Italian couple in New York who were able to substitute their desire for children by adopting homeless dogs and cats, and a family of children who were able to learn about death and closure, and the humanity of a homeless man in need of understanding and succor.

Much of what we deal with in therapy involves our own self-loathing, projections, denials and magical thinking. Messages from childhood dented our self-esteem, messages that are projected on to others to spare ourselves psychic pain. It is less threatening to project negative and scary thoughts and feelings on to animals as well as to utilize them for succor and affection. Dogs in particular touch our basic instinct by letting us focus on to animals as well as to utilize them for succor and affection.

BOOK AND FILM REVIEWS

**Catch Them Before They Fall: The Psychoanalysis of Breakdown**

by Christopher Bollas


Reviewed by Marianne Horney Eckardt, M.D.

This fascinating book has this urgent message: Be prepared to fully meet the special needs of the occasional patient who has an acute breakdown while in psychoanalytic or psychotherapeutic therapy. The challenge is great. The breakdown can be turned into a breakthrough of great therapeutic benefit, but if not met, it has the potential of diminishing the functioning of the patient for life.

The therapist must make himself available. Christopher Bollas offers longer and more frequent sessions or, if necessary, all-day-long sessions for as long as three days. Availability means just that. In the past, Bollas has cancelled other scheduled patients. He cancelled a last-minute professional trip to Austin Riggs. He flew to Seattle to rescue one of his patients there. His writing is direct, appealing, lucid, and informs in great detail. Three case histories are not just illustrative, but are a means to convey his thoughts about why he is doing what and about treatment in general. These contemplations are also presented in additional chapters, which are concerned with the topics of meaning and context in histories, the importance of time, emotional experience, and psychic change.

The last chapter, “Questions,” represents an interview conducted by Sacha Bollas of Christopher Bollas, posing questions that are frequently asked about this radical approach. The appeal of the book emanates as much from these comments and contemplations as from his dramatic challenge to catch the patients before they fall. His aim in writing the book is modest. He hopes it might serve as a meeting place for other therapists who have worked with extended sessions in time of crisis.

Bollas is a psychoanalyst practicing in London. He worked for a time as Director of Education at Austin Riggs and has lectured widely in the United States and Europe. He writes with a passion of conviction about the value of psychoanalysis that is not encountered often these days, and conveys the logic of its premises as he sees them. He considers himself to be a classical psychoanalyst, but, obviously he has the flexibility of adjusting the treatment to meet the individual patient’s needs.

In the first chapter he writes about becoming aware of a certain group of patients whom he characterizes as “broken selves.” Though differing in many ways, they have in common a history of a breakdown, mostly in early adulthood, which was not given adequate care. They fail to respond to therapy, as they live a resigned life with new assumptions, such as: It is best not to seek help; best to choke off all feelings; best to seek a safe fallback position; and best to give up on all ambitions, hopes and desires. They function way below their capacities. They do, however, have a hidden ideal self with unrealistic dreams of success, a sort of ghost of past potentials. They cling to analysis, in spite of no progress, as a kind of insurance policy against future trauma. Bollas pondered whether some of his patients had become “broken selves” due to breakdowns while
in therapy with him. Several of his patients came to mind and suggested to him that he may have failed to give adequate help to these patients.

The second chapter is devoted to describing early signs of breakdowns, signs that could alert the therapist and allow him to catch the patient before he or she falls. A breakdown may be triggered by an obvious event or by a seemingly minor occurrence. The patient’s appearance, mood, behavior, ways of talking, or of responding may change. The therapist’s unconscious will pick up the cues and sense something is occurring, but not what. A classically trained analyst is told not to intrude himself by asking questions. But under these circumstances it is very important that the analyst inquire to find precipitating events. Information gathering becomes essential. Once the triggering event has been pointed to, then the patient needs time to discover its past meaning. Bollas writes, “time is the crucial variant in how well one can help a patient on the verge of a breakdown” (p.25). The event will have touched upon past mental pain, which the patient cannot process, and thus causes dysfunctions and panic. Bollas details symptomatic manifestations and defenses.

Before describing in detail his work with these patients, Bollas tells us, in a chapter called, “Guidelines,” how he provides an adequate framework of time and safety to make treatment possible. To create a holding environment, Bollas has the back up of a team: a social worker; a psychiatrist who, if necessary, can hospitalize and give medication; a friend or relative who is to stay with the patient overnight. Bollas has a minicab pick up and return the patient back home for the sessions. He assures the patient that following standard practice, he will not charge for the extra sessions. He does not want to add financial worries to the patient’s distress.

How to estimate how much clinical time will have to be set aside is a crucial issue. It is safer to over- rather than underestimate, as providing adequate care is so essential. Bollas tends to provide additional sessions over a period of time when dealing with a gradual breakdown, while, if confronted with an acute dysfunction, he will recommend all-day sessions. Bollas writes, “I do not know how to convey the deep significance of this human-to-human commitment. Over and above the contract, the analysand understands that a human being is committing themself to seeing them through the worst of what is to come” (p.37). Bollas is very precise in telling the patient what to expect. An all-day session will be from 9:00 a.m. to 6:00 p.m., with an hour break for lunch. This precision establishes the patient’s trust in the new procedure.

The three case histories are the central feature of the book. Emilie was an early patient, a partial failure that made Bollas aware that his cautious adherence to conventional rules of treatment had led to inadequate help in a period of great disorienting crisis. This insight led to his determination to establish an effective care system, should a similar situation arise. The case histories of Anna and Mark totally convince that the effectiveness of their treatment was due to the availability of therapeutic time. The main therapeutic events are presented as vivid dialogues. We feel as if we were witnessing the event.

Valuable reflections enrich each page and especially the final chapters of the book dealing with general issues of psychotherapy. I will mention only one. Bollas frequently mentions the importance of clear interpretations, but interpretation can mean many things. On other pages he mentions that the analyst should be guided principally by the inherent logic of the analysand’s free associations and transference images. I assume this is true for his interpretations. He also comments that a patient in crisis can only take so much interpretation. The analyst’s remarks may touch on something known yet not thought. It is important for the analyst to disappear as an interpretive presence to let the patient drift on his own path. He needs whatever time he needs.

This little book is a treasure. I highly recommend it. It radiates with Bollas’ love and concern for his work, a love that he conveys by an exceptional clarity of thought and precision of logic.

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As Sonu Shamdasani, the leading Jung historian of our generation, says in his introduction to this captivating volume (the first of two that will constitute the authorized biography of James Hillman, who died in 2011 at the age of eighty-five), Hillman is the Jungian whose originality lies in the degree to which he “took on Jung’s daimonic inheritance” (p. xi). By this, the scholar means that Hillman, perhaps more than any other of Jung’s followers, made it his business to take aboard Jung’s seminal insight that the psyche is fundamentally informed by archetypal powers that cannot be reduced to personal history. Hillman might have said that this is because we are lived by them far more than we gain insight into them, for the psyche is not in us; rather we are in psyche.

Dwelling in psyche meant for Hillman, as it had for Jung, being in soul: it is the soul that enables the archetypes to find a place in consciousness - not the ego, as a more Freudian view would have it. Hillman radically restituted the locus of consciousness in psyche, which made necessary a whole new school of depth psychology, archetypal psychology. He challenged developmental models in both psychoanalysis and analytical psychology that privileged the individuation of the ego. Instead of insisting as nearly every other depth psychologist of his generation was doing, that consciousness is a consequence of ego development, Hillman took the position that whatever the psyche knows has to emerge from its existential acceptance of what it means to be a soul.

How Hillman became the psychologist most skillfully to argue this position, after Jung himself shortly before his death in 1961 had decided that he had failed in his “foremost task,” that was to convince his contemporaries that the human being had a soul (Rolfe, Eugene, 1989, Encounter with Jung, p. 158. Boston: Sigo Press), is the story recorded in this account of Hillman’s formative years. The biographer, Dick Russell, has a background in sports and political writing, and that shows in the subtitle he has chosen for this first half of The Life and Ideas of James Hillman: The Making of a Psychologist. This comes across, as Russell tells it, like the making of a prizefighter or a
to Zurich. One was a visit to Indian Kashmir in search of a spiritual vision. There in the high mountains he had a dream that humiliated him so much that even fifty years later it was hard for Hillman to share it with Russell. The dream was simply an image of his mother and grandmother lying in bunk beds. Here I have to interpret a bit, but as I read what Hillman immediately saw in the dream, it couldn’t have been clearer that he hadn’t really gotten beyond the concrete, acquisitive, sensation-seeking attitude toward life of his mother and her mother complex and into something he could call his own.

The other major event, which actually came earlier, was his decision to marry his best girlfriend from Paris, the Swedih Kate, only to notice on his wedding night that his face in the mirror had a demonic underface. Not only was he not over his original family, his own soul was unreliable, maybe too divided to be entrusted with a woman that, unlike his mother, could truly help him make a life. Not long after, with both husband and wife suffering from depresions with what they worried might have psychotic features, Hillman and Kate went to Zurich in search of some psychological education and what they had heard was the best analysis available for people like themselves. They both went into analysis with C. A. Meier, who had been a trusted assistant of Jung’s in the 1930s and in the early 1950s was still a power in the newly formed Zurich Institute. (He gave up its presidency in 1957 after a disagreement with Jung.)

Hillman was able to meet with Jung individually on several occasions to discuss psychological ideas, but it was with Meier that for the first time in his young life he really promised himself to submit. As both patient and analyst-in-training at the Zurich Institute, Hillman, who was simultaneously pursuing a PhD in psychology at the University of Zurich, came to the realization that he could “be a psychology writer” (p. 414) rather than a novelist and still convey what he found most interesting, the story of the soul.

Soon, however, he began to challenge the very limited intellectual view he found in the Jungian parochialism of the 1950s. After his graduation from the Zurich Institute, he became its first Director of Studies, with the aim of opening up the training to new voices, among them his own. His efforts seem to have created considerable resentment in C. A. Meier, who made a series of moves that, as put together by Russell from interviews and contemporary letters, would be hard to interpret as other than hostile to his former analysand. When Hillman learned that Meier had been “intimately involved” (p. 511) with Hillman’s wife, who was still Meier’s patient, Meier refused to accept any rebuke from Hillman, claiming that the sexual involvement was over, had been brief, and only happened as a way to contain his patient. Not long after, Meier would openly censure Hillman’s 1964 book Suicide and the Soul, which argued rather sensitively for a therapeutic technique that would contain, rather than immediately step in to prevent, the expression of suicidal emotion within analytic sessions as in the long run the best way to deal with suicide risk. This view was still controversial, but it struck a responsive chord in many practitioners, even in suicide prevention centers, who realized that one key to lasting transformation is allowing emotion to have its say.

Meier made it well known in the Zurich Institute that he
thought Hillman’s clinical approach was “dangerous” (p.497). When Hillman himself got caught in a countertransference mess of his own, falling in love with a patient and acting out his feelings with her, Meier became an actor in the conflict. The woman had returned to the United States with her husband, who intercepted a letter from Hillman in which he reflected on their now ended affair. The husband sent a copy of the letter to Meier, who had been his own analyst, as well as Hillman’s. Meier urged the husband to sue Hillman and located for him an attorney in Switzerland (where adultery resulting in alienation of affections could result in a two-year prison sentence). He reportedly told Hillman, whom he summoned back for an analytic session to receive his paternal advice, that he ought to resign from his job at the Institute “in the name of ‘scapegoat’ to protect our name and group” (p. 540). Russell, who has interviewed both this husband and his wife, who are still married, quotes the husband as saying that Meier sent him a letter in which he stated that Hillman “was one of two people in his lifetime he had known personally that he considered evil” (p. 537).

This was the crisis that precipitated Hillman’s move from an analytic to an archetypal understanding of how the soul secures its own means of survival in the face of the madness not just of persons but also of institutions. Hillman’s decision not to resign from the Zurich Institute, that the governing Curatorium of the Institute sustained after investigation on the grounds that he was genuinely remorseful and not an unethical person in attitude despite the egregious mistake, was a very deeply reflected one on his part. The man who stepped forward at the Institute to stand up to Meier was Franz Riklin, son of the Riklin who had worked with Jung on the latter’s pioneering studies on word association that had popularized the notion that a complex can cloud our mental functioning. This mad and wounding scenario, which Russell describes with consummate thoroughness so that the reader can make up his or her mind as to what to feel about the series of outrages that occurred in the name of analysis, constituted the initiation Hillman had been seeking. Through it, he learned to live with his own soul. Forty-five years later, speaking at the Library of Congress, he would say, “We are all scandals . . . but each differently of course” (https://www.youtube.com/watch?v=Oy-x7BLIBYg, consulted 1.12.14).

But in the mid-1960s, when so many people were learning the limits of what can be trusted about psyche, this was the ordeal that forced Hillman to exercise his own judgment as to whether he could continue to be trusted with the care of the soul. As if in answer, during this period, he produced what is probably his best essay, “Betrayal,” establishing, against odds, his trust of psyche; his bravest defense of the analytic process, *Suicide and the Soul*; and “On Psychological Creativity,” the clearest explication of his own way of proceeding with soul-creating. The latter, his first “Eranos” lecture, given in 1966 at the Conference with that name in Ascona Switzerland, which since 1933 had been bringing scholars from many fields together to examine the implications of Jung’s archetypal hypothesis, inscribes Hillman’s enduring vision that soul is the central hypothesis of depth psychology.

The question of how it can be that the same soul Plotinus knew, rather than a Freudian superego or a Jungian Self, can possibly provide not just the moral inspiration but the actual psychological integrity human beings need to live alongside their passions, would occupy Hillman for the rest of his life. By the end of Volume 1 of this singular biography, we are convinced that at 43 the wunderkind had faced his limitations sufficiently to be ready to clarify the values that were going to inform his future psychology.

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**Jung on Art: The Autonomy of the Creative Drive**

By Tieu Van Den Berk


Reviewed by Crittenden E. Brookes, MD

This is a highly relevant and creative work, but perhaps only so to the few who are quite familiar with Carl Jung’s writings and find them meaningful and relevant. Such persons are much too rare in the contemporary field of science, psychiatry and psychodynamics, although they are quite common in the arts and humanities. The current split between these two fields is one of the sad testaments to and probable causes of our current human predicament.

The reasons for this as far as psychotherapy and the healing arts are concerned are buried in the history of psychodynamics and psychoanalysis. The sense of psyche, of what it is and how it relates to human mental function and especially to mental pathology, was co-opted by the long-term consequences of the Freud-Jung split around one hundred years ago, but even more so by views of the nature of reality that were in turn biased by the philosophical assumption, seldom made explicit, that the world we experience exists separately from our experience of it.

Although we cannot prove that this is so, we usually accept this arbitrary distinction as a fact, *a priori*. In science and the technology derived from it, the idea of a reality separate from experience is so automatic for us that we accept it as a kind of religious position. Such an automatic assumption was central to Freud’s thinking, which has held sway over our views of human mentality and its pathology during the past century of conceptualizing the nature of human suffering as well-being. Under his assumptions and the consequent development of traditional science, the psyche was relegated to the status of a mere *epiphenomenon* or “froth on the wave” of substantial physical reality.

The development of ideas about the nature of mental function and dysfunction was tied first (by Freud) to instinct. Later, such ideas evolved to extensive consideration of the psychology of the ego. Even later, social and subsequently relational and inter-relational factors expanded our psychological understandings to include much more than instinct theory, focusing as they did on interactions between or among two or more of us. Unfortunately while doing this, such understandings maintained a rather “fuzzy” position in which subjective experience itself, the final and only thing that each of us has, is treated as only a reflection of the reality assumed external to our experience of it, which we automatically assume to be central and primary.

Currently, even the psychological position has been relegated to the back seat of understanding human mentality and behavior. As we increasingly obtain the capacity to observe and measure brain function itself as a corollary of subjective experience, we commit a fundamental error of understanding: we imply that...
such function is the cause and therefore the ultimate base of experience, rather than its physical corollary. All of this is at least temporarily reassuring to us.

The above is, although usually assumed and seldom explicated, an arbitrary philosophical position for which we have to thank western intellectual culture, steeped as it is in Aristotelian and Newtonian metaphysics, i.e., suppositions about the nature of reality. The fact is that science itself, in search of the laws that govern the world that we experience as real, has increasingly had to include the central importance of the experience of something as an essential element of that which is experienced. This inclusion moves contemporary science far ahead of the now outdated metaphysical position of more traditional science that we continue to take when we assume that brain function is the basis and sole cause of the experience of being alive, and then go further to confuse that position with the nature of psychodynamics.

Carl Jung anticipated this error long ago by creating a strictly phenomenological theory, with its data based on subjective experience as potentially scientific data, together with a newly defined science that works appropriately as validation of that theory. There is no space in this review to elaborate on his theoretical system or to expand on the nature of the science that underlies it, except to say that the data of such a science are human experiences themselves—subjective and phenomenological, and are therefore strictly psychological, i.e., are underpinned by descriptions and constructs (such as ego or sublimation) that elaborate the nature and function of the psyche, which is itself a strictly phenomenological, i.e., experientially derived concept. The ego for example is conceptualized in an attempt to explain and understand certain subjective experiences.

Psychodynamics in Jung’s terms becomes an investigation and description of the laws that govern what Jung called the autonomous psyche—i.e., the psyche as the world of personal experience, which has a substantial, separate existence of its own, rather than being an epiphenomenon or shadowy reflection of a reality assumed to be external to it.

It is with this information in our minds that we can turn to the text Jung on Art: The Autonomy of the Creative Drive. Tjue van den Berk, a well qualified Jungian scholar from the Netherlands, succinctly points out the rationale for his book as follows: “The psychiatrist and cultural philosopher Carl Gustav Jung (1875-1961) never wrote a monograph on art. Nevertheless, throughout his work he intensely engaged with this theme on many occasions” (p.xi). The author goes on to cast his book as an attempt to fill the gap left by a lack of a Jung monograph on the topic, through pulling together, assembling and condensing various writings out of the forty volumes of written work by Jung that refer to it. He has done an excellent job.

The book well outlines how Jung’s theoretical position as regards the nature and function of the psyche applies itself to the phenomenon of artistic production. It is a delightful read, perhaps even for someone unfamiliar with Jung’s writing, for the very reason that it is couched in experiential terms, characteristic of course of all Jungian writing, which if the reader understands certain basic concepts and attitudes, makes an immediate impact on anyone immersed in the act of being alive as a human being. I will hope in this review to elaborate those concepts and attitudes, in ways that can be understood by most intelligent readers of whatever background.

First, Jungian theory honors mystery as an inevitable fact. In this, it stands in diametric opposition to the pathological phenomenon of intolerance of ambiguity, a concept developed to try to understand the denial of Nazi crimes by many of the German people during World War II (Frenkel-Brunswik and Adorno, The Authoritarian Personality, 1950). In fact, Jung embraced the unknown and ambiguous, and made it a fundamental aspect of the theoretical position of what (to distinguish it from Freud) he called analytical psychology.

Fear and the consequent freezing or fixation of ego processes, then by implication becomes the basis for much psychological pathology. Not being able to tolerate ambiguous and unknown situations or possibilities becomes a basis for the nature of much of mental pathology—the latter topic that Jung constantly implies and alludes to, but which does not appear as a central focus of his work. Analytical psychology may be seen as more focused on the function rather than the dysfunction of the psyche, although such dysfunction is regularly implied.

Jung had great respect for the unconscious mind, which he saw not only as a repository of content rejected or avoided by the conscious attitude (a repository which he termed the shadow), but as essentially of unfathomable depth. He further maintained that the unconscious can only be known or characterized to a certain degree. The “borderland” between the known and the unknown became the venue for much of Jung’s theoretical formulations. His concept of participation mystique posits a “root area” of the psyche, occasionally experienced non-consciously but powerfully (again, this is an experiential theory), accompanied by a fundamental emotion for which he borrowed the name numinosity (awesome or deeply moving), but which cannot be ever truly known objectively because it is a precursor element of human experience. “Here, (in a state of mind involving participation mystique) psychic and physical processes permeate each other, and the subjective and objective (in this case, the naming of things) coincide. The artist becomes submerged in it, he becomes enthralled and resurfaces with his enchanting instrument; a work of art” (p.xv).

For Jung, the transition between such unconsciousness (unknown but apprehended in experience) and objective, conscious and nameable experience is marked by the concepts of complex, symbol and archetype. Only brief reference can be made to them here.

“Hidden memories” (a psychic process called cryptomnesia) are characterizations of the deeper nature of reality that can be both individual and collective, and which drive to conscious recognition through autonomous (existing in their own right) complexes, which are of many forms.

One of these complexes is the creative processes, or it might be better to say that all complexes provide the possibility of creativity, if they are recognized and made use of. This makes art not a sublimated sexual complex as Freud thought—but a specific drive, whose roots reach deep into the unconscious.

The appearance of an unconscious element into consciousness as art (and its subsequent production) is marked by a symbol coming into existence. “The symbol is the connecting chain between the unconscious and conscious psyche; it is the great transitional reality” (p.xv).

Taking a cue from Suzanne Langer (Philosophy in a New
Jung held that as opposed to a sign, which has a one-to-one referent to something experienced, a symbol prompts us to think about the experience in such a way that it becomes evocative and moves beyond its own image. Both Langer and Jung felt that symbolization is a uniquely human process. And Jung elaborates that following the symbolic lead is a creative act.

The concept of archetype can be understood only in the context of another term: the collective unconscious. The collective unconscious "consists of inherited regulatory principles within the structure of the brain that contain possibilities of images, visions and creative ideas (note the similarity with contemporary brain studies). The term Jung used to describe these principles is archetype" (p. 51) “Of course this term is not meant to denote an inherited idea, but rather an inherited mode of psychic functioning, corresponding to the inborn way the chick emerges from the egg, the bird builds its nest, a certain kind of wasp stings the motor ganglion of a caterpillar, and eels find their way to the Bermudas. In other words, it is a pattern of behavior” (Jung 1949/1977: 518)

Van den Berk points out that the term may be easily equated with the concept of psychic instinct. It elaborates the idea of the recovery of “hidden meanings” that Jung sees as a central aspect of artistic production.

The body of the book rests largely on an extensive and fascinating elaboration on the ideas just mentioned. But an intriguing set of questions and associated ideas manifest themselves. For example, the author addresses questions such as: “is the ‘insane’ mind a source of creativity?” (chapter one), the “art complex “ has animal roots (chapter two), the nature of fantasy thinking (chapter four), the distinction between art and aesthetics (chapter five), how Jung’s Red Book fits into the concept of art (chapter six), the significance of Jung’s work in stone at Bollingen (chapter 6), the artist does not have a personal message (chapter 7), Jung’s dislike of “modern art” (chapter eight), Jung’s analysis of a Surrealist painting (chapter nine), and art as a synchronistic phenomenon. I will leave it to the reader to find a definition for the principle of synchronicity (a central concept in Jungian thought).

This a fascinating book, and a great introduction to and amplification of Jung’s thought, provided that one is equipped with at least a basic understanding of the overall thrust of that thought. Interestingly, it does not take up to any degree the topic of the creative act as a possible corrective for mental pathology. That question should be taken up by others.

I will end this review with a quote from Jung, also cited by van den Berk, since it moves to the essence of the artist, who as according to Jung is the spokesperson for something transpersonal that is beyond himself or herself:

“It is not Goethe that creates Faust, but Faust that creates Goethe. And what is Faust? Faust is essentially a symbol” (Jung 1930/78:103)

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I do not usually go into raptures over a book, but The Well of Being is extraordinary, and I am compelled to recommend it to all the people I know who would appreciate it.

The author, Jean-Pierre Weill, is an artist; you can easily find links to his studio through Internet searches. This book is apparently his first attempt to employ his artistry to illustrate thoughts expressed in words. He calls it a “children’s book for adults,” which is to say that he puts words to illustrations in a way that recalls those picture books our parents read to us – and which I’m sure we’ve read to children -- a word or a phrase and a picture for each page spread. The pictures are exquisite watercolors that add meaning to the words and suggest questions and thoughts. Why does the giraffe return? Is the water tower a well? Why is the train late, and where would it be going?

The text is based, the author says, on the teachings of an 18th century Italian philosopher and mystic. Everything began as One, and when we can connect to the One that is our self, we achieve what the author calls “well being.” However, when I first read the book myself, I found myself thinking of Horneyan psychology when Weill says that the child whose offering of art was rejected “practiced ways to rearrange himself, to make himself acceptable so that he could return home.” The lion that sees a cat in the mirror, and a cat that sees a lion in the mirror suggest Kohutian self psychology, as does the boy whose artistic offering is rejected. One friend who read the book with me found hints of Buddhist and Hindu philosophy. Another friend saw Stoic philosophy in some of the text. The overall message might be summed up as a search for a Winnicottian real self (but there is so much more to it).

This is a book that can be read in ten minutes, turning one page after another, reading the sparse text and admiring the illustrations. Or it could be read in two or three hours, turning back a few times to connect images in the illustrations as they return, thinking carefully over the interplay of word and picture.

The physical book is itself a work of art. It is large, big enough to spread over two laps so you can share it with a friend. Each page opens with an illustration on the right and some text – from a word or two to a sentence. It is printed on a heavy stock of paper with lots of white space around the text and the pictures.

I am not sure yet what I want to do with my copy of this book. It is large even for a coffee-table book, and who reads coffee-table books. It would never fit on an ordinary bookshelf.

In any case, I want to share it, and maybe I’ll just leave it on the table in my office waiting room.

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A Boyish God
By Peter Alan Olsson
Reviewed by Ronald Turco, M.D.

In appreciating this novel it is important to understand that Dr. Olsson is a recognized expert in the study of malignant and sociopathic figures such as Osama Bin Laden, the Rev. Jim Jones and many others. The book found its genesis when his office janitor asked him that, if he had treated the Reverend Jim Jones when he was twelve years old, would the 918 deaths have been prevented.

The story involves a young man, Will Powers, who is in the
The Latter Day Dude
Film Review by Harvey Greenberg, M.D.

The Big Lebowski, written and directed by Joel and Ethan Coen, was released in 1991 to mixed reviews and slim box office. It has since achieved cult status: its stoner hero, The Dude – aka Jeff Bridges, Jeff Lebowski, The Dudeler, or El Duderino “if you’re not into that brevity thing” – has become a pop culture icon.

Thousands attend yearly Lebowski festivals in Louisville and London, to revel in trivia and bowling competitions, listen to the Dude’s favorite rock music, while guzzling White Russians – his favorite tipple. (The cocktail is a nauseous confection of vodka, Kahlua, cream, and chipped ice.)

Smaller Lebowski parties thrive at homes and bars, where acolytes clutch obligatory White Russians to their bosoms while lip-synching the onscreen dialogue. Lebowski studies are a minor cottage industry in academia. There’s also an online Church of the Latter Day Dude.

Follows an exploration of the film’s idiosyncratic pleasures, along with speculations as to why The Big Lebowski has entered the cult pantheon:

Just as a therapy session’s opening moments often announce its central theme, a film’s establishing sequence often captures its core concerns. The Big Lebowski begins to the background tune of the antique cowboy serenade, “Tumbling Tumbleweeds”, as one of those weeds rambles across what seems an arid Southwestern landscape.

It comes to rest on an overlook. The camera ascends: one expects a desert vista to unfold; instead a carpet of Los Angeles’ glittering nightlights stretches to the horizon. (The Coens regularly subvert viewer expectation.) In a rich Texas drawl, Sam Elliot’s voiceover begins a “durn good yarn.”

Elliot’s story (the credits identify him only as “The Stranger”) is set sometime during our first war with “Saddamm.” Meandering along like a tumbleweed, it’s a tall tale of the sort nourished in our country’s rugged spaces. The hyperbolic, discursive style informs Mark Twain’s yarns (e.g. Huckleberry Finn) and many Coen projects -- e.g. “Oh Brother Where Art Thou.”

Elliot opines as how The Dude is one of those men who somehow fits the spirit of their time. In point of fact, he epitomizes the spectacularly unmotivated “slackers” who drifted onto the scene a decade or so after the hippies drifted out. His history is hazy: college was spent in unspecified futile political protests, getting stoned, and downing White Russians. After several years of vague employment in “the music industry,” he slipped into slackerdom and stayed put.

When he’s not stoned or soused, bowling is his passion. Although sloppily attractive, romance apparently holds no interest for the Dude. His social life totally devolves around rolling “strikes and gutters” with fellow addicts, unmoored as himself. I deem the dialogue on the lanes and off “Lebowski speak:” one character declaims, exhorts, or denounces (often profanely), then the other responds in kind -- or just listens.

The Dude’s loopy best buddies are Donny, a gentle, befuddled naif always one beat behind the moment (Steve Buscemi), and Walter Sobchak (John Goodman), a Vietnam vet whose default behavior is cantankerous complaint erupting into fulminating rage.

The Dude’s first appearance in a squeaky clean LA supermarket proclaims his slacker modus vivendi. He’s slurping from a milk carton; wearing a bathrobe, shorts, T-shirt and flip flops. His wardrobe is quintessential Malibu surfer-grunge, and shuffles back to his comfortably squalid bachelor apartment.

Two thugs burst in, beat him up, and demand the money his zillionaire wife owes a porn baron. The Dude points out that his grotty digs doesn’t resemble a Beverly Hills mansion, and
his toilet is up: the pair of yobbos have shaken down the wrong Lebowski!! Out of sheer pique one urinates on the Dude’s favorite rug before they decamp. (Such rank chuckleheads pervade the Coen universe: “The Big Lebowski” assembles their largest collection of stupendous stupids.)

The Coen’s oeuvre is wonderfully diverse – twenty pictures and counting over nearly thirty years. The brothers are known for bending the conventions of classic Hollywood genres, especially crime-related genres - e.g. the gangster film in “Miller’s Crossing”; film noir in “The Man Who Wasn’t There.”

The Big Lebowski is their screwball reinvention of the 30’s and 40’s private eye caper, particularly the capers of that most hard-boiled shamus of them all, Raymond Chandler’s “Philip Marlowe.”

Typically, Marlowe was hired to recover a lost or stolen item. Alfred Hitchcock called this a “macguffin,” after a hoary English joke. The macguffin’s value is of no consequence: it chiefly serves to power the plot. Marlowe’s macguffin usually propels him into a labyrinthine web of corruption and mayhem, involving a wealthy family with at least one dark secret.

Defying attempts to throw him off the track, harassed by hamfisted or corrupt cops, routinely beaten unconscious, the hard-boiled eye emerges with his skin and integrity preserved and desperate truths revealed. In Marlowe’s capers, as with other writers in the genre, a seductive femme fatale resides at dead center of the mystery’s web, and the shamus must confront and face down mortal peril to expose her evil.

The epitome of these spider ladies is surely alluring Brigid O’Shaughnesy of “The Maltese Falcon”, whose helpless mask is torn away by Dashiell Hammett’s Sam Spade. Like the Falcon, she’s proven lethal to every man who thought he possessed her until Spade “sends her over” to the hangman. She’s also an imposter in name and personality: mistaken identities and downright imposture are discovered throughout the hardboiled genre.

“The Big Lebowski” deploys every Marlowe motif, uproariously topsy-turvy. Its first macguffin is the Dude’s shabby, ruined rug. “That rug really pulled the room together” is his recurrent complaint. “This aggression will not stand!” Walter roars, echoing George Bush’s denunciation of the Kuwaiti incursion seen briefly on the supermarket’s TV. The Dude re-echoes it further down the line - repetition of a catch phrase is another Coen trademark.

Walter demands that the Dude find the “real” Big Lebowsky, Jeffrey, not Jeff: a pompous, paraplegic gazillionaire, married to Bunny, a high maintenance ex-porn star. He’s enraged by the Dude’s indolence - “THE BUMS WILL ALWAYS loose!!!!,” prompting the Dude to boost one of his rugs. Bunny gets kidnapped; The Big Lebowski unaccountably hires the Dude to deliver a million dollar ransom to the bad guys; a suitcase kidnapped; The Dude recompense for exposing The Big Lebowski’s scam is a nicer rug and the restoration of his slacker lifestyle, as honorable to Walter’s hilarious perseveration to the war takes on a darker significance when read as a stigmata of PTSD.

The price of restoring the status quo is also a main character’s death. It leavens the prevailing goofiness with an unexpected poignance. Our Vietnam debacle and its young soldiers’ suffering quietly shadows the film. It’s not unlikely that many of the bowlers are vets: one, Smoky, suffers from obvious PTSD. Walter’s hilarious perseveration to the war takes on a darker significance when read as a stigmata of PTSD.

The Big Lebowski is pitch-perfect, artfully sending up - while paying homage to genre antecedents like “The Big Sleep” and “The Long Goodbye.” It’s terrifically scripted, photographed and acted. The mise-en-scene and costuming flesh out the nineties’ setting with adroit touches from earlier decades. Only a Coen musical score could embrace classic rock, the Mozart Requiem, and Yma Sumac - a fifties Peruvian prodigy who claimed a four octave range and descent from Incan royalty - another imposture. Assuredly an absurdist masterpiece. But many great pictures, while perennially popular (“Gone With The Wind”, “Key Largo”) never become cult movies. The reasons for the cult phenomenon are over-determined and elusive, nor do they obtain in every example.

The cult film’s appeal is incomprehensible to the general public, and often to fans of other cult pictures as well. The cult movie ranges across every genre. Fandom may be substantial, but many films have relatively few, but no less ardent devotees (e.g., Ed Wood’s oeuvre). Many are well crafted, but exquisite badness can be a prerequisite (Wood’s “Plan Nine From Outer Space” is hailed or derided as “the worst movie ever made.”)

The majority don’t do well on release: instead, a fan base develops over years. Cult movies may be ahead of their time (“Blade Runner”), or evoke their time - but capturing the Zeitgeist may only be fully appreciated after that time has
“The Big Lebowski” continues to evoke nostalgia for the free spirits of the activist ’70s and the slacker ’90s. Lebowski contains other key elements of cult cinema: it has memorable oddball characters (some delightfully unlikeable); it can be watched repeatedly; and it’s filled with cherished lines fans perennially quote to each other (see www.imdb.com/title/ tt01187151/quotes). And watching it makes you feel good. (So does “Night of the Living Dead”, but here the good feeling stems from being extravagantly grossed out while safely seated).

“The Big Lebowski” draws fans across a wider age range than most cult films. I believe older as well as youthful devotees savor its spirit of playful anarchy, glorious indolence even when not at rest, living in and for the moment. One encounters this spirit across the centuries in Zen masters, in Rabelais, in fictional characters like Falstaff, Mr. Micawber, and Huck Finn.

The Big Lebowski’s carnivalesque ambience, in which the Dude lives poor but well after his own stoner fashion, mocks the frenzy of overwork endorsed by American culture since the republic’s birth (especially hollow at a time of epidemic unemployment).

The stringent ethic of unremitting toil, often for its own puritanical sake, reaches back to the industrial revolution, further back to the rise of antique mercantilism; and arguably began when Adam and Eve, driven from the garden, were compelled – in Hamlet’s words – “to grunt and toil under a weary life.” Perhaps The Big Lebowski puts us in touch with the inner Dude tucked away in so many weary, dispirited hearts.

The film concludes at the bowling alley. The Stranger (in the flesh, sporting a cowboy rig deliciously inappropriate to the setting), asks the Dude how things are coming along. He replies – “oh, the usual...strikes and gutters...ups and downs” (but)... the Dude abides!”

The Stranger (drawing to the camera): “The Dude abides!!!...I take comfort in that – It’s good knowin’ he’s out there – takin’ it easy for all us sinners...”

Although not baptized in the Latter Day Church of the Dude, this sinner prays our slacker hero will abide forever.

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Eugene Blank: Obituary and Book Review
USMC 45703, 2010, Lexington, KY, By Eugene Blank, MD
Reviewed by Ronald Turco, M.D.

Eugene Blank died July 15, 2013 at age 89. He enlisted in the U.S. Marine Corps during World War II and served in the Pacific Theatre. After the war he received his undergraduate degree from Johns Hopkins University and his medical degree from the Johns Hopkins School of Medicine in 1954. He then practiced pediatrics in Bennington, Vermont and returned to train in pediatric radiology at the University of Pittsburgh Children’s Hospital. He served as a pediatric radiologist at the Oregon Health & Science University from 1970 until his retirement in 1991. He was an avid reader and Shakespearian scholar. He published Pediatric Images-Casebook of Pediatric Diagnosis and USMC 457703. For the troglodytes in the Academy this is a trip down memory lane as it highlights the major events in WWII which are interspersed with his experiences in the South Pacific. For the “young uns” in the Academy it is an education. I suggest this book to both groups.
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   d. Space once before and after using a quotation mark. For example:
      John said, “Your epigenetic model was spot on.” Then the research ended.
   e. Any articles that contain pictures of any kind must include the actual picture file in addition to the article.
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