

ACADEMY FORUM

Vol. 64, No. 2 - Fall 2019



Table of Contents

Volume 64, Number 2 – Fall 2019

Message from the Editor	5
Ahron Friedberg, MD	
Message from the President.....	6
Gerald P. Perman, MD	
 REPORTS, UPDATES AND LETTERS	
Richard Friedman, MD's letter on APsaA's apology	7
David Lopez, MD's Response to Dr. Friedman's Letter.....	8
Douglas Ingram, MD's Response to Dr. Friedman's Letter.....	8
David Forrest, MD's Response to Dr. Friedman's Letter	9
Report from the WPA Psychotherapy Section	10
César A. Alfonso, MD	
Report from the APA Assembly to AAPDPP.....	12
Barry Fisher, MD	
Update on OPIFER	13
Joan G. Tolchin, MD	
Update on the 64th Annual Meeting	14
David L. Lopez, MD and Jessica Eisenberg, MD	
Update on Teichner Award.....	16
Sherry Katz-Bearnot, MD	
 ARTICLES	
The Media is Not the Message—the Relationship is: On the Effectiveness of Distance Treatment.....	16
Robert M Gordon, PhD, ABPP	
Death instinct and Knowledge: Newborn's Vitality and Early Intersubjectivity.....	17
Daniela Polese, MD	
Celebrity-ism in America	18
Peter A. Olsen, MD	
The Hungry Child: Reflections on Affect as an Underpinning of Behavior in the Medication Management of Children ...	21
Edward M Stephens, MD	
Features from the Psychiatrist WellBeing/Support Project.....	23
Douglas H. Ingram, MD	
The Child with Bipolar Illness and the Unique Value of Peer Support	24
John S. Tamerin, MD	
Residents Roundtable: The Psychiatry Resident's Immigrant Experience.....	25
Douglas H Ingram, MD	
 BOOK REVIEWS	
<i>Winnicott's Children: Independent Psychoanalytic Approaches with Children and Adolescents</i> , edited by Anne Horne and Monica Lanyado	26
Reviewed by Ed Malewski, MD	
<i>Handbook of Psychodynamic Approaches to Psychopathology</i> , edited by Patrick Luyten et. al.	28
Reviewed by Jo-Ann Elizabeth Leavey, NP EdD C.PSYCH	
 IN MEMORIAM	29
NEW MEMBERS	31

Cover Photo

This photograph is titled “Freedom and Possibility.” It was taken by Susannah Karajannis of her daughter Thalia. They are the daughter and granddaughter of David V. Forrest, MD.

Editorial Policy for THE ACADEMY FORUM

Articles may be submitted to the editor of this magazine by anyone who wishes to write about topics related to psychoanalytic psychiatry.

Authors who submit an article to THE ACADEMY FORUM magazine for publication agree to all of the following:

1. the editor may proofread and edit all articles for content, spelling and grammar.
2. the printing of the article in THE ACADEMY FORUM and the printing date and placement are at the discretion of the editor.
3. the author of the article may submit his/her article published in THE ACADEMY FORUM to additional magazines for publication after obtaining permission from THE ACADEMY FORUM.
4. THE ACADEMY FORUM does not normally accept previously published articles but may do so at the discretion of the editor.

Criteria for Submission:

1. All articles must be sent electronically as an attachment in a Word file (or text file) to articlesforforumeditor@gmail.com. Any pictures embedded in the file must be high quality JPG files of each picture used.
2. Articles should be 1,000 to 2,500 words in length although the editor may make exceptions. Book reviews should usually approximately 1500 words. Please note that lists and examples take up room and decrease the number of words allowed.
3. Submissions should be of interest to the membership of the American Academy of Psychodynamic Psychiatry and Psychoanalysis including medical students, psychiatric residents, academic psychiatrists, research psychiatrists, psychiatrists in private practice, and psychiatrists working in the public sector.
4. Articles should be educational, new, informative, controversial, etc. Adequately disguised case vignettes with an informative discussion are welcome.
5. Although we edit and proofread all articles, Please spellcheck your document before submitting it for publication. Be especially careful with names and titles.
6. Please use a word processor such as Microsoft Word and do not attempt to do fancy formatting. It does not matter whether you use a PC or a Macintosh computer. Do NOT use old, outdated programs as we may not be able to open the files.
7. Any photographs being submitted for publication must be clear and have excellent contrast. Please include a note with names of people in the photo or a description of what it shows.
8. Electronically created images should be in JPG format at 300dpi. JPG formatted images should be actual size or larger. Small JPG images will distort when enlarged, but larger ones look fine when made smaller.
9. Since editing submissions for publication is time consuming, we ask you to:
 - a. Never use the space bar more than once in succession. This includes at the end of a sentence after the period.

- b. If you want more than one space, use the tab.
- c. Space once before or after using a parenthesis. For example: (1) Freud or Freud (1)
- 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.
- f. If something comes up at the last minute, call or email to see if you still have time to submit your article for that issue.

Deadlines for Article and Ad Submission

- THE ACADEMY FORUM is published electronically in October (the Fall issue) and in April (the Spring issue).
- Confirmation for submissions are due seven weeks prior to the month of publication.
- Copy (articles) is due four weeks before publication

ADVERTISING

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The Academy Forum welcomes contributions from readers. All manuscripts must be submitted in computer-readable format. All manuscripts are subject to editing for style, clarity, and length. All communications, including manuscripts, queries, letters to the Editor and changes of address should be addressed to: Ahron Friedberg, MD, at ahronfriedberg@gmail.com.

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Message From the Editor

Ahron L. Friedberg, MD



Firstly, I'd like to thank Dr. Perman, the Editorial Board of the Academy Forum, and members of the Academy for the honor of becoming Editor of the Forum. It deepens my commitment to the Academy and relationship with our community.

I consulted extensively with Dr. Perman before

having my name considered as a candidate to become the next Editor of the Forum, following the editorial tenure of Dr. Angela Hegarty. Dr. Perman expressed the pleasure that he took serving as Forum Editor for 10 years. In particular, he enjoyed the opportunity to interact with the many contributors to the Forum; he valued the opportunity to enhance his editorial skills; and he appreciated the contribution to his continuing education by being able to review so many interesting and informative articles and book and film reviews over the years. Dr. Perman also expressed his appreciation to Dr. Sarah Noble for her able assistance in her role as Forum Book and Film Editor, and to Ms. Marie Westlake, Executive Assistant, for the excellent support that she consistently provided in getting the Forum to press in a timely and efficient manner. Dr. Perman told me that his experience as Forum Editor deepened his connection to the Academy and to many of its members, and that he encourages all Academy members to seek out opportunities to become involved in our wonderful organization.

With that in mind, in this issue we've formalized a section in the Forum of "Reports, Updates and Letters," so please send us relevant material, information and your thoughts. Dr. Richard Friedman's important letter in response to the American Psychoanalytic Association's apology for its previous position on homosexuality generated much productive discussion and commentary. Three letters are reprinted here. The first by Dr. David Lopez, a past President of AAPDPP, supports and extends Dr. Friedman's view that we shouldn't apologize for incorrect scientific conclusions. The second by Dr. Doug Ingram, another past President of AAPDPP, sees the issue in terms of how apologies to individuals and groups can usefully acknowledge a mistaken belief and help to move forward. The third by Dr. David Forrest astutely reasons for correcting our prejudices more broadly.

Dr. César Alfonso's excellent report from the WPA Psychotherapy Section shows the significant contributions that various members of our group, including Dr. Allan Tasman and himself, are making to psychodynamic psychiatry internationally. Dr. Barry Fisher reports on work of the APA Assembly. Some highlights of the Assembly

include developing more psychiatric training in family medicine, eliminating financial costs for maintenance of certification, and expanding psychiatry residency training positions. Also, much appreciated is the Assembly's proposal to reduce our annual APA dues for members of AAPDPP and related organizations. Both Dr. Joan Tolchin and Dr. Sherry Katz-Bearnot in their pieces update us informatively on the OPIFER and Teichner Award initiatives respectively.

We have several original articles in this issue. Dr. Robert Gordon presents an important CAPA study on distance treatment and learning. It finds that the psychotherapeutic relationship, rather than two people being physically present in the same room, is a crucial factor in treatment. In her article on a newborn's knowledge, Dr. Daniela Polese extends the interesting work of Massimo Fagioli to consider the development of the infant mind based on early sensory experiences such as light through the eyes and touch on the skin. Dr. Peter Olsen in his piece "Celebrity-ism in America" extends his previous work on how we as a country tends to idealize the rich, famous and powerful. Such a trend can be problematic, although in moderation can also be a force for good. In his article on difficult children, which reflects a professional lifetime of clinical experience, Dr. Edward Stephens makes a timely contribution to psychodynamic psychiatry. He emphasizes that problematic behaviors in children and adolescents often reflect an underlying depression. Accordingly, they should be treated in an integrative way that includes psychotherapy and medication to address the mood disorder.

We are also pleased to publish two features from the Psychiatrists Well-Being/Support Project. Dr. John Tamerin shares a personal narrative about a unique peer support program for children with bipolar conditions, which he created over twenty years ago to better help his son and family. It now has a national presence in serving that community and is a model for other such programs. Dr. Ingram also presents on a fascinating roundtable discussion for psychiatry residents he led at our annual Academy meeting on the experience of immigrant residents. Additionally, Dr. Sarah Noble brings us engaging book reviews by Dr. Ed Malewski on psychoanalytic treatment of children and by Jo-Ann Leavey on psychodynamic approaches to psychopathology.

Finally, *in memoriam* we acknowledge the passing of Dr. Mariam Cohen, a gracious, generous and wise contributor to our field. Mims, as she was affectionately known, gave generously of herself to our Academy serving as Forum Editor, Trustee and a leader in this organization. While we miss her, Mariam's clinical and academic contributions and spirit carry on in our community. We also have a bounty of new members to note and welcome.

Recently, I was having lunch with Dr. David Forrest,

from whose great intellect I always learn. He reminded me of our motto, *scire facias* (Latin, meaning literally “to make known”), that he included in our logo to commemorate the merger of the Academy with the American College of Psychoanalysts. How apt in these times to make known the truth through evidence in

reaching a determination! He commented that the Forum plays an essential role for our community in being “breezy” like the wind rustling through summer giving voice to the leaves. It’s in that spirit we invite you to read our current issue.

Ahron Friedberg, MD

Message From the President

By Gerald P. Perman, MD



Dear Fellow Academy Members,

I have been enjoying my two-year term as President of the AAPDPP, now more than half over. I have been hard at work—a labor of love—in support of Academy activities and initiatives, some of which are listed below.

1. I am pleased to announce the appointment of our new Academy Forum Editor, Ahron Friedberg, who maintains his role as Book Editor of our journal, *Psychodynamic Psychiatry*. Dr. Friedberg has enthusiastically embraced his new job. Sarah Noble graciously continues as Book and Film Editor of the Forum. Please support their work and the Academy by submitting your articles, and book and film reviews, to the Forum.
 2. The Committee for the Advancement of Psychoanalysis (CAP) gave a well-attended and stimulating panel on dreams at our recent San Francisco meeting. Drew Clemens is Chair of the CAP Steering Committee that will help organize presentations at our annual meetings and invite psychiatric residents as Laughlin Fellows to attend.
 3. Douglas Ingram has continued to update his unique Psychiatrist Well-Being Project, which can be found on the Academy website. Doug put together a superb panel for the Opening Night presentation in San Francisco. Missing from the panel was Mims Cohen, whose narrative Doug read, and who has since lost her battle with terminal illness. Mims, former Editor of the Forum and a three-time Academy trustee, is the subject of an obituary by her husband, Barry, and is eulogized by a poem in this issue of the Forum.
 4. We now have a “closed” Academy Facebook page that you can access by going to your Facebook account, click on “groups,” and then “AAPDPP.” This was created by Academy member Joseph (J.J.) Rasimas at my request to give the Academy a social media presence on the web. This will help make the Academy more engaging and attractive to younger members and offer an additional platform for interaction and discussion. We already have a Flickr page created and maintained by Scott Schwartz. The Facebook page will be administered and monitored by J.J. and Marie Westlake, Executive Assistant staff member. We may consider opening it to the larger public at a later date.
 5. Sherry Katz-Bearnot continues to manage the Teichner Award teaching project (go to aapdpp.org for details). A joint meeting between the Academy and OPIFER, the only psychoanalytic association in Europe that welcomes contributions from analysts of all psychoanalytic persuasions (Freudian, Neo-Freudian, Kleinian, relational, interpersonal, Jungian, Lacanian, etc.), organized by Past President Joan Tolchin, meets in Florence, Italy in October 2019. Recent Academy Past President Jennifer Downey organized a well-received Academy panel at the 2019 APA meeting on the theme of Diversity Issues in Psychotherapy.
 6. Richard Friedman, Jennifer Downey, Cesar Alfonso, and Ahron Friedberg continue to do a superb job with *Psychodynamic Psychiatry*. Our journal uniquely represents this new psychiatric specialty and remains true to the ideals of the founders of the Academy by letting go of debunked psychoanalytic shibboleths while embracing new scientific and biological developments. *Psychodynamic Psychiatry* also welcomes the submission of psychodynamic and psychoanalytic case material that follows necessary guidelines for publication.
 7. The Academy is represented at APA Council by Barry Fisher, who has kept us updated with APA Action Items pertinent to the Academy. Long-time Academy member Eric Plakun is now in the important and prestigious role of APA Trustee.
 8. I have recently recruited several new members to the Academy through my supervision of psychiatric residents at the George Washington and Howard University Medical Centers in Washington, D.C., as well as through the APA online Psychotherapy Caucus. I encourage you to pursue your own recruitment efforts as well.
 9. A warm welcome to all former American College of Psychoanalysts members into the Academy. Please participate in Academy meetings and contribute to our publications!
- Finally, I am grateful to Academy Council members and Committee Chairs who volunteer their time and energy, and to Academy staff Ms. Jacquelyn Coleman and Ms. Marie Westlake, all of whom maintain the smooth and efficient functioning of the Academy. It seems like only yesterday that I took the reins from Past President Jennifer Downey, and yet I can now see President Elect Joanna Chambers

approaching in the distance, who will become the next Academy President at the end of the Annual Meeting in Philadelphia in April 2020. I hope to see each of our Academy members in Philadelphia and to make this the best-attended Annual Meeting in our history!
Best wishes to all,

Gerald P. Perman, M.D.
President, American Academy of Psychodynamic Psychiatry and Psychoanalysis

REPORTS, UPDATES AND LETTERS

Richard Friedman, MD's letter on APsaA's Apology



Dear Colleagues:

This letter is in response to APsaA's recent letter of apology for having once considered homosexuality to be pathological. Earlier drafts of this letter may have inadvertently been posted and should be discarded. I oppose expressing such an apology even while being aware of

the great suffering of gay and lesbian people because of invalid beliefs about sexual orientation in the past.

I have devoted much of my career to discussing how and why homosexuality should not be considered pathological by psychoanalysis. I based my conclusions about this on scientific research, academic scholarship, and moral reasoning. At the time I carried out my original work, I was the only psychoanalyst to integrate psychoanalytic thought and biological research in this area. I credit one of my papers, published with Jennifer Downey, MD in the *New England Journal of Medicine*, with helping to diminish homophobia throughout academic medicine. My first book on male homosexuality was published in 1988, and Richard Isay's was published soon after. Isay, a colleague and friend, was himself gay, however. I believe that the fact that I was not gay led our findings, when taken together, to have increased power.

Making errors because of beliefs that turn out to be false is an inevitable occurrence along the path of progress in medicine. Therapists are often faced with having to make decisions about interventions that may not be helpful or even may be harmful. There are many areas in which psychiatric treatment and assessment has been misguided. For example, notions about hysteria, the use of lobotomy, widespread institutionalization of the mentally ill, changes in the awareness and recognition of PTSD, the role of mothers in the etiology of severe mental disorders, the role of penis envy in the psychology of women, and excessive claims made about psychoanalysis as a treatment for diverse mental disorders all come to mind.

The pathological model of homosexuality was initially rejected by organized psychiatry under the leadership of Robert Spitzer, MD, who directed the revision of the DSM published in 1980 (DSM III). The response of the psychoanalytic community to this was not enthusiastic. Many psychoanalysts believed that psychiatry had rejected

the pathological model because of political pressures.

At the time I began presenting my work in the 1970s and 80s, gay candidates were not accepted at most analytic institutes, and there were no openly gay training analysts. Virtually the entire psychoanalytic profession believed in the pathological model of homosexuality, and there was a significant price to be paid for challenging its validity.

It has been a source of enormous satisfaction to witness the diminution of antihomosexual prejudice throughout American society. This has been influenced by progressive attitudes of modern mental health professionals to a great degree.

Issuing an apology, however, might convey the sense that the psychoanalysts who erred about homosexuality were motivated by antihomosexual prejudice, similar to racism for example. This was not the case in my view. Belief in psychoanalytic ideas about the positive Oedipus complex seemed to influence many. It is important to keep in mind that the field of psychoanalysis has also made errors in other areas of behavior. For example, at the time when psychopharmacological agents were introduced in the treatment of the mentally ill, it was not uncommon for psychoanalysts to object that the use of medication might interfere with the transference. In such instances there was a bias towards the use of a psychological technique to treat a biologically based disorder. This sometimes proved unhelpful and even harmful.

The needs of health professionals to ameliorate suffering may outweigh the scientific evidence that supports interventions. This is one reason that being a practicing psychoanalyst may require more than the capacity for empathy. It may require the courage and integrity of character associated with the capacity to make decisions in complex situations in which therapeutic guidelines may be ambiguous. Be that as it may, the present generation of psychoanalysts should be able to experience appropriate pride in its accomplishments without finding it necessary to stigmatize those of the past.

Richard C. Friedman, MD
Clinical Professor in Psychiatry
Cornell-Weill Medical College NYC, NY

Editor-in-Chief
Psychodynamic Psychiatry

Distinguished Life Fellow
American Psychiatric Association

Response by David Lopez to Dr. Friedman's Letter



Since the beginning, psychoanalysis has had two major traditions: one rooted in the humanities and another based on scientific thought. When Freud proposed psychoanalysis as a treatment, he rejected any notion related to mysticism and advocated to maintain what was considered at the time scientific thought.

This was the main reason why initially physicians were attracted to this discipline.

Now, scientific thought is extraordinarily fragile and unstable. A widely accepted core belief of a scientific discipline can be shattered and completely discarded if a new discovery proves it to be wrong. Undoubtedly, the textbooks of any medical specialty look completely different than the ones written one hundred years ago. On the other hand, literature, art, tradition, religion, and even philosophy are extremely stable. The intrinsic value of works of art and literary pieces has remained unchanged for centuries. Many traditions, religious beliefs, and philosophical notions have not changed for thousands of years.

If psychoanalysis is to be considered to have the same validity as a poem or a song—which elicit in us different emotions according to how we feel at the moment—then we should apologize on behalf of the authors if they offended our friends with their writings. Not only would I be appalled that we have not apologized to the gay community until now, but I would be infuriated that

we have not apologized to women (every member of this gender who has or ever had a uterus, that is) for the writings pertaining to Hysteria. Dr. Friedman mentions this point in his letter. In addition, we should also apologize to those who did not have an Oedipus complex, or any Jew who is offended by “Moses and Monotheism” (1939). In fact, we should apologize to all patients who were purportedly treated with a method that was based on the idyllic literary inspiration of a charismatic writer who died decades ago. That is, if psychoanalysis is as valid as a poem.

I want to believe that Psychoanalysis is based on scientific tradition, and I thank Dr. Richard Friedman for bringing this point forward. Scientists do not apologize for having been wrong. All scientists who have been disproven would have to apologize when they refute their previous findings, or when their colleagues do. Science is amoral and does not conform to social norms. In fact, I do not want scientists to apologize. I want them to continue to do their work and continue to research and present us with new findings. It is not a perfect way to find the truth, but it is the best we have.

Apologizing and being concerned with social niceties would only distract them from what they should be doing. Dr. Friedman makes the point that current psychoanalysts should have pride in their accomplishments without stigmatizing those of the past. I would add that being concerned with perhaps having to apologize in the future for being wrong would inhibit scientific curiosity and motivation to continue to share our thoughts.

David L. Lopez, MD
Past President

Response by Douglas Ingram to Dr. Friedman's Letter



I very much value Richard C. Friedman's taking to task APsA's apology to the LGBTQ community. I value it for its cogency and intelligence. Likewise, David Lopez's arguments seem clear and inarguable. Nevertheless, I believe that in emphasizing certain abstract concerns about the legitimacy of APsA's

apology, they miss the immediacy and benefit of the apology's public relations benefit, a benefit that accrues to the profession of psychoanalysis and to the LGBTQ community. I speak here of public relations in its best sense. There are instances when a person in public life, an organization, or a government might wish to deploy a public apology in order to amplify recognition of error in a signal fashion.

Before considering the immediate instance of APsA's

public apology, let's briefly consider the functions of apology. How do those functions operate in different contexts? How does, “I'm sorry,” neatly express both regret and respect? How, like “please” and “thank you,” does apology lubricate the most pedestrian moments of interpersonal life, those clumsy moments of inadvertent hurt? How does apology figure in the consulting room? Does the analyst apologize? When is apology likely to be seen as an expression of weakness? Of strength? Can one apologize for the absent, for the dead? What about the apology of the person of such pathologic self-effacement that “I'm sorry” issues forth at every opportunity as if the earthly space the person occupies is regrettable? What about apologies that are not apologies, as in “I'm sorry you are ill?” Or where the apology is purely self-serving, as in “I'm sorry, we need to let you go.”

Admittedly, this exploration takes us afield from the matter of a public apology. What might be the criteria generally for offering a public apology and, then, does the American Psychoanalytic Association meet those criteria in

apologizing to the gay community?

Considering the variety of public apologies (see www.comml00.com/blog/public-apology-letter-example.html#psy) that include those from Tylenol, Barack Obama, Jet Blue, Bill Clinton, and Steve Jobs may help establish those criteria. Also, recall Pope John Paul II's apology to Jews, Muslims killed by Crusaders, Galileo, and women. We also have Pope Francis apologizing for the sexual abuse by priests. Other examples are the 2008 congressional apology to the blacks, or, the same year, Australia's apology to its aboriginal population.

I believe we can draw provisional criteria for when public apology can be beneficial, and then apply those criteria to the apology issued by APsaA.

First, the public apology must bear little or no risk of lawsuit or a demand for reparations or, if monetary compensation is likely, might offer mitigating impact.

Second, there must be a likelihood of public relations benefit.

Third, the public apology must be decidedly creditable.

Fourth, the cultural currents of the era need to appreciate that the public apology would have legitimacy.

Fifth, the apology should not provoke renewed resentment or otherwise face a backlash, e.g., "too little, too late."

Does APsaA meet these criteria in its apology to the LGBTQ community? I believe it does. The formal criteria that Friedman and Lopez bring to the matter are correct. Yet if we apply the criteria of an enlightened public relations perspective, we can recognize that the benefit of the public apology outweighs those more formal and abstract objections.

Response by David Forrest to Dr. Friedman's Letter

Richard Friedman, M.D. is a careful thinker who with Jennifer Downey, M.D. must be thanked and not asked to apologize for relying upon available scientific evidence to argue for equal rights for practicing homosexual people, adding not needing to be heterosexual to not needing to be a Caucasian male property owner in order to vote, hold office, stay out of jail, and be as free to pursue happiness as the rest of us are free.

They found no evidence that homosexuality was pathological, as it was surely deemed to be as by the psychoanalytic theory of the day, which focused on the progressive maturation of bodily erogenous zones, and the necessity to complete a triadic Oedipal development in a standard family model. Homosexuality was considered an immaturity and an inversion of the normal.

Homosexuals felt discriminated against by this, and not just because of the discrimination it was thought to justify, not the least not being permitted to train as psychoanalysts. I think people who feel discriminated against are usually the best judges of it, and I would begin by apologize to them.

But may there not be a serious moral oversight in arguing that homosexuals should not be discriminated against because they are not found to be "pathological,"

I have a passing acquaintance with Lee Jaffe, the President of the American Psychoanalytic Association (I am a member of both the American and the Academy), and asked him what the reaction has been and whether there has been backlash. He responded, as follows (printed with permission):

"Hi Doug...the response has been overwhelmingly positive, both from a number of psychoanalytic organizations who decided to join the apology and from the public. The past president of APA (psychiatric) wrote to thank me. I believe it was time and so have many others.

Best,
Lee"

Do I think the Academy should join in the public apology? Not at all. The Academy is an organization quite unlike APsaA. The Academy does not tend to specify what is and what is not a disorder. Also, the Academy's leadership, including Judd Marmor and (yes!) Rick Friedman, have not regarded homosexuality as pathological and have even taken a stand in support of the gay community. So, no, the Academy should not join in the public apology.

I congratulate the leadership of APsaA in its bold and courageous decision to apologize to the LGBTQ community for its past views that pathologized homosexual and transgender identities.

Doug Ingram

either in a tissue sense or "psychopathological" in their behavior? This would be because the obverse is so odious: that people who are pathological or psychopathological should be discriminated against, and the corollary, to close the elenchus, is that homosexuals should again be discriminated against if they were found to tissue pathology or psychopathology. As a physician, I believe no one with pathology or psychopathology should face discrimination under the law or stigma as a class.

What is immoral here is discrimination that is categorical and systemic, which is how Woodrow Wilson was immoral in categorically and systemically firing all people of color from the civil service. This is not to argue that membership in any classification inherently qualifies one to be a psychoanalyst. Homosexuals were excluded from analytic training at a time when personal qualities like an Adlerian lust for power, superego lacunae, or difficulty with intimacy were also considered unpromising traits. Erroneous judgments about a lack of intimacy were applied categorically to homosexuals despite all evidence anyone could see at the time of long happy marriages except in name. Even the humane "parameter" of combining medication with one's psychoanalysis of control cases could

delay one's certification by the American, and demand additional supervision, as happened to me.

Once again, categorical and systemic discrimination against whole classes of people is wrong. The current issue that risks this is the urgent campaign against gun violence, which has lost its head, as AAAS CEO Alan A. Leshner argued in his editorial in *Science* of 18 August 2019, entitled "Stop blaming mental illness." He gave statistics about the unfairness of assuming dangerousness by a general disqualification from gun ownership for all persons labeled mentally ill. I would add some practical reasons to think this through better, not just that "mental illness" is an encompassing tent. One is that possession of a weapon (preferably not military grade) can assuage and calm paranoid people, who are predominantly afraid. Most important, if one is indelibly labeled mentally ill because one consulted a psychiatrist, and thereby prevented from gun ownership, how many potentially murderous people will consult a psychiatrist for help they need? How many of

the non-gun owning general population will avoid going on record as having seen a psychiatrist or taken a psychotropic medication, and forfeit exercise of their second amendment rights in any future eventuality?

Not just anyone should be a psychoanalyst, but care must be taken not to base disqualification categorically on the stigmatization of "pathology." Perhaps "pathology" is a canard, and neither the previous prejudice against homosexuals nor their current wide acceptance is primarily based on the idea of pathology, or that they were sick. In fact, much of the shift toward approval remarkably occurred while large numbers of male homosexuals were sick, in fact, mortally ill, with AIDS, and the term "gay plague" reflected both the prevalence of that terrible disorder among them at the time their lifestyle being blamed for the epidemic, in company with intravenous drug addicts. Sympathy for their plight and the loss of so many among them, that touched everyone, advanced their cause.

Report from the WPA Psychotherapy Section (2017-2020)

by César A. Alfonso, MD



Allan Tasman

César A. Alfonso

Rizky Aniza Winanda

The World Psychiatric Association (WPA) has 250,000 members from 120 countries. Psychiatrists and trainees often ask: "How do you become a member of the WPA?" The answer may come as a surprise to some—if you are a member of the AAPDPP and/or the APA you are already a member of the WPA. National organizations, and not individuals, pay dues to the WPA as member societies, and all members of national organizations, such as the APA, are automatically members of the WPA. The AAPDPP, in addition, has an official status as an affiliate association of the WPA. Please take advantage of your WPA official links and membership and engage in multiple opportunities for international academic collaborations. I specifically invite you to participate in the activities of the WPA Psychotherapy Section.

The WPA sections are *de facto* study groups that function independently and with absolute academic freedom. There are 70 sections at present. Each section has a chair, co-chair, secretary and a committee or board of up to 5 officers. Officers and committee members are elected by section members and serve for three years. AAPDPP members César Alfonso (USA), Allan Tasman (USA), and Rizky Aniza Winanda (Indonesia) currently serve as Chair, Co-Chair, and

Secretary of the WPA Psychotherapy Section, respectively. Committee members include Daniel Nahum (USA), Renato Alarcón (Peru), Dusica Lecic Tosevsky (Serbia), Hazli Zakaria (Malaysia) and Ekin Somnez (Turkey). These officers were elected at the WPA World Congress in Berlin in 2017 and will serve through the Bangkok WPA 2020 World Congress. In the current triennium, the Psychotherapy Section has grown to 135 members from 30 countries and all continents and continues to expand.

The WPA Psychotherapy Section has 9 active Special Interest Groups (SIGs). SIGs have co-leaders and provide mentoring and opportunities for networking. The section's SIGs and co-leaders include:

1. **Psychotherapy in Consultation and Liaison Psychiatry:** Feranindhya Agiananda (Indonesia) and David Teo Choon Liang (Singapore)
1. **Psychotherapy in Late Life/Geriatrics:** Kanthee Anantapong (Thailand/UK)
2. **Psychotherapy with LGBTQ populations:** Asher Aladjem (USA) and Wei Han-Ting (David Wei) (Taiwan)
3. **Psychotherapy with Refugees/Survivors of Torture:** Amir Hosein Jalali Nadoushan (Iran) and Katerina Duchonová (Czech Republic)
 - a. **Cultural Adaptations of CBT:** Reham Aly (Egypt) and Haifa Mohammad Algahtani (Saudi Arabia/Bahrain)
 - b. **Cultural Adaptations of IPT:** Xavier Pereira (Malaysia)
 - c. **Cultural Adaptations of Psychodynamic Psychotherapy:** Alma Jimenez (Philippines) and Saman Tavakoli (Iran)
4. **Cultural Adaptations of Supportive Psychotherapy:** Erin Crocker (USA)
5. **Cultural Adaptations of Motivational Interviewing:** Faiz Tahir (Malaysia)

We recently held the 1st International Meeting of the WPA Psychotherapy Section (WPA Co-sponsored Conference Zone 16), in conjunction with the 23rd Malaysian Conference of Psychological Medicine in Kuala Lumpur, 11-13 July 2019. The President of the Malaysian Psychiatric Association, Hazli Zakaria, gave the section generous space in their program and coordinated registration arrangements. The program was rich with close to 100 delegates from 20 countries presenting plenaries, symposia, and workshops on the theme “Evidence-based Psychotherapies.” The conference was attended by close to 500 registrants from all continents. Program Co-Chairs Alfonso, Tasman and Zakaria orchestrated presentations focusing on research, cultural adaptations of psychotherapies, and integration of treatment modalities, with attention to special populations and public health needs.

WPA Executive Council members gave prominent presentations: Roy Kallivayalil (India) spoke on “A public health approach to suicide prevention,” Michel Botbol (France) “Contributions of psychoanalysis to psychiatry,” and Roger Ng (Hong Kong) “Cultural Adaptations of CBT.” Other plenary speakers included Reham Aly (Egypt) “Evidence-based CBT,” Saman Tavakoli (Iran) “Cultural Adaptations of Psychotherapy,” Constantine Della (Philippines) “Psychotherapy for the Medically Ill,” and Rizky Aniza Winanda (Indonesia) “Psychotherapy in Underserved Areas of the World—an Early Career Psychiatrist Practicing in West Papua.” We had large attendance from neighboring Southeast Asian countries—Indonesia and the Philippines in particular, but also close to a dozen presenters from Iran. Other participants from Denmark, Australia, India, Sri Lanka, France, Italy, Egypt, Bahrain, Saudi Arabia, USA, Thailand, Czech Republic, Canada, Hong Kong, and Taiwan participated in a cordial exchange with Malaysian psychiatrists.

Academy members Joseph Silvio, Sylvia Detri Elvira, Petrin Redayani Lukman and Timothy Sullivan chaired symposia in a variety of clinically relevant topics and proudly represented the AAPDPP, which was one of a dozen international organizations co-sponsoring this conference. Joe Silvio spoke on “Psychodynamic Factors in Psychopharmacology Practice,” Sylvia Detri Elvira on “Spiritual Aspects of Psychotherapy with Transplant Recipients in Indonesia,” Tim Sullivan on “Contributions of Cultural, Evolutional and Moral Psychology to Psychotherapy,” and Petrin Redayani Lukman on “Assessing Residents’ Competencies Building a Working Alliance.” Teri Silvio (Joe and Nancy Silvio’s daughter), Professor of Anthropology in the Academia Sinica in Taipei, spoke on “Transitional Objects in Taiwanese Popular Culture.” I gave a keynote address on “Psychotherapy, Epigenetics and Childhood Trauma” and Allan Tasman a keynote on “Paradigms and Parallels, the Transformation of the Self, East and West.”

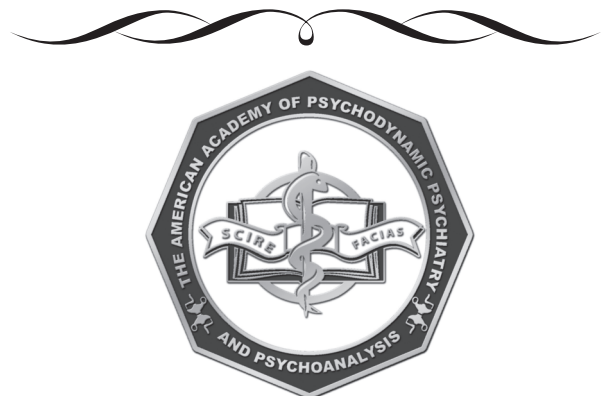
Our section leaders and conference registrants enthusiastically embraced organizing future meetings following this model at no cost to the WPA or affiliate

organizations. The Philippine Psychiatric Association has offered to host the Second International Meeting of the WPA Psychotherapy Section in Manila in 2021 and the Egyptian Association for CBT will host the Third International Meeting of the WPA Psychotherapy Section in Luxor in 2022. AAPDPP members will be alerted of these conferences in advance to encourage participation.

In addition to sponsoring these major conferences, our section organized panel presentations and symposia at the following WPA meetings: 2017 (Berlin), 2018 (Mexico City), 2018 (Addis Ababa), 2019 (Duhok, Iraq), 2019 (Lisbon), and will submit proposals for upcoming meetings in St. Petersburg (2020) and Bangkok (2020). WPA sections are given priority and some space in the international WPA congresses to present, in particular if symposia are collaborative and “intersectional.”

Our Academy friend, Michel Botbol, a psychoanalyst from Paris, currently serves in the WPA EC as Secretary of Publications. This position was previously held by APA Past President Michelle Riba. Through this link we are given an opportunity to publish invited articles in journals and present our books at meetings. Currently our section is working on an article based on presentations in a meeting in Duhok, Kurdistan, Iraq, on the psychiatric care of displaced refugees in war-torn areas that is being prepared for the British Journal of Psychiatry. Our members also recently published several articles in the British Journal of Psychiatry International. Lastly, the WPA Psychotherapy Section is preparing an edited book on “Transcultural Aspects of Psychotherapy.” The table of contents of this book is being finalized, and there are opportunities for Academy members to co-author impactful chapters.

Although 70% of the world’s psychiatric workforce are clustered in high income countries serving 30% of the world’s population (while 30% of the psychiatric workforce serves 70% of the world’s population living in low- and middle-income countries), psychiatrists worldwide continue to affirm the importance of psychotherapy as a core part of their professional and personal identity. Even when faced with challenges of extraordinary service needs and high-volume work environments, continuing medical education activities focusing on developing psychotherapy skills are embraced by most psychiatrists in all continents, making the mission of the WPA Psychotherapy Section timely and relevant.



Report from the APA Assembly to the American Academy of Psychodynamic Psychiatry and Psychoanalysis Executive Council (May 17 - 19, 2019)

By Barry Fisher, MD

Outcomes from the APA Assembly Meeting:

Among the 49 action papers submitted to the APA Assembly, seven papers were withdrawn, four papers were voted down, and 38 papers were approved. The following are specific outcomes to the papers individually cited in the Proposals section of the previous report that were of interest to the AAPDPP:

- Collaborating to Improve Psychiatric Training in Family Medicine Residencies. This paper was approved with changes suggested by the reference committee. The overall intent of the paper was unchanged with the stated purpose that the APA through the Council on Medical Education and Lifelong Learning collaborate with the Association of Family Medicine Residency Directors (AFMRD) and the ACGME to enhance and standardize training of family medicine residents in psychiatry, including working with psychiatrists in longitudinal care, including integrated care practice.
- Board Recertification for Lapsed ABPN Diplomates. This paper was withdrawn. The reference committee did not support the paper because a pathway to recertification already exists and only one psychiatrist was named as having been impacted. Currently, the pathway for recertification is to go through the written and oral board certification again. The committee did not feel that the paper offered a clear alternative method of recertification to the one that already exists.
- Medical Supervision of Psychiatry Residents and Fellows. This paper was withdrawn. The reference committee felt that a final position could not be crafted within the confines of the meeting and the committee recommended the paper be referred to the Council on Medical Education and Lifelong Learning for review.
- A Feasibility Study for an APA Alternative Process for Specialty Certification. This paper was approved that the APA will conduct a feasibility study to determine the cost and means of creating an alternative process to certify physicians in the specialty of psychiatry. The committee was clear in rejecting the part of the proposal that the APA would run a credentialing program, stating a clear distinction in roles between the APA and the ABPN. The APA's role is education of members and the ABPN's role is certification. The APA has no interest in establishing a credentialing body that it manages. However, it was felt by the majority on the committee that understanding the cost of running such a program is worthwhile as the APA works with the ABPN to manage the cost of certification in a suitable way that is cost effective and that the ABPN not

make large profits from the running of the Maintenance of Certification program.

- Eliminating a Financial Barrier to the Article Based Assessment for Maintenance of Certification (MOC) for APA members. This paper was approved without changes. The APA will now endeavor to provide all articles required by ABPN for Maintenance of Certification (MOC) free of charge to all members.
- APA to Develop and Advocate for Life Long Learning (LLL) instead of Maintenance of Certification (MOC) for Professional Credentialing. This paper was not supported by the reference committee citing that the APA should not be involved in the credentialing process. The paper was withdrawn.
- APA Recommendations for Lowering Prescription Drug Prices. This paper was supported as written by the reference committee and passed on a voice vote.
- Rejection of the Term Provider and Client in Psychiatry. The paper was supported as written by the reference committee and passed by a wide margin in the Assembly vote. Some members, especially those in addiction psychiatry were opposed to the paper on the grounds that many of the individuals they work with prefer the term client and do not see themselves or refer to themselves as patients. Others were concerned the inflammatory comments about Nazi Germany could offend many members. However, the great majority supported the paper and saw the use of terms like provider and client as an erosion of the special relationship that exists between physician and patient.
- Staying in Our Lane? Aligning the 3e 13 Financial Contributions of the APA PAC with the Stated Policy of the APA Regarding Firearm Regulation. This paper was withdrawn by the authors. No reason was provided for the paper being withdrawn.
- Psychiatry Residency Position Expansion. This was approved by the committee and placed on the consent calendar without a floor vote. This action is taken when a paper is so widely supported and straightforward that Assembly debate is unnecessary.
- One Member One Vote for APA Assembly Elections. This paper was written and introduced by a reference committee member and sponsored by the committee's chair. Therefore, the reference committee abstained from taking a position on the paper. It was widely discussed in the Assembly but was defeated on an 81/87 majority

vote. There are two regions in the Assembly that feel their voting power has been eroded over the last 20 years by other restructurings of the Assembly and that passage of this paper would lead to a further erosion of their vote. Apparently, this topic has been introduced in some form in many assembly meetings since ACROSS was created. This is the closest vote that has occurred so far. It is likely a similar paper will be submitted again in future assembly meetings.

- Ability to Respond to Online Reviews. This paper was approved and referred to the ethics committee to create a process to respond to negative online reviews.
- Changing the Name of Borderline Personality Disorder (BPD). This paper was withdrawn because the reference committee did not support the paper. The committee cited that a process already exists within the DSM committee to make proposed changes and that the issue should be taken up through the appropriate channel with the DSM committee.

Many other issues were taken up by the Assembly in this session. Assembly approved funding to hire an outside consulting firm to help the APA improve public understanding of psychiatry. It was understood that the cost could be very high and will likely exceed \$1.5 million. However, it was widely felt that this is money well spent to educate the public and meet the needs of the APA membership, who often find themselves explaining to the public the differences between a psychiatrist, psychologist and other mental health practitioners. The wider issue of Maintenance of Certification (MOC) was taken up in multiple ways during the meeting. The president of the APA

came to the Assembly and spoke on the issue at length. She related that she and others in the APA are working closely with the ABPN to revise MOC policies and to make the MOC process less burdensome in terms of time and money and asked that members be patient because change will take time. The Assembly voted to make all articles used in the MOC pilot program available for free to all APA members and for the APA to provide CME credits for review of these articles during the MOC process. Three papers were introduced and two passed in support of the APA directly addressing climate change and the effects and potential effects on mental health, and a paper was approved to research/investigate partnering with another entity to certify a green medical practice that would involve paying a fee to the entity and show that green (environmentally friendly) practices are being carried out in the doctor's office.

Additionally, a paper introduced to request the DEA monitor all marijuana prescriptions in a manner consistent with other controlled substances was defeated as untenable and in contradiction to APA policy which states that cannabis is not a medicine. It was also felt that such a proposal could be an infringement on patient rights. Other papers addressed substance related issues and were approved supporting wider testing for substance use and supporting safe prescribing of controlled substances. Also, papers supporting the recognition of International Women's Day and a paper supporting guidelines for Emotional Support Animals were approved. Lastly, and importantly for the AAPDPP, a white paper proposed the formation of a pilot program to reduce APA dues for individuals who belong to both the APA and ACROSS organizations (like AAPDPP). If the pilot program is successful there will be a permanent reduction in dues for all AAPDPP members who are also members of the APA.

Update on OPIFER

By Joan Tolchin, MD



There is still room to register for the Seventeenth Joint Meeting of the American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP) and the Organizzazione di Psicoanalisti Italiani - Federazione e Registro (OPIFER) to be held October 19-20, 2019 in Florence Italy. The title of the conference is

“Psychiatric Practice and Psychoanalysis Today: In the Footsteps of Silvano Arieti.” The meeting venue is the historic Hospital of Santa Maria Nuova, founded in 1288, and the oldest hospital still active in Florence. The Academy Office has hotel information and registration forms.

Outstanding speakers at this meeting include Academy President, Gerald Perman; Past President, Silvia Olarte; and Academy Fellows, Daniela Polese and Richard Brockman.

The first Joint meeting of the Academy and OPIFER was held in Venice in 1999. The title of that meeting was

“Reciprocal Influences in Psychoanalysis: In the Footsteps of Silvano Arieti.” The subtitle was kept for all subsequent meetings. “In the Footsteps of Silvano Arieti” honors the eminent psychiatrist, born in Pisa, who was an Academy President and an Editor of its Journal and who is a strong link between the two organizations. Joint meetings have been held since 1999 in cities through northern and central Italy, such as Pisa, Bologna, Milan, and Rome.

Our Joint Meetings with OPIFER have enriched the Academy by bringing in many new members. More than a dozen outstanding Italian psychiatrists and psychoanalysts who attended these meetings have become Academy members. As a result of their participation in the Joint Meetings, at least three American psychiatrists have also joined, including Past President David Lopez, Dr. Charles Nemeroff and Dr. Craig Katz.

To date, we have 35 International Members of the Academy. Twelve of these International Members (34%) are from Italy and represent 2% of our total membership. It is my hope that the rich collaboration between the Academy and OPIFER will continue for many years.

64th Annual Meeting Thursday, April 23 – Saturday, April 25, 2020 Philadelphia, Pennsylvania

Psychodynamic Psychiatry and Relationships

By David L. Lopez, MD and Jessica Eisenberg, MD

The members of the American Academy of Psychodynamic Psychiatry and Psychoanalysis understand Psychodynamic Psychiatry as a discipline that has emerged from a fusion of psychoanalytic and extra-psychoanalytic psychology, neuroscience, and academic psychiatry (Psychodynamic Psychiatry 41(4) 511-512 2013).



Whether we are describing interactions between mother and infant, parent and child, teenager and group, adult and group, or romantic and sexual partners, most psychodynamic phenomena occur in the context

of relationships. It has been the purview of psychodynamic clinicians to develop a wide array of observations and conclusions that derive from relationships. Relationships and psychodynamics are the focus of this meeting.

Transference, countertransference, and the therapeutic relationship as a whole are considered manifestations and reflections of relationships that occurred early in life. The theoretical understanding and clinical proficiency that students of psychodynamics can attain in this meeting will enhance their ability to engage patients, understand their immediate and historical psychosocial reactions, help patients navigate complex life events, as well as care for patients with long standing mental illness.

The American Academy of Psychodynamic Psychiatry and Psychoanalysis is the APA affiliate society that provides this forum for psychiatrists and collaborates with social workers, teachers, and psychologists. The Academy is also a member society of the World Psychiatric Association. Our annual meetings provide an opportunity to interact in a collegial and enriching relaxed environment. There will be many opportunities for discussions since our presentations always leave ample time for audience participation. This meeting will also provide multiple opportunities to meet and socialize with experts in psychodynamic psychiatry.



Philadelphia is the birthplace or home of some of the finest leaders and thinkers in American history and is also the city that fostered

development of the ideas that constitute the foundation of our system of governance. In the mid-twentieth century Philadelphia became the bastion of many of the seminal developers of psychiatry and psychoanalysis. Our Academy now has the opportunity to provide an engaging and interesting gathering in this superb cultural and academic setting.

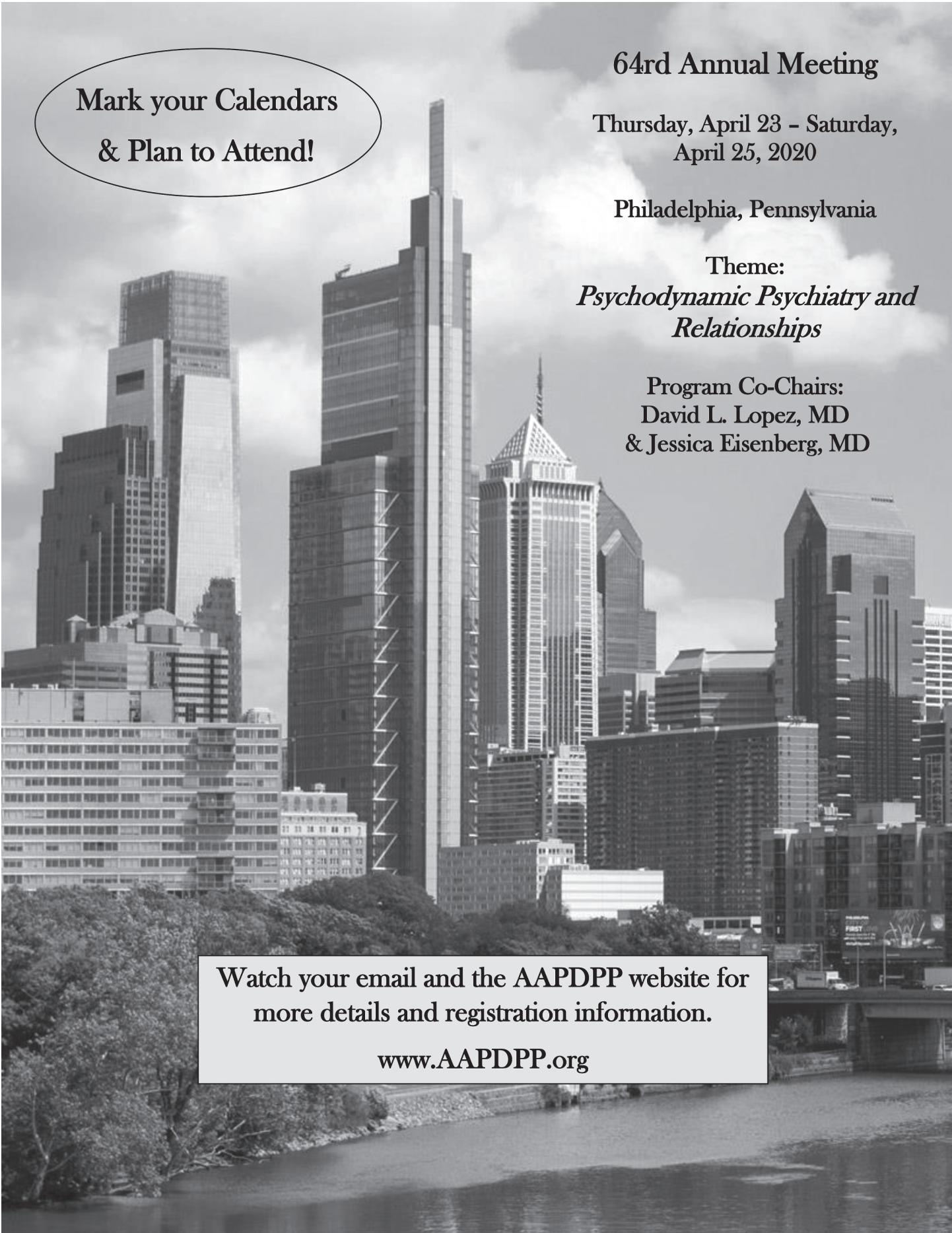
The AAPDPP leadership, its Program Committee, and the Co-chairs of this 64th Annual Meeting in Philadelphia, April 23 – April 25, 2020, wish to invite you to help us elucidate how daily work with patients is framed, informed, and inspired by Psychodynamic Psychiatry and relationships.

The Program Committee will review proposals for panels, paper sessions, symposia, and workshops. This year we are emphasizing our curiosity on presentations that are focused on experiential aspects of psychodynamic psychiatrists. Examples of such experiences could be:

- 1) Going through divorce, mourning, or transitions in life while in practice.
- 2) Having a parent, significant other, or a child who is physically or psychologically ill, and how this affects your work.
- 3) Balancing parenting responsibilities with professional responsibilities.
- 4) Disclosing personal views or experiences with patients.
- 5) Having a history of a traumatic experience with a family member or significant other, and assessing its effect on our work.

**Deadline for abstract submissions is Midnight on
September 30, 2019.**

For further information, please call the Academy Office at
888-691-8281.



Mark your Calendars
& Plan to Attend!

64rd Annual Meeting

Thursday, April 23 - Saturday,
April 25, 2020

Philadelphia, Pennsylvania

Theme:
*Psychodynamic Psychiatry and
Relationships*

Program Co-Chairs:
David L. Lope, MD
& Jessica Eisenberg, MD

Watch your email and the AAPDPP website for
more details and registration information.

www.AAPDPP.org

Teichner Award Update

By Sherry Katz-Bearnot, MD



The winners for this year's Teichner Award are Miriam Rahmani, MD, Training Director and Michael Shapiro, MD, Director of Psychotherapy Education (DOPE) from the University of Florida at Gainesville Child and Adolescent Program. They attended our annual meetings in May—

so you might have met them there. This year is the first time we have given the award to a child and adolescent program, but the application was stellar and the preparatory work they have done in their program has been exemplary. We felt we were offering our Award to a place where the seeds of psychodynamic psychiatry would find fertile soil. They chose Gene Beresin, MD, my longtime Co-Chair on the Teichner, as their Scholar. They had a plan to include the General Psychiatry trainees as well as the Geriatric Fellows in the visit.

We look forward to their reporting on the experience.

ARTICLES

The Media is Not the Message—the Relationship is: On the Effectiveness of Distance Treatment

By Robert M. Gordon, PhD ABPP

The fundamentals of a therapeutic relationship have not changed since Freud's day, but the opportunities for it have. Today psychodynamic treatment is available anywhere there is tele-communication. But how effective is it?

The China American Psychoanalytic Alliance (CAPA) through its Research Grant Committee has been supporting the study of this very complex issue. To research something with many interdependent variables is best accomplished with expert and consumer opinions.

Our first empirical study was published in 2015. Gordon, Wang, and Tune (2015) asked 176 CAPA faculty and treaters their opinions about the effectiveness of teaching, supervising and treating over videoconferencing (VCON) Chinese students and patients. Our results indicated that the faculty and treaters felt that, overall, VCON minimally reduces effectiveness and that individual client characteristics may be a significant factor in effectiveness. Most of the therapists in this study, about 60%, rated treatment of CAPA students over VCON as similar to in-person office work.

We then wanted to look at the issues that concerned the low raters of effectiveness. Gordon, Tune and Wang (2016) found that treaters who gave low ratings of treatment effectiveness (about 40% of treaters) felt that videoconferencing mostly did not compare well to in-person psychotherapy in exploring the mental life of the patient. Nevertheless, low raters of effectiveness and high raters of effectiveness generally agree that treatment over VCON is valuable since it offers high-quality treatment to underserved or remote patients, and it is valuable when the patient is house-bound or travel would be impractical.

Our next step was to assess the Chinese consumers of

distance training and treatment (Gordon & Lan, 2017). We surveyed our CAPA graduates who received their psychoanalytic treatment during their training. Ninety graduates who were currently seeing patients responded to our survey. They made excellent respondents since they are highly intelligent, high-functioning consumers with an unusual degree of insight and objectivity into the effectiveness of their training and treatment as compared to the average psychotherapy patient. We used the Comparative Psychotherapy Process Scale (CPPS) along with our survey questions. We found that distance psychoanalytic training was highly effective. The number of years of CAPA distance education correlated significantly with the number of years of personal psychoanalytic treatment, and also with the number of years working psychoanalytically with patients. The degree the graduates use a psychoanalytic formulation was best predicted by a greater number of years in distance education and the more days a week in personal therapy. This supports the idea that practitioners are more likely to become psychoanalytic in their clinical practice when they receive a longer period of training as well as intensive psychoanalytic therapy themselves. The graduates' ratings of how they are currently practicing psychoanalytic psychotherapy were highly correlated with how their own therapists practiced psychoanalytic treatment, as measured by the CPPS items. Graduates highly rated the effectiveness of their own psychoanalytic therapy over VCON.

The CAPA graduates thought that the therapist variables (warmth, wisdom, empathy, and skillfulness) were much more important in the effectiveness of their treatment than whether the treatment was in-person or with VCON, or the cultural differences with their therapist (1= not important; 7= highly important).

Warmth of therapist	M = 6.0, SD = 1.2
Wisdom of therapist	M = 5.9, SD = 1.1
Empathy of therapist	M = 6.4, SD = .85
Skillfulness of therapist	M = 5.4, SD = .96
Cultural similarity of therapist	M = 4.1, SD = 1.4
The use of video conferencing	M = 3.9, SD = 1.5

In conclusion, there is a good deal of support for distance training and treatment and that the issues of teletherapy and cultural differences seem to be minor and analyzable. However, what remains is the importance of the qualities of the therapist regardless of culture or media. The next issue that needs to be studied is what patient personality factors interact with the use of teletherapy.

References:

(Full copies of these articles are available on Research Gate or www.mmpi-info.com)

Gordon RM, Wang X, Tune J: Comparing psychodynamic teaching, supervision and psychotherapy over video-conferencing technology with Chinese students. *Psychodynamic Psychiatry* 43(4):585-599, 2015

Gordon RM, Tune J, Wang X: What are the characteristics and concerns of high and low raters of psychodynamic treatment to Chinese students over VCON? *Psychoanalysis and Psychotherapy in China* 2:86-96, 2016

Gordon RM, Lan J: Assessing distance training: how well does it produce psychoanalytic psychotherapists? *Psychodynamic Psychiatry* 45(3):329-341, 2017

Death Instinct and Knowledge: Newborn's Vitality and Early Intersubjectivity

(Article based on presentation at AAPDPP Annual Meeting 2019)

By Daniela Polese, MD

The concept one has of how the unconscious works is crucial in the practice of psychodynamic psychotherapy. As our objective is to draw psychodynamic psychotherapy to psychiatry, which is a medical discipline, we could use the term 'physiology' (from Greek *physis* = nature) to refer to the natural functioning of the unconscious. We can thus infer the existence of a corresponding physiopathology to refer to the loss of such natural functioning and to a therapy that can restore it.

I would like to highlight what we regard to be an advance and an innovation in the field of psychodynamic psychotherapy.

Traditionally, in psychodynamic psychotherapy, there is a shared consensus on the concept of unconscious as Freud defined it. For instance, Freud defined the unconscious as a chaos of primitive and perverted partial drives, going as far as considering children's unconscious as the unconscious that expresses itself in the most extreme way. In particular, in his *Three Essays on the Theory of Sexuality*, Freud defined children as "polymorphous perverse", "narcissistic" and "auto-erotic", as being unable to relate fully with the external environment and human beings. The authors who came after him and criticized him by moving away from his basic ideological precepts did not completely reject this concept.

For instance, over the past few decades, in the field of

psychodynamic psychotherapy, there has been an increasing interest in object-relations, and these have been essentially based on behavior—we can recall, amongst others, Hartmann and his "Ego Psychology" in the fifties—thus preventing further research into the unconscious. Indeed, no theory was ever formulated that could question the Freudian concept of unconscious. Melanie Klein theorized about newborn's schizoid-paranoid condition until 3-4 months of age, Bion introduced "the role of psychotic personality", Mahler spoke about "normal autism" and a constitutional psycho-physical splitting in human beings. She held, "The biological birth of the human infant and the psychological birth of the individual are not coincident in time."

What if the birth of the human mind coincided with the birth of the human body? Unlike what was stated by Otto Rank, who tried to carry out research into human birth in his *The Trauma of Birth*, in 1926, Freud wrote: "There is much more continuity between intra-uterine life and earliest infancy than the impressive caesura of the act of birth would have us believe... In this scheme of things there is no place for the abreaction of birth trauma."

I would rather not dwell on any criticism to or express my views about these positions but rather carry out the epochè Husserl was so fond of and consider a new line of thinking in psychodynamic psychotherapy. In 1972, *Death Instinct and Knowledge* by Massimo Fagioli, a psychiatrist, psychoanalyst and psychotherapist, was first published in Italy. The book has been recently translated into English. In the foreword to the first edition of the book, the author wrote: "Presenting myself to colleagues and to an increasingly greater number of enthusiasts of psychoanalysis with a book undoubtedly requires courage... Psychoanalysis has reached such a deep and broad level of knowledge and concepts as to make it extremely difficult to keep abreast of all authors' studies and publications. My efforts in taking part in current analytic debate are coupled with my efforts, which are essential, in continuously reviewing and elaborating the fundamental texts."

He continues, "It may sound a *priori* outrageous to add oneself to the list of those who, instead of limiting themselves to listening and learning, wish to be listened to as they think they may have something to say. This action, which might easily be dismissed as being useless and annoying, is basically justified by two reasons:

1. The relevance I could give to an unconscious fantasy, which I have never found clearly mentioned in books or in discussions amongst colleagues, although many, or rather a huge number of fundamental psychoanalytic concepts make reference to it. I am referring to what I have defined as the disappearance fantasy.
2. The second reason, which I find more difficult to explain, is, on the one hand, the desire for and the need to have a platform from which to start, meaning an organic, consequential and as far as possible coherent discourse on the basis of which I might then discuss and elaborate single issues, which could

only be done by expounding concepts in the form of a book; and, on the other, the desire to describe how my research and therapy are oriented towards a global approach to the human psyche.”

Please, refer to the forward to the first edition of the book for any further reference.

Fagioli theorized that the human mind forms at birth. Contrary to what has been considered to be true so far, according to Fagioli, biological birth coincides with psychological birth. The newborn's reaction to the external environment is immediate and biologically determined, as the brain's reaction to light. (The newly formed mind reacts with pulsion thereby making that which is inanimate disappear). Newborns react to the external non-human environment drawing on their vitality. Their physical vitality, which is measured based on their ability to react with the Apgar score, is linked to their mind's vitality. This does not result in a newborn's autistic closure but rather in the creation of an image, which derives from the contact a foetus's skin had with the amniotic fluid and the newborn's capability to imagine (which the author defined with the German term *Vorstellungvermögen*). This is a universal species specific characteristic and is there as from the very first few instants of life, as early as birth.

Based on a patient's dreamlike images, this image has been first defined by the author as “unconscious calm sea” and is the expression of the mnestic trace of the contact the foetus's skin had with the warm and calm amniotic fluid. This allows newborns to hope, be certain there exists another body, another human being like themselves. Newborns realize their own existence, and with it, the certainty that there is a breast.

According to Human Birth Theory, it is through pulsion, the so-called annulment pulsion, that newborns realize the disappearance of the external non-human world, whilst simultaneously making themselves disappear. However, their vitality makes the capability to imagine arise in them thus making them form an image. After they have realized the image, this will draw them towards the external animate and human world, which is similar to the trace they have onto their skin—and newborns will actively search for the breast. This is the reason why, in 2016, Fagioli wrote that newborns can be left alone for up to 12 hours, then, just as they will have to be physically nourished, they will need connection with another human being. This human being will allow them to develop their capabilities and qualities within the relationship. Human beings' non-material reality, meant as mind or thought, is physiologically fused with their material reality, their body, and this is true as early as birth. Thus, newborns are endowed with a natural tendency towards interhuman relationships, with intersubjectivity.

After they have been in relation with the other, or at the end of every suckling, newborns will separate with the memory-fantasy of the experience they have had and will increase their vitality and develop new internal images, which will combine so as to develop human beings' initial Self at birth. Through the relationship with the other during the first year of life, the qualities that are there as early as

birth will grow with the body, thus allowing the mind to develop until a complete psychic identity is achieved at weaning.

However, if the person the newborn relates to is disappointing, the newborn's original vitality, instead of increasing, diminishes. This may lead to non-physiological dynamics such as newborns addressing the annulment pulsion against the human world, the breast, others, and their own affections. This dynamic will result in the lack of affectivity.

A psychodynamic approach demands that therapists take responsibility towards their patients, given that they act as physicians to treat in order to cure an illness. By acknowledging a primal, physiologically healthy mental condition, psychotherapists have the role to help patients recreate it through an inter-human relationship within a setting that should differ from the unconscious relationship that contributed to the onset of the disease.

This requires that psychotherapists get actively involved in the therapeutic relationship. They should not remain silent, but rather express their presence through interpretation. Psychotherapists should interpret transference and dreams and do that in an unconventional way. For instance, based on this psychotherapeutic approach, dreams are not to be interpreted via free associations.

Psychotherapists should interpret the patients' unconscious annulment pulsion that aims at making the psychotherapeutic work that has been carried out disappear, while confirming patients' valid images whenever they appear. This will allow psychodynamic psychotherapists to slowly but continuously draw patients towards reality, which differs from patients' negations, projections and identifications. In this way they will wait together with patients for the reappearance of the “image at birth” and the vitality patients have lost, which represent the fundament of original intersubjectivity. This is based on the creation of images within early inter-human relationships that characterize human beings as early as birth.

Celebrity-ism in America

Peter A. Olsson, MD

What has been is what will be,
and what has been done is what will be done,
and there is nothing new under the sun.
Ecclesiastes 1:9

Celebrity-ism is the narcissistically saturated, psychosocial process affecting leaders and the led. It is based in a complex, societal reverberating, cybernetic phenomenon involving extensive narcissistic gratification, financial rewards, and notoriety for a political, entertainment, athletic, literary, or artistic leader-figure. The large group-self of a society is also gratified or mesmerized by vicarious emotional investment in the leader that is supported by hero or anti-hero worship and group think. Such profound focus on the leader involves bestowing him or her significant

power over the group that goes beyond good or original ideas, artistic creativity, or oratorical or athletic skill. Celebrity-ism seems inversely correlated with the decline in influence of traditional religious forms and church attendance.

The bright and dark sides of celebrity status

Many celebrities use their fame, stature, wealth and notoriety to sponsor very helpful charities to aid the sick, poverty stricken, and troubled souls among us. Their humility, kindness, and meaningful contribution to our society is an inspiration to Americans. When ex-presidents do noble and benevolent things, America's political differences experience some moments of healing.

What is it about celebrity, notoriety and fame that can distort, corrupt and degrade the conscience, morality and ethics of celebrities? Do some celebrities like Icarus, metaphorically and psychologically, fly too close to the sun? Why does the status of "star" stir the star's narcissism beyond healthy vocational satisfaction and self-esteem? Is star-power so seductive that it dissolves humility and moral integrity? How does inevitable human acquisitiveness progress to consuming greed and seeming inevitable worship of wealth as a source of fame, power and prestige? Do fame, fortune and celebrity seductively whisper to inner fantasies or illusions of invulnerability? Omnipotence? God-like immortality?

For example, Bill Cosby is no longer considered a humorist or positive role-model. He helped us to laugh heartily for decades. He and Felicia Rashad helped us to find joy and enjoyment in the family life of Dr. Huxtable. We grieved with Cosby at the tragic loss of his college age son by murder. Now, we experience collective shock, disbelief, revulsion and sadness at the reports of his alleged misuse of celebrity power via sexual abuse of many women. Was Cosby's star status located too close to the sun?

Or consider the billionaire celebrity George Soros, who has given voice to this sense of grandiosity many times and in a variety of different ways. In his 1987 book *The Alchemy of Finance*, for instance, Soros wrote:

"I admit that I have always harbored an exaggerated view of self-importance—to put it bluntly, I fancied myself as some kind of god or an economic reformer like Keynes or, even better, a scientist like Einstein."

Expanding on this theme in his 1991 book, *Underwriting Democracy*, Soros said:

"If truth be known, I carried some rather potent messianic fantasies with me from childhood," fantasies which "I wanted to indulge ... to the extent that I could afford."

In a June 1993 interview with *The Independent*, Soros, said he saw himself as "some kind of god, the creator of everything." He portrayed himself as someone who shared numerous attributes with "God in the Old Testament". Soros told his biographer Michael Kaufman that his "goal" was nothing less ambitious than "to become the conscience of the world" by using his charitable foundations. Some might say a leftist political conscience for the world. (Quotes abstracted from---www.DiscoverTheNetwork.org)

Politicians and celebrity-ism

American presidents have increasingly become celebrities over the decades. After they serve, they continue to gain wealth, notoriety and fame. Such celebrity status affords them opportunities to do good or to become or appear to be pathologically greedy deceitful, unethical or corrupt. A few recent examples illustrate the point.

Jimmy Carter, after a mediocre presidency, has distinguished himself by using his celebrity status to promote his foundation to foster efforts to resolve conflicts and violence between nations and groups. Carter has personally worked with Habitat for Humanity projects.

George HW Bush, our 41st President, has used his stature as ex-president to do fundraising to help victims of disasters around the world. He collaborated with Bill Clinton to help the victims of the tsunami in Indonesia. Such efforts also enhanced bipartisan cooperation. Bush is seen as a wise American elder statesman.

George Bush, 43rd President, has not spoken critically of president Obama, who came after him. Bush has also through his talents as painter and champion of Wounded Warrior projects helped troops wounded while serving under him—perhaps to assuage his guilt for sending them into two wars.

With Obama and Clinton, charm, charisma and abundant narcissism helped define their celebrity status. Charm may have as its earliest origin in the smile response that occurs normally at three or four months of human development. An infant's engaging smile helps caretakers to bond in delight with him. Some infants more than others have the gift of glowing smiles. In the Darwinian sense, the smile reduces any potential propensity to destroy or harm the innocent infant by a stranger. Barack Obama's smile says volumes before he ever says a word. Obama's boyish charm has helped him survive a difficult childhood. It also helped create and sustain his dazzlingly rapid ascent to political power.

Even as a boy Barack Obama possessed a winning smile and early gift with and command of words. His white grandmother whom Obama calls Tut (pronounced toot) thought, not without reason, that young Barack was a genius, especially with words.

In his book about Obama, David Maraniss describes Barack Obama's comment to the English class of Ms. Czurlis-Nelson at Punahou school in terms of terms of fear. Obama said, "... words are the power to be feared most... whether directed personally or internationally, words can be weapons of destruction."

As one observes Obama's verbal skills in action, it is impressive how he entwines graceful movements, a winsome smile, and a smooth charm that accompanies his powerful wielding of words. His verbal based charisma is significantly connected to the timing of his rising and falling baritone intonations. These seem studied and resemble other influential speakers like Bill Clinton, Martin Luther King, Jr. John Kennedy, and Billy Graham.

Barack Obama seems spellbound by the omnipotent fantasy of the imagined pure power of his words. It's as if the programs and policies he would establish, and their successful results, were already on record. Obama seemed to think that conservative Republicans had to yield to his word power—he would not play well with them. How could anyone disagree with the smooth magic of his words? Some pundits would say that Obama's presidency was heavy on words and short on effective action.

Obama's post presidency like his presidency is certain to be heavy on words and community organizing of America. Obama is likely to be critical of president Trump, who is undoing Obama's policies. Obama has already been criticized for accepting huge speaking fees and lucrative book contracts. Perhaps he will donate the proceeds to American charities and not merely to create clones of himself and his leadership style. Time will tell.

Bill Clinton was always the teacher's pet. First in His Class, as David Maraniss titled his biography of Bill Clinton. Clinton seems to enjoy implementing his political magic and speech-making. Clinton's supporters continue to adore him even after he flagrantly lied to America on TV and atrociously violated sexual boundaries. Clinton has done good things, but his Clinton Foundation has been significantly criticized for financial shenanigans. Clinton's huge speaking fees and related activities have raised both Republican and Democrat eyebrows.

Celebrity-ism, narcissism and other professions

The erosion of a celebrity's soul appears to get ever more active the longer the time period of his or her status ferments. The early years of famous performers and celebrities often reveal a delightful Billy Budd sort of innocence. Then over time, economic fortune and fame accumulate, percolate, and gain momentum—almost in direct proportion to the glitzy mirrors of TV and movie cameras. Remember Elvis Presley, Kurt Cobain and Michael Jackson towards their drug addled ends? The adoring fans, media, voters, entourages, and political minions won't dare dent their celebrity hero's narcissism by speaking truth to celebrity power. It is a rare celebrity who maintains sufficient humility, maturity and wisdom about the danger of falling in love with their own image or words. Billy Graham, Martin Luther King Jr., Harry Truman, George Bush 41, and Ronald Reagan are a few celebrity-leaders who avoided flying too close to the Icarian sun. Their good character trumped possible pathological narcissism.

A famous and highly successful Brooklyn Dodger pitcher once told the author, "Pete, in the early Brooklyn days we would have almost played for a keg of beer and the adoring applause of Dodger fans." As time went on professional athletes have progressively and exponentially been dazzled by their flight close to the sun of fame, huge paychecks and fan adoration. The quest for fame, fortune and notoriety have led readily to the use of performance enhancing drugs. Destroyed marriages and families, infamy upon exposure of their violations of professional integrity,

and even flagrant violation of the law occur among the jock "stars." Contemplate the careers of baseball players like Mark McGuire, Sammy Sosa, Bobby Bonds and Roger Clemmons or bicyclist Lance Armstrong. Some loyal fans say their hero's accomplishments and status as role models are not marred by their drug use. Other fans see such athlete's behavior as sad and reflecting negatively on their accomplishments and status as role models. Charles Barkley of basketball fame says to parents, "I'm not some role model for your children."

Many Hollywood "Stars" earn and accumulate huge amounts of money, notoriety, fame and, naturally, celebrity status. Some use their fame and fortune to contribute to good causes, programs and activities that greatly benefit American society. Other "Stars" live lives of debauchery, drug abuse and addiction. They become anti-heroes of irresponsible sex, marital infidelity and outrageous behavior which promotes their notoriety. They become vicarious heroes of antisocial or illegal behavior for their worshipping fans, especially immature teenagers and young adults. They seem either oblivious or defiant and egotistical about their behavior.

Some celebrities use their celebrity power to espouse largely liberal progressivist political causes. They state their political opinions simplistically, defiantly and without humility or thoughtful engagement about their ideas. They often chose the president, law enforcement or other authority figures in America. Their valuable bully pulpits often become rigid, opinionated and trash-talking.

Nowadays, even scientists become celebrities in lieu of their notable research findings or discoveries. TV and other forms of publicity easily push the envelope from the area of their research into the use of their work to advertise merchandise or promote causes or political opinions or applications. Professors that gain renown for the lectures and teaching become heroes for their students. They can be edged into commercial enterprises and platforms of political ideology because of their authority or status. Sometimes the authority of academics and scientists can helpfully inform and change society for the better.

Dangers can occur when "scientists" are surveyed about their conclusions regarding political or financial situations. For example, clinical psychiatrists were surveyed about whether to continue including forms of "Ego Dystonic Homosexuality" in their nomenclature. The diagnosis was voted out of existence. This highly politically charged diagnostic designation for some homosexual persons who were disturbed about their forms of sexual behavior and wanted to change it had to be labeled with some generic term about "Anxiety Disorder".

Another example has occurred when enthusiastic promoters of the alleged apocalyptic dangers of "global warming" or later "climate change" surveyed "Climate Scientists" about climate change's severe dangers. Those intelligent laymen or scientists, who differ with the political evangelists, are labeled "Climate Change Deniers". In fact, genuine scientific study and research is a process that is anathema to politics. Science discovers facts about the world

that exist on a dialectic continuum. As new theories and hypotheses emerge to be tested and researched, facts about reality change and are refined, refuted and/or challenged. Theories about climate change also change like climate itself. Politicians would best be respectful and humble about advances in scientific knowledge as are true scientists. Arrogant polemic use of science and scientists by politicians pollutes our society and culture. Good political science reveals that polling scientists is not good science or good politics.

Conclusions:

Our American celebrities take many forms. With the decrease in traditional religious icons and institutions in America, celebrities seem at times to be our new “modern” Gods. This situation should give Americans pause about being too worshipful about celebrities and wary about celebrity-ism. Celebrities are best when they maintain enough humility, integrity and effort to stay a cut above in their ethics, morality and behavior. The temptation to fly higher and higher toward the sun of fame and fortune is great. Americans are free, but we all are more thoroughly human than otherwise. Presidents and ex-presidents as well as other leaders because of their inherent celebrity status need to stay very mindful of the dangerous domains of celebrity-ism.

The Hungry Child: Reflections on Affect as an Underpinning of Behavior in the Medication Management of Children

By Edward M. Stephens, MD

The hungry child cries. The crying gives the caregiver information. “Feed me,” it says. After proper decoding of the message and a little feeding, there is a period of quiet as the child’s needs are met.

The “hungry child cries” is a metaphor. It speaks to the child’s expression of affect laden communication of needs. The metaphor can be extended in many ways that all have the same import: “the upset child” manifesting that something is wrong by shows of inattention, irritability, anger, aggression, school failure, withdrawal or impulsivity, which can all be ways of communicating about basic needs.

This picture may be an over-simplification of the complexity and variability of influences that underpin ADHD, ODD, DMDD, early manifestations of bipolarity and childhood depression before even taking into consideration the basic temperament of the child. On the other hand, it establishes a basic connection between affect, behavior and a basic understanding of the ways children manifest their calls for attention to basic needs. In each child and in every situation of protest in support of needs, the meaning of the behavioral messages has to be seen for what it “communicates” rather than being simply seen as “behavior” that needs to be managed, extinguished or controlled.

When we see behavior as an outward manifestation of an inner state, we also realize that the cognitive distortions that are offered as rationalizations for those behaviors are more congruent with the affect than the behavior. In other words, while the behaviors may be troublesome, even dangerous, at some level, the real action and a significant opportunity for healing is rooted in the affective state of the child. Correction of behavior and any accompanying cognitive distortions have a place. In the larger picture, those therapeutic endeavors may be of a second order in relation to the deeper messages of hurt, fear or depression.

For example, the dysphoria of the “hitter” can be usefully explored. In one way or another, the experience of “invalidation” of one’s worth is commonly found as a root cause. In turn, invalidation is often part and parcel of the systematic and systemic experience in the child’s life and any particular protest must be seen as against a background of life circumstance which, while not readily apparent in the behavior, is carried with the child as an underlying state of dysphoria that leaves the child vulnerable to perceived slights. Under it all, the child acted out his feelings of upset at being seen or treated “unfairly” by the other child. The child felt disrespected and demeaned by the actions of the other child.

Dysphoria, not feeling emotionally well, is at the basis of many dysregulated behaviors in children. It often manifests as aggression or antisocial behavior and tends to be missed or not seen as the engine of dysfunctional behavior. Dysphoria is often the last, sometimes the least considered, option in the face of “troublesome” behaviors when the troublesome behavior is usually the outward manifestation of the underlying dysphoria/depression.

What happens then in the management of the child is the “management” of the behavior, very often through powerful psychotropic medications. The child is controlled, for example, with Seroquel or Abilify and the like. The underlying affective disorder is then left untreated as the child’s “behavior” is controlled. This observation or any of the above is meant to dissuade the use of antipsychotic medications. It is meant as a caution to look deeper.

One of the major surprises of my work with children over the 50 years of my office practice has been the prevalence of childhood depression. It is often not even screened for or considered as a cause of the “difficult to manage” child.

As an antidote for this neglect, I have used a screening process in child evaluations that is quite simple, basically sensible, and often revealing of problems hidden in plain sight. My first question to the mother or father accompanying the child is: “What was your baby like when you brought him home from the hospital?” (I usually cradle my arms as if I were holding a baby when I ask this question.)

With this basic inquiry, I am trying to establish a base of affective and biologic functioning which will inform me about the serotonergic state of the child as an infant. Serotonin, of course, is considered to be the basic neurotransmitter responsible for a sense of wellbeing and the

basis of action of numerous antidepressants.

Some answers are, "Oh, he was a happy baby. He ate well, slept well and smiled all the time." Or I might hear another parent tell a story about trouble getting the "right" formula, problems with "gas", crying a lot or difficulty establishing a coherent pattern of sleep. A mother might respond, "We couldn't get him to stay asleep, and we couldn't seem to comfort him." There is an enormous variation of response to this basic question of "What was your child like when you brought him home from the hospital and what were the first weeks and months of life like?" I have invariably found that children who had difficulty eating, sleeping, or being consoled had further difficulties as time passed. They often reported terrifying nightmares, aggressive behavior toward other children, school refusal, anxiety, fearfulness or compulsive shyness.

Some other often neglected elements to be considered in the evaluation of potential childhood depression involve the physical and emotional state of both parents before, during and after the pregnancy. Was the mother or father depressed? If so, there is an increased likelihood that the child will either be depressed as a child or will experience depression at some point in life. Were the parents in good health or did they experience illness in the perinatal period? Were there any family crises such as divorce, death of grandparents, accidents, etc.? The father is included in all of these inquiries as there is incontrovertible evidence that his state of mind and physical health promote epigenetic influences on both the mother and the child.

Finally, while at times an antidepressant might not seem to be indicated as the parent's complaint or the school difficulty has focused on "behavior", no harm can be done with a trial of antidepressant medication. One of the difficulties encountered in this approach is that it is notoriously hard to get approval for a trial of medication in children because the kind of research necessary to support this use of medication is shunned by drug manufacturers, who are averse to the potential risks of legal jeopardy where torts are common and awards are high.

Hence, the clinician has to rely on "clinical experience" and the wisdom of years of work with children in order to initiate antidepressant medication with 3, 4, 5, and 6 year old children. The child psychiatric provider is faced with the same burden of absence of research support but somewhat less abhorrence in treating seven through teen patients. At the same time, absent full scale manifestations of depression (e.g., "I want to die."), the clinician is usually faced with more requests for "behavioral control" than treatment for an affective disorder.

In clinical practice in two recent settings, I was faced with these dilemmas and prejudices against treatment of the affective components of the children's lives. The first, CV, was an adolescent treatment center for boys age thirteen through eighteen; and the second, HI, was a day treatment center for boys and girls ages six through thirteen. At CV, while patients had a full spectrum of dysregulated behaviors, there was an almost uniform treatment response involving

major tranquilizers, Risperdal, Seroquel, Olanzapine with a reasonable smattering of medication for attentional difficulties.

A notable absence of antidepressant medication existed. The emphasis was on behavioral control and, as a corollary, cognitive behavioral therapy for emotional rehabilitation. Again, there appeared to be minimal direct attention paid to the underlying affective state of the child. It was as if the underlying emotional state of the child, like the force of gravity, was responsible for every material interaction in the physical world and, at the same time, an invisible force. The affective state, underlying the child's personality, is often as invisible as gravity. Over the course of six months of observations of treatment failure, children continued to be behaviorally dysregulated or treatment resistant. When they failed to comprehend or execute the cognitive skills taught, the question of depression was seldom, if ever, brought up as a treatment consideration.

In one case, XL, an eighteen year old who had been in residence for five years, still had to be watched carefully to prevent acting out of "problematic sexual behaviors" toward outsiders on trips, cottage mates and even toward female staff members. In turning eighteen, he had reached the limit of time at the facility and was "ready" for discharge with all the impulses in place that brought him to CV, i.e. Problematic Sexual Behaviors (PSB) toward younger siblings. With his discharge any acting out of his PSB in the real world would, more than likely, eventuate in his arrest and incarceration.

Several months before his discharge, I sat with him and went, as many others had, the serious consequences of his problematic behaviors on his release. However, working on the hypothesis that his impulsiveness and quest for pleasure through sexualized contact was coming from a wellspring of depression, I suggested that he start on antidepressants to pick up his mood and give him a better chance to manage his impulsiveness. My theory was that if he felt better, he would be less likely to seize opportunities for inappropriate gratification or excitement.

In this case, there were no outward signs of depression in a conventional sense. At the same time, seeing the behaviors as a metaphor for unhappiness seeking relief, depression, or at least unhappiness could reasonably be inferred. He accepted the antidepressant medication and the trial began. He was interviewed several times over the next few weeks and questioned specifically about his impulsiveness. He reported that it had diminished. He reported being able to be more reflective and self-contained in what had previously been situations that were an open invitation to offend.

The second child, MT, a thirteen year old girl, was admitted to the juvenile crisis center at CV for striking a matron at the foster home. She came with a history of oppositional defiant behavior (ODD) and sexual acting out while running away on several occasions. She entered the Crisis Center on Seroquel 300mg with the obvious stigmata of adolescent overweight produced by this medication.

In our initial interview she was pleasant, intelligent, cooperative and good hearted in her recounting of the

difficulties she had experienced over the last years in a series of foster homes in which she felt unhappy for mostly real difficulties of a child in these circumstances. I immediately sensed that the direction of treatment had been to control her behavior in spite of the disastrous metabolic consequences and that on this regimen she demonstrated very little improvement in the acting out of dysphoric senses of herself. While not depressed in the interview, she was giving clear and repeated evidence that her life was not working for her in ways that left her feeling bad and seeking a way out.

I only had a month to work with her. Over the course of a week or so, I reduced the Seroquel and dealt with her complaints of having difficulty sleeping by seeing her every day to the point where, after a few days, she reported “feeling better”. At the same time that I was reducing the Seroquel, I introduced the antidepressant desvenlafaxine and titrated it to 100mg. There was a noticeable improvement in the underlying agitation that had brought her into this treatment setting. At the same time, she reported having more energy and feeling less foggy.

Over the same period, with daily observations of her school performance, it became clear that she struggled with classical symptoms of Attention Deficit Disorder (ADD) and, accordingly, I began the psycho-stimulant medication Adderall. During the course of four weeks, her Seroquel was reduced to 25 mg at bedtime for sleep, and she was being maintained on 100 mg of desvenlafaxine and a small amount of Adderall. By the end of the month, she was like a new child. Throughout the entire month, there were no untoward behaviors. In fact, on Christmas Eve, the Doctor found her decorating the Christmas tree with the younger children following her lead. Not only was she regulated behaviorally, but she was also happy. It definitely also helped further that staff members at CV were both knowledgeable and nurturing.

In effect, what had previously been managed as primarily a set of behavioral problems was dramatically and positively affected by a reduction of a medication that produced sedation in the hopes of control and the introduction of an antidepressant. Additionally, careful management of her school performance picked up and treated attentional components, which are known to be associated with depression. Worth noting, the concomitant use of psychostimulants and antidepressants is not unusual as about 50% of children with ADD either have or develop clinically significant depression.

In the second treatment facility for six to thirteen year olds, HI, after a review of the medication records of their children, the same pattern of lack of attention to depression and aversion to antidepressants was apparent. The predominant treatment modality was with major tranquilizers aided by alpha adrenergic blocking agents (e.g., Guanfacine) for agitation and impulsivity. Depression as a cause of dysregulated behaviors was barely considered as evidenced by the pattern of medications.

It was clear that the children, by and large, came from emotionally invalidating homes and life experiences that

would be fertile ground for depression in almost anyone. So this paucity of treatment for depression was an anomaly. This impression was born out over the intervening weeks as I interviewed each of the children and found many instances where depression or another mood disorder was at least as likely to be the underlying the dysregulated behaviors as any thought disorder requiring management with major tranquilizers.

Over the course of my time at these two institutions, similar attempts were made to reduce reliance on antipsychotics and introduce treatment of, perhaps, more fundamental emotional issues. Since both situations were short term and not clinical trials, the opportunity for actual statistical analysis of the outcome is limited. What can be said again for emphasis is there was a paucity of treatment of depression or a prejudice against such treatment as if depression were more of a stigma than bad behavior.

In conclusion, the possibility of depression, latent or overt, as an underlying driving force in dysregulated behaviors needs to be considered. In most cases, apart from serious known pathology such as psychosis, a high level of suspicion needs to be maintained regarding depression as a driving force for “bad behaviors”. We need to return to the principles of treatment to promote mental health in the face of the current focus on controlling “behavioral health”. In the current climate of treatment, it is as if “behavior” was the disease rather than the outcome of an underlying affective state.

Features from the Psychiatrist WellBeing and Support Project

The two pieces below will appear on AAPDPP.org. The Task Force invites Academy members to submit accounts of stressful experiences, personal or professional, especially those that might offer benefit to other psychiatrists in similar circumstances. To protect privacy, narratives are generally anonymized and disguised. Also, we welcome commentaries that might be added to material already on the site. Finally, if you have interest in material presented and wish to discuss its content with the author, we may be able to arrange that contact. Please direct all correspondence to dhingrammd@aol.com. If you have interest in the presentation below by John Tamerin, MD, please write to him directly at jtamerin@optonline.net.

Douglas H. Ingram, MD, Chair, Task Force on Psychiatrist WellBeing and Support

Visit the AAPDPP website:
www.AAPDPP.org

The Child with Bipolar Illness and the Unique Value of Peer Support

By John S. Tamerin, MD

Challenges come in many forms. Perhaps few are greater than the profound illness of a child and the helplessness that a parent feels. I don't know if the challenge is greater or less when you are supposed to know something about how to solve the problem, and then discover how helpless you really are. As the parent of a child with bipolar disorder, I know what that feels like.

My son's illness began over 25 years ago. My son was diagnosed correctly with bipolar disorder which, at that time, was still called manic depression. His life was chaotic and several times he threatened privately and publicly to harm me. Once, he threatened to kill me.

I had been a board-certified psychiatrist for over 20 years and had treated hundreds of patients. Presumably I, of all people, should have been prepared for this challenge. The truth is, I wasn't.

He received the best available professional help – medication and psychotherapy – from a number of highly competent psychiatrists and was hospitalized 3 times at excellent facilities all in the New York area. Sadly, and tragically for him and for me, none of this was effective.

At first, I was not able to recognize and admit that it was not just my child who needed healing. I needed help as well. For quite a while, I chose not to discuss the issue rather than honestly facing my personal anguish, my fear that he might be killed or kill someone else, my helplessness, my anger and, sadly but honestly, my shame with my son's illness and its seeming insolubility.

When I couldn't find any solution for my son's illness despite over a half dozen attempts at treatment and several hospitalizations which extended over a 10-year period, I thought that perhaps I might be able to do something more that might help others with this disease including suffering parents like myself.

Long before this type of information was readily available on the internet, I searched for any existing support programs that might assist other patients like my son or parents like me who were struggling with their loved one's depression and/or bipolar disorder. I learned that there was an organization with that specific mission based in Chicago which had been started in 1985 by Jan Fawcett, a psychiatrist who encouraged a number of his own patients to start a group to support one another. This had grown in 15 years into the Depression and Manic Depression Association with chapters in a number of states and many support groups around the country.

With help from the national office, a few of us started a chapter and a support group in Greenwich, Connecticut in my home office. Since our first meeting in the fall of 1999, our group has held almost 1,000 meetings which occur every Friday afternoon for two hours. Groups are regularly attended by 20-25 members who may be either suffering

with depression or bipolar illness or may be a loved one of someone with these conditions.

I have been consistently impressed by the group's ability to accomplish a number of functions that I could not have achieved by myself or for myself. Some of these have been cited in the evolving literature on the efficacy of peer support groups. Among many benefits, participation in these support groups has resulted in our members reporting diminished feelings of isolation, anxiety and hopelessness, and an increased ability to accept and address their problems and their pain without blaming themselves or others.

Over the past 20 years our small group in Greenwich has helped many people, myself included. I never realized how much I needed the support, the wisdom and the guidance of other parents and patients. Together we learned not only how to cry but how to laugh. From despair we learned to rekindle and renew hope and in helping others we learned how to ultimately save ourselves. Perhaps as an optimistic aside, I should add that my son, an excellent tennis player, is doing fine. We play competitive tennis together at least twice a week and I have to admit that on the tennis court he often kills me!

This account has been on our Greenwich DBSA website for close to 20 years as my "Founder's Statement." My son is well aware that this group in Greenwich exists only because of his illness and that hundreds of patients and their loved ones have been helped. Neither of us have any shame but rather pride in his recovery and in my commitment to facilitate a pro bono support group that has met weekly for 20 years that has literally saved dozens of lives.

Over many years I have witnessed the transformative value of peer support. So, when the issue of physician depression and burnout became a national concern and an issue of great interest to Anita Everett, our past APA president, I spoke with Rick Summers, whom Dr. Everett appointed to be the chairman of a newly-created special task force on physician wellness and burnout. Rick invited me to serve as a consultant to that committee.

One of the recommendations of the committee was that psychiatrists respond to this crisis by developing specific programs to address these issues within their institutions and organizations. I felt that an ideal place to carry this message and a setting where it might be successfully implemented was our own organization as I have found AAPDPP to be a particularly caring and congenial community, and small and nimble enough to be able to implement these ideas.

Eventually, this initiative led to the development of an Academy website with specific, carefully selected and solicited articles addressing a wide range of stressors in the lives of practicing psychiatrists and offering strategies to deal with these potentially painful situations. Along with the help of a committee of dedicated consultants, a substantial work product of easily uploaded articles has been produced, the site Psychiatrist WellBeing and Support. This will undoubtedly help our members deal with a wide range of stressful situations that they are likely to encounter at some point in their professional careers.

I would like AAPDPP to go further. My vision is that someday one of our members who is struggling and suffering as I was 25 years ago could speak to another member in any part of the country who had experienced a similar stressful situation and talk about his or her pain, and receive the kind of support, caring and wisdom which emerges from the type of shared personal experience that I and others receive every week in our support group in Greenwich.

Furthermore, I believe that this type of human interaction would result in lifelong friendships, deepen commitment to our organization both by those who request help and those who offer it and serve as a relevant factor in attracting new members who would see AAPDPP not only as an organization where members met once a year for intellectual sharing and stimulation but as a uniquely caring community of colleagues and an organization which could significantly enhance the quality of their lives.

It should now be quite obvious that my primary goal at this stage in my life is to reduce stigma of bipolar and other mental disorders, so that more people, whether they be colleagues or laymen, can accept this diagnosis in themselves or a loved one and commit to a regimen of recovery rather than hiding in the shadow of shame.

Residents Roundtable: The Psychiatry Resident's Immigrant Experience

By Douglas H. Ingram, MD

Towards the end of this academic year, I was invited by Scott Schwartz, MD to chair a roundtable discussion of resident psychiatrists, nearly all immigrants, about their "American experience." Scott is Director of the New York Medical College's

Psychoanalytic Institute and the residents all from New York area hospitals are students in its psychodynamic psychiatry program.

I had a thin acquaintance with some of the residents from classes I taught at the Institute. I valued Scott's invitation, but I know nothing of the immigrant experience. At most, I swear indignantly at the plight of migrants at our southern border. I am cloistered in the pleasant predictability of a private Upper East Side practice. I decided to put my ignorance into the service of learning about the immigrant residents' experience. I'd ask them to teach me about their circumstances.

I was greeted by fifteen or twenty residents. Scott introduced me and started off asking what it was like to be an immigrant in a psychiatric residency. One woman offered to start. She said she was Jordanian and had come to the U.S. several years earlier to study psychiatry when her husband, a Sudanese, was accepted for a CL fellowship. As it turned

out, his fellowship and her residency were two hours distant. With their two children, they could meet only on weekends. They have no family support. Since they are from different countries, they need to meet with lawyers every month. Visa status, I learned, needs constant attention.

I also learned that 35% of residents and early career psychiatrists are foreign medical graduates, a large proportion of them immigrants. Most of these residents have J-1 visas. This means, as I also learned, that on completion of residency the newly minted psychiatrist needs to either return to his or her home country or work for three years in an underserved area in the United States. Doctors choosing the latter course may then apply for a Green Card becoming legal permanent residents. Five years later they can apply for citizenship.

I soon realized that the residents announced themselves not by their name, residency program, or areas of interest, but by their immigration status. They had visas, Green Cards, or had become citizens. Yet even those who had acquired citizenship keenly felt their immigration status. With sudden intensity one resident announced, "I am an American citizen. I came here ten years ago. Nevertheless, I feel lonely. No matter that I am a citizen and have a family—if you are an immigrant, you are always an immigrant. My dream was to be a doctor in America. I accomplished my dream. But I am alone." Another resident, a citizen born in the United States, but whose father was an immigrant, agreed. She underscored how much the immigrant experience—regardless of Green Card or citizen status—shapes the future. The shadow of alienation is persistent.

Increasingly, I could sense the challenge these residents encountered. One resident, the Jordanian, said, "Resilience is very important for us. I've seen people who get sad, who go back to their countries and even become suicidal. Residency directors don't appreciate what we go through. And the residents who come here don't realize how little they know of what they are in for. The residency program directors and department leaders are not fair to foreign medical graduates."

One man highlighted the fortitude and initiative of many of the residents: "For me, it has always been about the visa. Always the visa. I came as a student with an F-1 visa. When I applied for residency, about half the programs were closed to me. I'd read at the bottom of an application something like, 'We will not accept you if you are here on any visa.' So, I studied for a Masters of Public Health. I was on a student visa, after all, and could stay on as a student. I was feeling very lonely. My sister said I should come to New York. I transferred my student visa to another program. I got what's called an 'observership'—shadowing a physician—which eventually got me into a residency. But it took three years. I went from visa to visa for a very long time. I am still on a visa."

There was no humor, no joy. The group was deadly serious until another woman told her story. An American, she said, had proposed marriage to her some time ago. She didn't trust the relationship and feared the marriage might break up. She refused to marry the man. If she married, she'd live with the

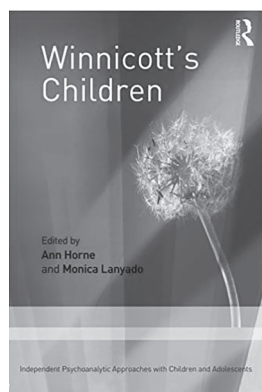


accusation that she married solely to get a Green Card. She stayed in her residency on a visa. Later, she said, she did get married.

As if in unison, the group called out, asking, “Who did you marry? The same man?” “Yes,” she said, “The same man.” The group cheered and laughed with delight. A wonderful note to close the evening’s discussion!

The next morning, I walked to my office a bit disheartened at what now seemed to be the uncomplicated privileged upbringing, schooling, family and professional world that I had lived. I envied the hard challenges the residents had faced and were still facing—their perseverance, courage, initiative—their successes. Soon, by the time I stepped into my office, I identified my reaction as romantic fallacy. I felt much better.

BOOK REVIEWS



Winnicott's Children: Independent psychoanalytic approaches with children and adolescents, edited by Anne Horne and Monica Lanyado, Routledge, London and New York, 2012, pp. 206

Reviewed by Ed Malewski, MD

At a time in the history of child and adolescent psychiatry that psychiatric treatment is reduced to 10 minute “med checks,” antipsychotics are the treatment for deprived and hostile children, and diagnoses are derived from checklists, it is refreshing to become reacquainted with the man whose interventions are not so bound by demands for efficiency, conformity, and detachment. The most difficult and complex cases in child mental health care require a far more empathic, inquisitive, interactional, and time-intensive approach.

Fortunately, *Winnicott's Children* provides us with clues to making this approach worthwhile and productive. Unfortunately, however, many child clinicians do not even know the name of Winnicott, and at best have a limited understanding of his most meaningful contributions such as that of “transitional object” and “facilitating environment.” For instance, a transitional object may be thought of as just a teddy bear or a pacifier—something to reduce separation anxiety—and a facilitating environment may be understood as a permissive place that responds to the wishes of a child. In reading *Winnicott's Children*, however, we find a comprehensive collection of writings that from the beginning takes us into a far more profound experience of Winnicott’s thinking. Throughout the book, a world is revealed to us in which a facilitating environment can be as disturbing as it is comforting, where anger and hatred are not always so frightening and can become signs of hope, where withdrawal and withholding can be as revealing and poignant as a good

dialogue, and where interacting with children may provide more information than talking with parents or undergoing screening tests. In this way, *Winnicott's Children* opens our minds to Winnicott’s insight into the mysteries of attachment and effective communication, whether for the purpose of psychoanalysis or medication management, whether for parent education or treating the most challenging disturbances. Again, it is refreshing indeed to be reacquainted with Winnicott who recognizes so well that the unconscious holds meaning, that silence cannot be rushed, that protest should not be silenced, and that understanding is something created between two people.

Winnicott's Children is very much an inspirational and experiential book. In what may initially seem unnecessarily repetitive, the opening contains a forward, a prologue, and an introduction. These parts nicely come together, however, not to present a coherent overview of essential concepts, but to create more of an immersion into a patchwork of Winnicottian ideas which ultimately point to the intricate and challenging beauty of doing psychotherapy. Starting with this section and developing throughout the many examples in the book, we are reminded that the therapeutic process is often a tentative and uncertain one, depending not so much upon what is said, but what is made of the dialogue between therapist and patient, thus guiding and allowing the participants to experience and acquire the wonderful ability to play—that is, to be flexible and adaptive. *Winnicott's Children* clearly illustrates that this dialogue is not very unlike what one also strives for in supervising therapy or in becoming a good-enough parent—activities both of which require some spontaneity, curiosity, an acceptance of the unknown, and a willingness to listen carefully and proceed despite the lack of assurance that you understand exactly where you are going. Winnicott, we learn, is all about listening without the predetermined outcome.

Winnicott's Children is also a practical book. The examples provided are relevant to our work with the complex children whom we now see in community mental health programs, detention centers, hospitals, foster homes, and residential care. They are the severely traumatized, neglected, and rejected children who act out their disturbing experiences on the world around them and who typically require medications to dampen the intensity of their memories. They are the children who do not even know how to play, or communicate, or relate. They are the ones who do not have the wherewithal to follow directions, rules, or laws. Their parents may be negligent, ill, abusive, ordinary, or just confused. Fortunately, the authors of this book are enthusiastic therapists and psychoanalysts with broad and extensive experience in teaching, writing, and working with these same demanding children and their families in their communities, schools, and placements. Since Winnicott also worked with such children in all the same settings, the authors see themselves in a way as Winnicott’s children, as they aspire to walk in his footsteps and use his psychoanalytic principles, object relations theory, and real-life suggestions.

Winnicott's Children is comprised of 12 chapters divided into three sections: Concepts, Transitional Themes, and The Outside World. The first chapter is actually outside this schema and is an abbreviated biography mostly of Winnicott's developmental and psychoanalytic thinking based on the influences of Melanie Klein, Anna Freud, and John Bowlby as well as a brief presentation of his pediatric and school work, government policymaking, and his creative therapeutic tools such as the Squiggle Technique. The information in this chapter is fairly cursory and one can find a much more in depth overview of how his ideas developed from authors such as Grolnick or a much more personal and poetic biography from his second wife, Clare.

The first section on Concepts is really about communication in one form or another. In this section the authors describe the need for psychotherapists to be attentive, authentic, and conversational in their dialogue. They also clarify the importance of mirroring in early development, illustrate the nagging internal dialogue between therapists and their "hate" countertransference, and point out the haunting influence of bodily memories guiding the thoughts and actions of the child. The chapters of this section are full of engaging case examples that completely immerse the reader in the subject. Especially outstanding is Chapter 3 which delves into the tension a therapist feels in trying to respect silence and avoidance in a patient while juggling between the tendencies to withdraw or become intrusive. This struggle is nicely portrayed through a close look at the well-known Winnicott aphorism: it is a joy to be hidden, a disaster not to be found. Chapter 4 on mirroring is equally outstanding as it describes the immense importance of a mother figure being present and interactive with the child from the earliest moments in order for the child to develop affect regulation, empathy, and a sense of reality. Winnicott's ideas here clearly seem to be supported by research in neurophysiology regarding mirror neurons as providing a bridge between the body and mind, behavior and thought.

The middle section on Transitional Themes provides a more concrete view of transitional phenomena and the facilitating environment in the creation of change. Interesting in this section is the inclusion of how mindfulness techniques and psychoanalytic supervision both could encompass the same kind of experiences attributed to the transitional space. One thoughtful conclusion is that psychoanalytic training is really beneficial not just for learning psychoanalysis but for learning any type of treatment which aims to be thorough, creative, and revealing.

The final section on the Outside World looks at milieu therapy, school consultations, parent counseling, and dealing with adolescent issues. This section illustrates how Winnicott's methods differ from the formulaic, behavioral approaches seen on such popular reality television programs as "Supernanny." Parents and others working with difficult children are often driven by the need to control or alter the child using all of the latest techniques. The ideas offered here are more about how to think over a situation in a way

that can lead to a more meaningful and relevant solution. In either case, caregivers often will not be satisfied without some "tips" and specific advice. In this section, the authors note, however, as Winnicott had done previously, that when dealing with the antisocial adolescent in particular, all suggestions will fail if familial and environmental concerns are not addressed first. Is there a home that provides boundaries and non-retaliatory responses to behavior, is the environment safe, is the school engaging and encouraging? When all is said and done, we are left with the thought that working with parents of adolescents often just comes down to helping them tolerate their children.

My only criticism of *Winnicott's Children* would be on behalf of readers who are not that familiar with Winnicott's basic terminology and theories. For these readers, this book will not provide much instruction, and I would suggest an examination of such books as Grolnick (1990) and Winnicott (1978). Otherwise, *Winnicott's Children* is truly a gift to all of us who have struggled with how psychoanalytic principles can be integrated into current, everyday practice of child psychiatry, to all of us who question ourselves about whether to speak or to be silent, and to all of us who vacillate between adhering to a set of plans and rules or allowing the patient to lead the way. This book, however, is not only about therapy but is also about teaching, supervision, consulting, and influencing the political environment. These were areas Winnicott deemed equally important and areas that point to the urgent conclusion of this book, especially living under the current specter of such things as child detention camps and lifetime prison sentences for young adolescents: that the dissemination of understanding is perhaps the most critical function for the child psychotherapist of the future.

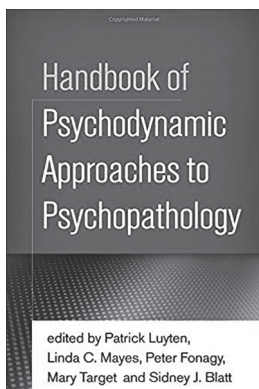
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Handbook of Psychodynamic Approaches to Psychopathology
Ed. Patrick Luyten, Linda C. Mayes, Peter Fonagy, Mary Target, and Sidney J. Blatt.
The Guilford Press, New York; 2015. pp. 578.

Reviewed by Jo-Ann Elizabeth Leavey, NP EdD C.PSYCH.

In this highly acclaimed handbook, the editors and

authors have done an extensive review and presentation of psychological disorders that may be experienced across the child, adolescent, and adult spectrums. The authors built their presentations on research materials largely based on traditional approaches mixed with some contemporary viewpoints. Interspersed with theory, models, and concepts, the authors provide case examples to illustrate understanding and treating psychopathology from a psychodynamic viewpoint.

This text is informative on a foundational level for beginning students, whereby the chapters present an overview of psychopathologies, classifications, interventions, and consider possible future directions for children, adolescents, and adults. The chapters attempt to integrate a broader view that incorporates traditional, foundational, and contemporary thinking from neuroscience, social psychology, attachment theory, and cognitive behavioral sciences. The authors should be lauded for their attempt at pulling together vast fields of research in largely un-integrated and diverse fields of thought and approaches.

It is pointed out in Chapter 25, Future Perspectives, that diagnostic concepts are increasingly more integrative, transdiagnostic, and developmental. However, we need to be cognizant not to lose touch with the broader scope and orientation of a psychoanalytic/ psychodynamic approach, which is informed by society, culture and other factors. Chapter 25 further illustrates the need to consider more efforts to balance knowledge from diverse fields to pursue an even broader understanding of human function. Chapter 25 identifies that the boundaries we now experience between fields may in fact evolve and emerge into a new transdisciplinary approach, focusing more on how interventions change functioning in the areas of biology, interpersonal relations, and self-definition. I would even argue that we need an epi-disciplinary view or perspective that evolves over time.

As a first step, and although not a theoretical aim of this textbook, sex and gender modalities, lived experiences of youth and children, and adults, trauma-informed research and practice could perhaps be identified and incorporated into the 2nd edition, providing a more inclusive look at intervention, change, and recovery. It might consider how dynamic psychoanalysis can perhaps facilitate an epi-disciplinary transformation into self-discovery, recovery, and beyond.

I highly recommend the text for foundational knowledge for beginning students, clinicians, researchers, and theorists of psychodynamic psychoanalysis.



STILL TIME TO REGISTER!

Seventeenth Joint meeting of the American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP) with the Organizzazione di Psicoanalisti Italiani Federazione e Registro (OPIFER)

Dates

October 19-20, 2019

Location

**Hospital of Santa Maria Nuova
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**To registration or for more details
contact Marie Westlake at the
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IN MEMORIUM



Eulogy for Mariam Cohen, MD

By Barry Schnur

Mariam was a complete person composed of many elements which might have been seen as complete in their own right.

At the Shul, over nearly two decades, she was a regular—Sunday morning minyan, Wednesday morning minyan, Friday night Kabbalat Shabbat (these were services I attended with her regularly), and Shabbat morning services where she read Torah at least once a month for years. Even with her terminal cancer illness, she tried to persevere reading Torah once in the summer and once in the fall. Clearly her presence will be missed.

People at the Shul also may have observed another of her worlds at play. She crafted Torah covers and the parapet as well as wall hangings. In fact, one of her legacies will be a new Torah cover for the third Torah when the Shul has that in hand.

So, people at the Shul know that Mariam very well. They also might realize that one of the frequent sayings at the Shul, “There is no they here, it is all we” was coined by her. I noted the crafts work—this house has many of her works on the walls, needlework and photography. Mariam’s craftwork inventory over the years got seriously extensive. There are a number of completed pieces in inventory which are not blocked or framed but could be. As a photographer on our many trips, Mariam took thousands of photographs which she filtered into scores of photo books stored in the house. Her craftwork also was the work of a “complete” person, and there are communities who know her that way.

Then there is Mariam the psychiatrist and psychoanalyst, a working profession and passion for Mariam, which spanned over three decades. During that time, she helped scores, maybe hundreds of people through their troubles and into be better emotional and mental places. This work, of course, was private. As her husband I had a small window into it, made a bit larger by my interactions with former patients during Mariam’s struggle with cancer.

Regarding Mariam as a psychiatrist and psychoanalyst, she was more than this, she had an academic bent as well with numerous published papers, reviews, presentations, and her work on the Board of Directors of a major organization—the American Academy of Psychodynamic Psychiatry and Psychoanalysis—along with several years’ work as Editor of the Academy Forum. So here too, Mariam was a “complete person” integrated with a caring and appreciative community.

Mariam’s ongoing work here in Tempe, even while dealing with her cancer, is reflected in an article published in the March 2019 American Journal of Psychoanalysis, and another paper presented at the last conference meeting of the American Academy of Psychodynamic Psychiatry and Psychoanalysis, which she had hoped to attend. That paper was a reflection on her dealing with her cancer over a period of months and was presented by Douglas Ingram, Past-President of the Academy, with tears in the eyes of many. At that conference she was also awarded the organizations’ 2019 Presidential Award “in recognition of deep devotion and tireless service.”

So, OK – a lot of “full person” there. But Mariam was more than that: she became entranced into the field of religious studies in her 50’s. She earned her Masters Degree in religious studies and then her PhD in religious studies in her 60’s. She did this while doing all the other “full person” activities noted above. She taught classes at Arizona State University, including two courses she created. She concluded her teaching association with Arizona State in the Spring of 2018 with the onset of her cancer.

In addition to her thesis and dissertation, she published numerous papers in this field. In some cases she integrated her religious studies perspective with her psychoanalytic perspective and training to produce truly unique papers, which addressed the interstices between two fields that often look away from one another. Again, this is yet another “full person” of Mariam.

There are some people at the Shul who shared her interest in academic religious studies and so that could see the multiple worlds of Mariam. For that matter, Mariam integrated that academic orientation into her study of Talmud with others in the Shul.

And of course, with all these Mariam as a full person, there is this other major full person Mariam. Mariam was my wife of more than 38 years. That full person shared portions of those other “full person Mariam” components, but also shared her life with me in ways that are now deeply ingrained in my person. We lived a long and full life together, with much joy, a little sorrow, a lot of major shared traveling noted by thousands of photographs along with a lot of life. Even though this was a long and full life, when the diagnosis was made last April, which we knew was a when, not if, we wanted more.

With all that, Mariam was a reader and a collector. Over the last several months of her illness, we and then me by myself, packed up literally thousands of books to be donated to one group or another. She had a major collection of mystery books, paperback and hard cover— thousands of volumes. She had perhaps one of the largest private libraries of psychiatric and psychoanalytic books in the state, again, thousands of volumes. She had a very large collection of books regarding religious and Jewish Studies, again among the largest private collection of books in the state. She also had, undoubtedly, the largest collection of religion and psychology books and the largest collection of conversion to Judaism books in the state. Further, she likely read most of her collections. As I have packed away these enormous collections, I have been reminded of just how voracious a reader (and collector) my wife was.

So, to be honest, as we celebrate the fullness of Mariam’s life, I must admit to having a feeling of being cheated of more time with all the worlds of Mariam. I feel that loss intensely. I suspect the other communities of the “full lives of Mariam” also feel that loss and that is something we can all share.

Me, Mims and the Academy

By Gerald P. Perman, M.D.

President, AAPDPP

I knew Mims in the Academy for many a year
As soon as I joined, she brought me good cheer.
She was Editor of the Forum,
with whom I worked alongside,
Until I too became Editor of this publication dear.

Mims was complex, her road not easy to travel
And for a long time, her world, it did not unravel.
Into Christianity she was born, she later became a Jew—
Sensitive to the mind, the soul, at both did she marvel!

The Academy became a central part of her life
A trustee three times, she resolved administrative strife.
She and I co-chaired a winter meeting in Tempe,
On Freud, Hashem and, yes, even Christ.

I remember one day we took a long walk,
The sun was bright in the sky, a breeze as we talked.
At an Academy meeting, we had both taken a break,
We laughed and we joked,
like kids playing on the sidewalk with chalk.

Mims had a good sense of humor, hidden under her intellect,
And with her warm smile, she did easily with others connect.
With flowing white hair, and long dresses always,
A flower child she was...
or maybe just from some Western sect?

She wrote and she published on Freud and on Torah,
And in addition to knitting, she took many a photo.
With a long happy marriage to her husband, Barry,
She had a full life, a complete life, cut short by glioblastoma.

And yet, even at the end, as it cruelly approached,
To the Academy she made contributions of note.
To Doug Ingram’s initiative Psychiatrist WellBeing Project,
Mims added a moving narrative of how she was smote.

Articulate and balanced, as level as could be,
Her story brought tears to the eyes of you, thou and me.
In my mind, she’s still knitting, listening, smiling,
Seated toward the back of a presentation
at an Academy meeting—

Mims, you are missed by all who knew you in the Academy.



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