

# ACADEMY FORUM

**Vol. 65, No. 1 - Spring 2020**



The American Academy of Psychodynamic Psychiatry and Psychoanalysis



# Table of Contents

## Volume 65, Number 1, Spring 2020

Message from the Editor .....	5
<b>Ahron Friedberg, MD</b>	
Message from the President.....	6
<b>Gerald P. Perman, MD</b>	
<b>REPORTS, UPDATES AND LETTERS</b>	
AAPDPP Presidential Symposium at APA meeting .....	8
<b>Jennifer I. Downey, MD</b>	
Update on 65th Annual Meeting, Los Angeles, CA.....	8
<b>César A. Alfonso, MD and Mary Ann Cohen, MD</b>	
Update from the World Psychiatric Association (WPA) Psychotherapy Section, 2017-2020 Triennium .....	9
<b>César A. Alfonso, MD and Rizky Aniza Winanda, MD</b>	
Report from the APA Assembly to AAPDPP.....	11
<b>Barry L. Fisher, MD</b>	
Opinion Letter in Support of President Trump .....	12
<b>Peter Olsson, MD</b>	
Reply to Peter Olsson, MD .....	13
<b>William P. Moore, MD</b>	
Reply to Peter Olsson, MD .....	14
<b>Ronald Turco, MD</b>	
Reply to Richard Friedman MD's Letter .....	15
<b>Lee Jaffe, PhD</b>	
64th Annual Meeting, Philadelphia, PA.....	17
<b>ARTICLES</b>	
The Relevance of Clinical Autobiography.....	19
<b>Marco A. Bacciagaluppi, MD</b>	
Patient Suicide: Impact on the Psychiatrist and the Health Care System .....	20
<b>Kimberly R. Best, MD and Douglas H. Ingram, MD</b>	
Lessons from Lacan: How his Ideas Can Help Your Psychodynamic Psychotherapy Practice .....	21
<b>Gerald P. Perman, MD</b>	
Long Term individual Psycho-Analysis: Do we still need it for Therapy?.....	24
<b>Reimer Hinrichs, MD</b>	
The Fisher King .....	27
<b>Greg C. Mahr, MD and Jamie Sweigart, DO</b>	
Role of Resilience in the Treatment of Complex Neuropsychiatric Disorders: Psychodynamic Case Review .....	29
<b>Vladan Novakovic, MD</b>	
Resilience: From Birth to Thirty: From Soldiers; From Ethiopian Children, to the Biblical Joseph and the Ego Ideal and Attachment .....	31
<b>Nathan M Szajnberg, MD</b>	
Resilience in Psychodynamic Psychiatry: Commentary and Conclusions .....	34
<b>Ahron L. Friedberg, MD</b>	
<b>BOOK REVIEWS</b>	
<i>Finding the Body in the Mind: Embodied Memories, Trauma, and Depression.</i>	
Marianne Leuzinger-Bohleber; Karnac, 2015, London; 278 pp.....	35
<b>Reviewed by Jo-Ann Elizabeth Leavey, NP, EdD, C Psych</b>	
<i>A Psychoanalytic Exploration of Dante's The Divine Comedy</i> , by David Dean Brockman, MD,	
Routledge/Taylor and Francis, 2019, 199 pp.....	34
<b>Reviewed by David V. Forrest, MD</b>	
<b>IN MEMORIAM AND NEW MEMBERS</b> .....	37-38
<b>David R. Edelstein, MD</b>	

### Cover Photo

This photograph is titled "A Relationship for Mutual Survival." The photo was taken by Amy Carafa, BFA, MEd. Amy is an art teacher who does professional photography. She is the daughter of Gene Della Badia, DO.

## 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](mailto: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 be 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

Advertising is accepted for all ACADEMY FORUM issues that is directly of interest to psychoanalytic and psychodynamic psychiatrists. Contact the Editor for advertising requests. See above for deadlines for ad submissions.

## ACADEMY FORUM

**Editor:** Ahron L. Friedberg, MD

**Past Editors:** Angela M. Hegarty, MB BCh, Gerald P. Perman, MD and Mariam Cohen, MD, PsyD, PhD

**Editor Emerita:** Ann Ruth Turkel, MD

**Book and Film Review Editor:** Sarah C. Noble, DO

**Associate Editors:** Abby I. Altman, MD; David V. Forrest, MD; Harvey R. Greenberg, MD; Jeffrey M. Koffler, MD; Peter J. Stein, MD; Edward M. Stephens, MD

**Corresponding Editor:** Roman Anshin, MD

### The American Academy of Psychodynamic Psychiatry and Psychoanalysis

**Officers:** Gerald P. Perman, MD, President; Joanna E. Chambers, MD, President-Elect; Kimberly R. Best, MD, Secretary; Jeffrey W. Katzman, MD, Treasurer  
**Trustees:** Jessica Brown, MD; Norman Clemens, MD; Mary Ann Cohen, MD; Elizabeth Greene, MD; Angela Hegarty, MB BCh; Sarah Noble, DO; Joseph Silvio, MD; Jeffery Smith, MD; Allan Tasman, MD

**Executive Director:** Jacquelyn T. Coleman, CAE

**Executive Assistant:** Marie L. Westlake

**The Academy Forum is a journal of news and opinion published by the American Academy of Psychodynamic Psychiatry and Psychoanalysis. Opinions expressed in the Academy Forum are not necessarily those of the Executive Council and do not represent the official policy of the Academy.**

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](mailto:ahronfriedberg@gmail.com).

Subscriptions: \$20.00 per year (U.S. and Canada only). Order from the Academy.

Email: [info@AAPDP.org](mailto:info@AAPDP.org)

Website: [www.AAPDP.org](http://www.AAPDP.org)



# MESSAGE FROM THE EDITOR

Ahron L. Friedberg, MD



Firstly, a special thanks to Dr. David Lopez and Dr. Jessica Eisenberg for organizing a superb meeting titled “Psychodynamic Psychiatry and Relationships”. As colleagues know, it is April 23 - 25 at the Philadelphia 201 Hotel. They’ve curated an innovative meeting that incorporates the latest

findings in neuropsychanalysis and attachment theory into psychodynamic work. It’ll be both educational and very interesting to participate in.

In his President’s letter, Dr. Gerald Perman shares of his path to the Academy. It might serve as an example and even inspiration for aspiring younger members for AAPDPP. From grappling with the Oedipal beasts of his youth to earning the achievements of his professional life, it’s been a remarkable journey! His accomplishments as our President are especially notable for overseeing the merger with the American College of Psychoanalysts, helping to develop the Psychiatrist Wellbeing and Support Project, and enhancing our Academy’s professional footprint and membership.

Dr. Jennifer Downey informs us about the Presidential Symposium she was asked to organize at the APA. It is a terrific honor for her and, of course, good recognition for our Academy. Her Symposium deals with the important subject of achieving change in psychodynamic treatment—and we should all try to attend it.

Drs. Cesar Alfonso and Rizky Winanda give us an excellent update on the important activities of the WPA and its Psychotherapy Section, which represents over 50 countries. Dr. Alfonso currently serves as its Chair. Their most recent 2019 meeting in Lisbon had as its theme evidence-based psychotherapies and was attended by over 500 psychiatrists from around the globe. We owe Dr. Alfonso and our WPA colleagues our gratitude for forwarding our shared mission of advancing psychotherapy treatment and practice worldwide.

Dr. Barry Fisher reports to us on the activities of the APA, which has been partnering with other medical disciplines like pediatrics and family practice to promote access to mental health care, parity, and gun violence. The APA is also addressing Maintenance of Certification issues (MOC) and access to care, which is an important issue for both patients and health care providers. Many of the topics that the Assembly takes up in its Action Papers and meetings such as bullying, the decline of social dialogue in communities, and discrimination against people with mental disorders are relevant to our membership.

Dr. Peter Olsson’s Opinion letter in support of President

Donald Trump is certainly provocative. He sees President Trump as an effectively compensated narcissist that has had a strong reaction formation to the need for anaclitic love. He acknowledges the tendency of psychoanalysts to apply our theories as psychological cudgel rather than analytical tools. In his response, Dr. William Moore presents a different view of President Trump in which his narcissism is pathological and rampant over our democracy. In his response, Dr. Ronald Turco sees President Trump on balance as a flawed but effective leader. It’s interesting that intelligent and experienced psychoanalysts can hold such different points of view.

In his response to Richard Friedman’s letter from our fall issue, Dr. Lee Jaffe, President of APsAA, reminds us of the discriminatory policies of that organization. They continued for years after homosexuality was removed as a disorder from the DSM. He finds it is imperative that our practices be based on scientific and clinical evidence and not biased beliefs.

In his article on the relevance of clinical autobiography, Dr. Marco Bacciagaluppi eloquently and generously shares of his own personal life story with its traumas, resilience, and grace. We can take valuable lessons from his contributions to psychoanalysis and apply them to our own practices and even ourselves.

Drs. Kimberly Best and Douglas Ingram continue their important work with the Physician Wellness Program and contribute an article on the impact of patient suicide on psychiatrists. It is sensitively, indeed poignantly, rendered, integrating clinical material with information about psychiatrists dealing with patient suicide.

Dr. Gerald Perman does us a terrific service in his piece about Lacanian psychoanalysis, deciphering his abstruse ideas into clinical pearls. It demonstrates Dr. Perman’s mastery of not only psychodynamic principles but also an openness to broadening the approaches and techniques we use in our daily work.

Dr. Reimer Hinrichs in his contribution considers the need for long-term individual psychoanalysis as a treatment in Germany. He elucidates the complexes of that system of training and treatment, and convincingly demonstrates how psychodynamic principles rather than psychoanalysis per se are useful in treatment.

In their fascinating article, Drs. Maher and Sweigart use the story of the King Fisher to illustrate clinical lesson about chronic pain and the mind-body relationship that our current medical narratives commonly do not adequately address.

Finally, Drs. Nathan Szajnberg and Vladan Novakovic consider the role of resilience in psychodynamic work both in and out of the consulting room. It is interesting how slowly the psychodynamic community has been to adopt these well-established clinical principles with a substantial evidence base.

In her book review section, Dr. Sarah Noble presents Dr. Peter Olsson's review of Justin Frank's book on President Trump (constructive criticism), Jo-Ann Leavey's review of Marianne Leuzinger-Bohleber's book on neuropsychanalysis applied to trauma and depression (strong contribution), and Dr. David Forrest's review of Dean Brockman's psychoanalytic exploration of Dante's Divine Comedy (scholarly).

We note the passing of our esteemed friend and colleague Dr. David Dean Brockman in a poignant tribute by Dr. David Edelstein. We gladly also welcome several new members to our Academy.

Ahron Friedberg, MD  
Editor, Academy Forum

## MESSAGE FROM THE PRESIDENT

### My Path to the Academy and the Academy Today

By Gerald P. Perman, MD



In elementary school in the fifth grade, I wired together the sides of cardboard boxes into large flat structures that I cut out to resemble dinosaurs. I imagined the carnivorous beasts killing and devouring my Oedipal competitors and other rivals. My deep interest in the past continues into the present as I recently named a new car

"Jerry's Blue Beast" in memory of my dinosaur bestiary.

In early adolescence, I spent many a night outdoors with my 6" diameter reflector telescope gazing at Saturn, Jupiter, star clusters, and nearby galaxies, fantasizing about space travel. I later obtained an application for astronaut training but nixed the idea when I learned that I would have to move to Houston for five years. So, the future also grabbed my attention.

The past and the future are two main themes our patients grapple with in psycho-dynamic psychotherapy: we help them work through past traumatic experiences and regrets and help them create a best possible future for themselves.

Completing college, I received BS degrees in Psychology and Biochemistry (a good combination for a future psychodynamic psychiatrist) from the University of Maryland in College Park. After studying French for nine weeks in Pau and Vichy, I attended medical school at the Free University of Brussels for three years and, after two more years, I received my MD from the University of Maryland Medical School in Baltimore. I trained in psychiatry at George Washington in Washington, D.C., where psychoanalyst Jerry Wiener was a superb department chair and mentor, who also served as President of the APA.

Like many of us, I have been a member of a number of professional organizations over the years. One of these was the D.C. Chapter of the American Society of Psychoanalytic Physicians (ASPP). The ASPP was begun by Henry Laughlin, MD, who also founded the American College of Psychoanalysts that recently merged with the Academy to the benefit of both organizations. I took over as Editor of the ASPP Bulletin from long-time Academy member, Richard Chessick, MD, PhD, and it was through

Richard that I learned about the Academy. Richard, too, has been an important mentor to me, and I learned much by reviewing several of the many excellent books he has published.

After joining the Academy, I soon landed the position of Associate Editor of the Academy Forum with then-Editor Mariam Cohen, MD Mims's recent death was a great loss to her husband, Barry, to me, and to the many people who knew her in the Academy.

I began serving in a variety of other capacities in the Academy, becoming a Trustee, co-chairing meetings, and so on. The Academy became my home organization that has allowed me to support my beloved profession of psychodynamic and psychoanalytic psychiatry and to receive support from it. I am continually amazed by the breadth and depth of the talent and creativity within in the Academy.

These are some of the major initiatives that have come to fruition, or have continued to thrive, during my tenure as President:

1. I am pleased to have been able to support the merger of the former American College of Psychoanalysts with the Academy, now represented by the Committee for the Advancement of Psychoanalysis (CAP). Many individuals had vital roles in making this happen, but I will highlight the hard work of Doug Ingram, Jennifer Downey, Joe Silvio, Mark Unterberg, Drew Clemens and David Edelstein in this regard. A process of mourning continues to take place among former College members, but the Academy has extended open arms to welcome its new members who offer us renewed energy and a commitment to the art and science of psychoanalysis. Thank you for your contributions to our now even more beautiful organization!
2. I am grateful to Ahron Friedberg for having accepted the role of Editor of the Academy Forum. The Forum keeps our membership up-to-date on Academy activities and provides an opportunity for members to publish articles, and book and film reviews, in a chic and sophisticated psychiatric magazine with a psychodynamic and analytic focus. I warmly recall having received articles over the years when I served as Editor from Marianne Eckardt, Clarice Kestenbaum,

Scott Schwartz, Richard Chessick, Cesar Alfonso, Ron Turco, Marco Bacciagaluppi...and the list goes on!

3. The Psychiatrist Wellbeing and Support Project that can be found on the Academy website ([www.aapdpp.org](http://www.aapdpp.org)) is a timely and important initiative begun by Past President Doug Ingram that provides a resource to psychiatrists and trainees both within and outside of the Academy. It is only in recent years that our profession has begun to look at the many stressors that we all experience whatever our practice environment and throughout all stages of our careers. I have served for many years on the Physician Health Committee of the D.C. Medical Society that evaluates and monitors “impaired physicians.” A number of years ago one of my former psychiatric supervisors, who later became one of my closest friends, died by suicide—that makes Doug’s initiative even more up close and personal.
4. I am extremely proud of our highly acclaimed journal, *Psychodynamic Psychiatry*, edited by Richard Friedman with co-editors Jennifer Downey and Cesar Alfonso and book editor, Ahron Friedberg. This editorial team and its many associate editors work hard throughout the year to make this a top-notch publication that is unique in the field.
5. The Victor T. Teichner Award under the continuing leadership of Sherry Katz-Bearnot remains a jewel in the crown of the Academy. The Teichner Award provides underserved psychiatric residency programs with visiting Academy scholars who teach psychodynamic topics of interest. Go to the Academy website ([www.AAPDPP.org](http://www.AAPDPP.org)) to learn about becoming a Teichner Scholar.
6. The Academy now has a closed Facebook page created by J.J. Rasimas that allows Academy members an

additional venue to communicate with one another and to post announcements and photographs of interest to our membership-at-large.

7. I am grateful to all our members who volunteer their time and energy to co-chair annual meetings, to serve on our various important committees, to serve as Academy Trustees, and to contribute to the Academy in many other ways. Barry Fisher, our Representative to the APA, and Eric Plakun, APA Trustee, both keep the Academy connected to the APA, of which we are an affiliate organization.

I have had weekly conference calls with Ms. Jackie Coleman and Ms. Marie Westlake throughout my tenure as president, and I have made two trips to Bloomfield, Connecticut to conduct Academy board meetings from their offices. Jackie and Marie have been incomparable staff members with whom to work – easy-going, reliable, and who consistently show excellent judgment with a sense of perspective and good humor. My advice to my successors: seek out and follow Jackie and Marie’s advice to help you do your job!

It has been a pleasure and a privilege to serve as your President over these past two years. The leadership of the Academy remains in capable hands with former Teichner Award winner, Joanna Chambers, becoming our next President, and my long-time friend and colleague, Joseph Silvio, having been nominated to become our next President-Elect.

Gerald P. Perman, MD, DLFAPA  
President AAPDPP

# REPORTS, UPDATES AND LETTERS

## Presidential Symposium: Change During Psychodynamically-Oriented Treatment

By Jennifer I. Downey, MD



The field of Psychiatry as a whole has no cohesive scientific theory of change. Each successive wave of psychiatrists—previously, psychoanalytically trained physicians, more recently biologically oriented psychiatrists—have claimed that they had a comprehensive theory to explain human

suffering. Each wave has essentially failed. They could neither explain etiology of mental disorders and human distress nor offer an evidence-based rationale for how change might be accomplished.

Psychodynamic Psychiatry is an emerging field that does not concern itself with controversies between schools of psychoanalysis that have never been resolved. Psychodynamic Psychiatry's knowledge base comes from four different sources: (1) psychoanalytic thought, (2) academic psychiatry, (3) academic psychology, and (4) the neurosciences. The psychoanalytic ideas psychodynamic psychiatry focuses on are those that have now mostly been empirically validated. Our approach is biopsychosocial, a concept first proposed by George Engel, MD in the 1950s, but still relevant today. It reminds us that all parts of the patient—the biological, the psychological, and the social environment in which he

or she lives—are vital for the physician to consider.

The session will focus on what psychodynamic psychiatrists do to achieve change with treatment and what we know about why these changes occur.

Presenters will speak about how outpatient psychodynamic treatment of anxiety and depression causes change (Dr. Debra Katz); how treatment of a woman with Borderline Personality Disorder restored her ability to love (Dr. Michael Stone); how the manualized psychodynamic treatment, Transference Focused Psychotherapy, fosters change in patients with borderline conditions (Dr. Richard Hersh); and what psychodynamic change can be achieved in patients with treatment-resistant psychiatric disorders (Dr. Eric Plakun).

The discussant, Dr. Vincenzo Di Nicola, Professor in the Department of Psychiatry & Addictions at the University of Montreal and Clinical Professor at George Washington University, has long been interested in what makes psychotherapy work and what makes it fail. The moderator is Jennifer Downey, MD, Past-President of the American Academy of Psychodynamic Psychiatry and Psychoanalysis.

Participants will learn about the different kinds of change psychodynamically informed treatments can produce and what clinical and existential problems this treatment addresses particularly well. Finally, participants will understand how the treatment alliance can benefit any patient.

## Update on 65th Annual Meeting Thursday, April 29 – Saturday, May 1, 2021 Los Angeles, California

Meeting Theme: “How to Replenish a Passion for Medicine:  
Psychodynamic Psychiatry and Consultation-Liaison Psychiatry”

Program Co-Chairs: César A. Alfonso, MD and Mary Ann Cohen, MD

Chair of the Scientific Program Committee: Joseph R. Silvio, MD

CME Committee Chair: Silvia W. Olarte, MD



Rita Charon, MD  
Keynote Speaker

Mary Ann Cohen, MD  
Meeting Co-Chair

César A. Alfonso, MD  
Meeting Co-Chair

The American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP) affirms its place as an organization interested in protecting psychotherapy in psychiatry, comprised of creative academic physicians who understand the complexity of caring for the medically ill. Consultation-liaison psychiatry and the biopsychosocial approach revolutionized medical care over the last fifty years, building on a substrate of psychoanalytic and psychodynamic theories that place illness and health within an intrapsychic, interpersonal, psychosocial and cultural matrix. Persons with multimorbidities, who constitute most of our patients, benefit from a multidimensional



biopsychosocial approach. Changes in systems of healthcare based on market-driven assembly line models of care have begun to magnify disparities, erode progress made, undermine physicians' capacity for empathy, threaten the physician-patient relationship, and decrease both patient and physician satisfaction.

The AAPDPP co-chairs, program committee and executive council leadership recognize the challenges of providing compassionate care when working in underserved areas with few resources and a high demand for clinical services and maintaining a therapeutic alliance when tasked with attending to the needs of vulnerable patients with chronic illnesses in acute distress. We will offer conference participants opportunities to learn how to design, implement and navigate collaborative systems of care in order to practice psychiatry and psychodynamic psychotherapy as physicians with comfort and enthusiasm. Additionally, we will address how to prevent burnout, improve work satisfaction and foment wellbeing among physicians, trainees and medical students.

We anticipate submissions that will address a variety of topics, including but not limited to:

- What medical schools, psychiatry training programs, and psychiatric organizations are doing to prevent depression, suicide and burnout and promote wellbeing.
- Clinical aspects of physician, trainee and medical student suicides.
- Physician and student suicide prevention strategies.
- Mental health stigma and its consequences and recommendations for prevention.
- Personal accounts of how mental health stigma impacts both clinicians and patients.
- Transcultural psychodynamic psychiatry and collaborative care.
- Consultation-Liaison psychiatry and collaborative models of care.
- Narrative medicine.
- Trainees' accounts of what helps them and harms

them during their training.

- Bioethics, clinical decision-making and psychodynamics.
- Psychodynamics of addiction.
- Impact of early childhood trauma on adult development.
- Trauma, epigenetics, and attachment theory.
- Integration of public health, behavioral health and primary care services.
- Psychodynamic psychotherapy with the medically ill.
- Psychodynamic formulations and clinical practice.
- Integration of psychotherapy treatment modalities.
- Countertransference experiences in clinical care.
- Psychodynamic psychotherapy at the end of life.

The American Academy of Psychodynamic Psychiatry and Psychoanalysis is an affiliate organization of both the American Psychiatric Association (APA) and the World Psychiatric Association (WPA). Our scientific meetings, held annually since 1956, include presentations by expert psychiatrists, other physicians, social workers, social scientists, academic psychoanalysts and psychologists. Our annual meetings provide an opportunity to interact in a collegial and enriching relaxed environment. There will be many opportunities for interactive discussions since our presentations always leave ample time for audience participation. This meeting will also provide multiple prospects to meet and socialize with experts in psychodynamic psychiatry.

The AAPDPP leadership, its program committee, and the co-chairs of this 65th Annual Meeting in Los Angeles, April 29 – May 1, 2021, wish to invite you to help us discover how to replenish a passion for medicine, revisit the Hippocratic Oath, keep care in healthcare and rehumanize medicine as an antidote to the contemporary market-driven productivity-oriented assembly line approach to medical care.

## Update from the World Psychiatric Association (WPA) Psychotherapy Section, 2017-2020 Triennium

By César A. Alfonso, MD and Rizky Aniza Winanda, MD



César A. Alfonso, MD   Rizky Aniza Winanda, MD

The WPA Psychotherapy Section is an international study group dedicated to the advancement of psychotherapy in psychiatry. The section has approximately two hundred members from over 50 countries in all continents. Elected officers (three-year term) include César Alfonso–USA (Chair), Allan Tasman–USA (Co-Chair), Rizky Aniza Winanda–West Papua, Indonesia (Secretary), and five Committee Members: Daniel Nahum–USA/Turkey, Ekin Sonmez–Turkey, Hazli Zakaria–Malaysia, Dusica Lecic Tosevsky–Serbia, and Renato Alarcón–Peru/USA. Elections for a new slate of officers will be held before the next WPA meeting in Bangkok in October 2020.



Over the last triennium, the psychotherapy section organized symposia at all major meetings of the WPA. These included presentations at the World Congresses in Berlin (2017), Mexico City (2018), and Lisbon (2019); at the Regional Congress in Addis Ababa (2018); Thematic Congress in Melbourne (2018); and Co-sponsored Meetings in Duhok, Kurdistan, Iraq (2019) and Kuala Lumpur (2019). The WPA Psychotherapy Section membership includes prominent academics, researchers and clinicians, as well as early and mid-career psychiatrists. The section is further subdivided into Special Interest Groups (SIGs).

The Special Interest Groups (SIGs) are tasked with advancing evidence-based psychotherapies and care for special populations in order to stimulate improvements in competence, mentorship, focused presentations and publications. Each SIG has co-leaders and diverse membership. They include: Psychotherapy in Consultation and Liaison Psychiatry (David Teo–Singapore and Feranindhya Agiananda–Indonesia), Psychotherapy with Adolescents and Young Adults (Luca Giorgini–Italy and Vanessa Cainhug–Philippines), Psychotherapy in Late Life (Kanthee Anantapong–Thailand/UK and Marco Christian Michael–USA), Psychotherapy with LGBTQ+ Populations (Asher Aladjem–USA and David Wei–Taiwan), Psychotherapy with Refugees/Survivors of Trauma (Amir Hosein Jalali Nadoushan–Iran and Katerina Duchonova–Czech Republic), Cultural Adaptations of CBT (Reham Aly–Egypt and Haifa Algahtani–Saudi Arabia/Bahrain), Cultural Adaptations of IPT (Xavier Pereira–Malaysia and Scott Stuart–USA), Cultural Adaptations of Third Wave Psychotherapies (Toshitaka Li–Japan and Loo Jian Lin–Malaysia), Cultural Adaptations of Psychodynamic Psychotherapy (Saman Tavakoli–Iran and Alma Jimenez–Philippines), Cultural Adaptations of Supportive Psychotherapy (Erin Crocker–USA and César Alfonso–USA), and Cultural Adaptations of Motivational Interviewing (Faiz Tahir–Malaysia).

The WPA Psychotherapy Section organizes international scientific meetings every two years. With close to 500 registrants, the conference held in Kuala Lumpur in July 2019 had as a theme Evidence Based Psychotherapies. The Kuala Lumpur conference was sponsored by the WPA and Malaysian Psychiatric Association, and cosponsored by a dozen international, regional, and national organizations (including the AAPDPP). The next meeting will take place in Manila with the theme Cultural Adaptations of Psychotherapies, sponsored by the WPA and the Philippine Psychiatric Association. Conference co-chairs for the Manila 2021 meeting include César Alfonso, Allan Tasman, Constantine Della, and Alma Jimenez. We will meet at the Edsa Shangri-La Hotel over three days, January 20-23, 2021. Two years later, in 2023, the congress will take place in Luxor, Egypt, cosponsored by the WPA and the Egyptian CBT Association. These conferences include keynote and plenary sessions, symposia, workshops, case conferences, poster sessions, and interactive sessions

with international experts. Social events are animated and memorable, with exquisite cuisine, traditional dance performances and a joyful atmosphere.

The mission of the WPA Psychotherapy Section is to provide a forum for the collegial exchange of diverse ideas and theoretical constructs in order to advance the practice of psychotherapy treatments within psychiatry. Section goals include to:

- Provide a forum for constructive exchange of ideas for psychiatrists practicing a variety of psychotherapy treatments
- Study core/common factors of psychotherapies
- Coordinate WPA intersectional collaborations.
- Determine standards for competency in psychotherapy for psychiatry
- Explore innovative ways of teaching and assessing psychotherapy competency
- Disseminate advances in psychotherapy theory and technique
- Innovatively use computer-assisted technologies to advance psychotherapy practice
- Explore culturally sensitive ways of meeting psychotherapeutic needs of diverse populations
- Understand the biological and neuroscientific underpinnings that validate psychotherapies
- Explore standards of cooperation for treatment jointly provided by clinicians from diverse disciplines, such as physicians, psychologists, social workers, nurse practitioners, religious advisors, and counselors.

We are fortunate to have AAPDPP members actively involved in the leadership and academic activities of the WPA Psychotherapy Section. The AAPDPP is an affiliate organization of both the APA and WPA. AAPDPP members who are APA members may join the SIGs and have the opportunity to present at international meetings. If interested in joining us at the Manila 2021 and Egypt 2022 meetings, please contact AAPDPP members Drs. Alfonso, Tasman or Winanda for more information.



*Opening Session of the WPA International Psychotherapy Meeting in Kuala Lumpur, July 2019. From L to R: Hazli Zakaria, MD (President of the Malaysian Psychiatric Association); César Alfonso, MD; Allan Tasman, MD; and Aida Razak, MD (Malaysian ECP).*

# Report from the APA Assembly to the AAPDPP Executive Council

## Outcomes from the APA Assembly Meeting, November 2019

By Barry L. Fisher, MD



For this report, I want to give a broader overview of activities at the Assembly Meeting beyond the Action Papers that were submitted and voted on. Saul Levin, the CEO of the APA, encouraged all academies to join the greater coalition the APA is a part of in lobbying congress and to sign onto different

positions that the APA is taking. Right now, the APA is partnering with pediatrics, family practice and other groups to promote issues like access to care, mental health parity, and gun violence among other positions on Capitol Hill and in state legislatures. He also encouraged support of the APA PAC that is lobbying congress and state legislatures on these same issues. The APA also provides resources, talking points, and possible connections to different federal and state legislators and encouraged anyone who is interested to volunteer their time in working with these legislators to be a resource to them and educate these legislators on mental health issues and approaches to consider for better outcomes. Dr. Levin also discussed ongoing efforts on a state by state level to pass legislation to enforce mental health parity payments by insurance companies after numerous examples of insurance companies violations of the mental health parity act have occurred. These legislative efforts have been broadly defined as The Mental Health Parity Compliance Act and legislation has also been introduced to Congress on the federal level to deal with this issue.

The ethics committee is working on how to manage online reviews that are often false or make distorted claims about clinicians. An Action Paper was submitted and then withdrawn titled “Google’s Role in Misinformation and Defamation of Physicians.” The paper as I understand it was withdrawn so that the ethics committee could make a broader look at the issue and determine the optimal approaches to deal with this issue that is negatively impacting many physicians in their practices.

The Maintenance of Certification committee met and relayed that there are three ongoing lawsuits against The American Board of Medical Specialties on antitrust grounds that there is restriction in competition and that the ABMS acts as a monopoly with no oversight on requirements or fees. The APA president continues to work with MOC on making requirements less burdensome in terms of time commitments and reducing the costs charged for MOC and to prevent ABMS or our particular branch, The American Board of Psychiatry and Neurology, from adding more burdensome requirements in the future. The APA is continuing to study whether to implement their

own MOC pathway, or whether to advocate for dismissing MOC altogether and focus on a process of lifelong learning instead. The incoming president of the APA is a staunch advocate of the APA developing their own MOC pathway and feels ABPN profits greatly from the process without any evidence to support that the MOC process as it currently stands benefits patient care.

The committee on Access to Care related litigation in California and Illinois where United Health was fined significant amounts of money for setting up obstacles to care and not fulfilling their contract with subscribers. The judge in the California case issued eight points that need to be considered in the future with regard to access to care. The committee is using those eight points as a starting point in promoting access to care. I am not on this committee and the eight points were not explained during the report to the assembly. I will try to follow the outcomes of this committee’s proceedings in the future as this is an important issue for all our patients.

Two action papers were brought directly to the floor by the rules committee, bypassing the normal reference committee review because of the timeliness of the issues and both passed on a voice vote. The first paper was titled “Care of Medically Vulnerable Immigrants in a Timely Manner.” The second paper was a position statement on controlling drug prices promoting a more expedited process for the introduction of generic medications. This paper promoted some debate about the fears that some generic pharmaceutical companies that import generic medications to the US do not have enough oversight and that the products are often inferior and do not work as well. The measure passed despite the concerns.

The APA Foundation stated that the APA website is getting four times the number of hits in 2019 than 2017, many around the content on workplace mental health, receiving over 400,000 views so far this year. The foundation has also started a project to certify schools and institutions to create a healthy work environment and identify and provide support to those with mental health needs or issues. The foundation has 91 fellowships that all members can apply for and the process to apply for these fellowships has been streamlined, making it easier to apply to multiple fellowships at once using the APA/APAF portal on their website. Two of the fellowships have stipends greater than \$100,000 per year. Anyone interested is encouraged to look at the different fellowships and focus on the research or work that the fellowships support.

On a procedural note, an amendment to the procedural code for the process of vetting and approving action papers was passed. The new process will place more emphasis on the review of action papers prior to the meetings; the reference committees will have a greater burden to amend papers and make sure they are in line with existing APA

policies. The plenary sessions will now spend less time vetting each action paper and will rely more heavily on the recommendations of the reference committees' decisions. There was debate that this changes the approach on voting on action papers to a consensus approach and could stifle minority descent. The Speaker Elect cited that the intent was to increase the opportunity for minority descent but at the reference committee level, not on the floor of the plenary sessions. The hope is that this will lead to greater efficiency of the use of time during plenary sessions and that the papers will be improved because of greater input and oversight during the reference committee review process. It was noted that this model is currently used by the American Medical Association and most other medical associations as well.

The Assembly is tasked with approving any changes to DSM. Changes were made to the criteria for Avoidant/Restrictive Food Intake Disorder eliminating the clause of failure to meet nutritional or energy needs. "Substantial disruption of family functioning, such as marked restriction of foods permitted in the home or inordinate accommodations to provide foods from specific grocery stores or restaurants, may also satisfy Criterion A4" was added to the criteria. Unspecified Mood Disorder was added back into DSM after having been removed from DSM V.

The ACROSS committee (of which I am a member) has been tasked with creating a workshop presentation at the May 2021 annual meeting. Topics proposed were bullying, white supremacy, the decline of social dialogue in communities, and approaches to deal with these issues.

## **OPINION: In Support of President Donald Trump**

By Peter A. Olsson MD

As a minority Trump supporter among American psychoanalysts, I think Trump can be seen as effectively compensated in some unusual ways. He has transcended alleged dyslexia, reading/learning disability, and neurotic character disorders of his parents to wield political power in unusual, often unorthodox ways in the Washington Swamp.

It was Sigmund Freud who observed that we love anacritically (relating to the mother who nurtured us or the father who protected us) or narcissistically (relating to the self we wish we were, the self we used to be, or in affiliation with another self that reflects favorably upon us). Anacritic literally means "leaning on" and refers to an infant's utter dependence on its mother or mother substitute for its sense of wellbeing and actual survival. Anacritic love is normal behavior in early childhood, but not in adulthood. Trump seems in his adulthood to have developed a strong reaction formation to any elements of a need for anacritic love. Trump can very well protect and nurture himself, thank you very much, you citizenry of mothers, fathers, and children.

Narcissism is not a psychiatric curse word of condemnation. Trump's obvious narcissism is a prominent thread within the complex skein of his remarkable ego strength and aggressive personality. A strong ego is not

I will update the executive committee when a topic is finalized because I imagine our Academy members would like to participate in the presentations.

Thirty Action Papers were approved by the Assembly. The papers addressed issues of appropriate care for pregnant and newly delivered women with substance use disorders, psychiatric participation in interrogation of detainees, accountability for climate change, discrimination against persons with previous psychiatric treatment, the need to monitor and assess the public health and safety consequences of legalizing marijuana, public education to increase responsible disposal of prescription medications, opposing non-psychiatrist evaluations for social security disability mental evaluations, improving mental health care in US nursing homes, addressing workplace bullying of psychiatrists in VA hospitals, awareness of physician suicide and burnout with a focus of removing barriers to support and care, improving recruitment and hiring of psychiatrists across the continuum of care with a focus on public health and adequate reimbursement for psychiatrists to allow psychiatrists the options of working in the public health sector and to discourage the use of nurse practitioners and other midlevel mental health providers simply because they cost less, the mental health needs of foreign nationals, racial and ethnic disparities in substance use disorders and treatment in the judicial system, improving access to the APA database, and opposing affiliate membership to the APA for non-psychiatrists with the concern that nurse practitioners, social workers and psychologists could use the affiliation to push for greater autonomy and greater ability to prescribe.

egotistical in the common-sense usage of the expression "big ego," but indicates accurate intuition, street-smart intelligence, and good judgment. Strong enough ego to withstand the attacks of bitter Democrats who never thought Trump would win the presidency. Strong enough to take on "the swamp" of Washington politics, politically correct liberal university professor enemies, and a massively anti-Trump and vicious liberal American press. Even smiling Republican Party enemies like John McCain and Mitt Romney were targets of Trump's successful but withering un-presidential tweets. As Trump implied early in his first campaign, he knows personally where all the political bodies are buried in Washington and how the pay-to-play swamp game is negotiated and deals are made. Trump has an accurate external reality orientation to Washington politics. He is taken for granted by traditional politicians, academics, liberal media pundits, and many psychoanalysts and psychologists.

In the domain of applied psychoanalysis and especially in describing politicians and the political domain, I have found it is easy to slip over the line in using psychoanalytic theory as a psychological polemical cudgel rather than an objective analytic tool. Genuine neutrality and objectivity are hard or



impossible to muster upon entering the psychoanalytic study of and writing about politics and politicians. Our American president is not our country's psychiatrist, large group therapist, social worker, or pastor. He is primarily our chief executive, national and international leader and policymaker, commander-in-chief, and signer and chief enforcer of our laws, who makes important appointments.

We psychoanalysts and psychologists as citizens are free to express our thoughts and opinions about our president, his leadership style, his personality, and the consequences of his words and policies. But, because of our professional training, clinical experience, and status or lack of it in

American society, we need to take care to make every effort to not politically weaponize our theories, observations, and opinions in the endlessly important but ambivalent, emotionally charged, and consequential domain of politics. The informed public rely on our clear, objective, reasonable use and explication of our applied psychoanalytic theories.

In my over fifty years in medicine, psychiatry, and psychoanalysis, some of my most valued discoveries have been the experience of observing people for whom the textbooks would predict disaster, but who triumphed over adversity to live unusually successful lives. I think Donald Trump, a flawed but effective person, is one of them.

## **Reply to Peter Olsson, MD**

By William P. Moore, MD

My opinion and Pete Olsson's opinion are two different views about President Donald Trump. Our audiences are members, subscribers to the Academy Forum. Their least IQ is probably 120. Their discernment skills are probably superior. They recognize obfuscation, dissemblance and denial. My opinion is not a diagnosis as I have never conducted a clinical evaluation of Trump. I have never met him. I think Pete Olsson and I are even on this.

With my opinion I will highlight, emphasize or even clarify some observations which anyone could evaluate for themselves. I will leave V. Putin and Kim Jong Un to our readers. I cannot cover everything, just my selections. Concerning misogyny, I recall a video clip of Trump saying he could get away with grabbing women's private parts because of his celebrity. Then he denied the Misogynist label as only men's locker room talk. My moral view is that gentlemen ought not to be discussing ladies in the men's locker room. Trump's denial is he's never shy about labeling his superior attributes.

The President's denials often connect to his "fake news" comment—a major insult to the media. It's more than inference that the media report was a lie. Loyalty to Trump includes acceptance of his version of the "truth." Where is loyalty to the US Constitution?

Professional journalists seek the truth in the news. When I was 11, my mother remarried to a man who at heart was a journalist. From that time on, editors and publishers from all over Texas and the principal centers of the United States were their best friends and my acquaintances. As a whole, they were honest, just, and fair-minded, even courageous patriots—a conservative bunch. I observe TV investigative reporters seeking the truth, not fake news. It serves Trump's will to convince the American people that journalists are not to be trusted. Who is to be trusted? Trump "fake" occurs whenever anyone disagrees with Trump.

We are living in crisis times. Trump leads us to fulfill his agendas. I'll list a few:

Global warming: Trump rejects the concept and reports of earth scientists. He believes he does not need to get an expert opinion. He is the expert of his choice despite such evidence as melting glaciers, sea level rising, and weather

changing. As warming progresses, many animal species, including homo sapiens, are increasingly threatened with extinction by gluttony of oil, coal, and fossil fuels.

Immigration: Any psychiatrist or child psychiatrist would have told him not to separate children from their families on our southern border. Anna Freud and Melanie Klein proposed sending London's children away to avoid the Nazi blitz of WWII. After the war Freud and Klein apologized, as separation was more traumatic to the children than the bombing could have been. Did Trump ask for any expert opinion about our southern border regarding impact on the families? TV recently showed a large border complex intended for children separated from their families. The complex, which cost several hundred million dollars sits completely vacant and unused. I expect Trump prefers not to discuss it.

Elitist: The Billionaires Club is mostly anonymous. But they have or control most of the money in the US. The way to raise wages is from their money. I doubt in raising the minimum wage a notable few have been philanthropic. I include the bankers in this elitist group. Can they rob us all with impunity? Who went to jail for their greed? Where is the Trump investigation?

Opioid Crisis: Nothing seems to work. Rehabilitation programs have promise. Addiction is not a mental choice of the addict. Their brain is changed. A billionaire's family owns a firm which floods the county with opioids. What's Trump's plan?

Trade Tariffs: Does anyone think his trade war will improve life for Americans? Farmers lose income from reduced profits.

Gun Control: Could Trump's Executive Order confiscate automatic weapons of war and their ammunition to decrease tragedy in America? Schools are too often the target populations. He seems particularly to favor his Executive Orders. The millionaires win again.

Fidelity/responsibility: Betrayal of the Kurds and other allies is a further consideration. Trump aims to keep the military exposed to betrayal of their fidelity to America. Maimed and neglected, our military are too often forsaken by the Veterans Affairs support.

Hunger in America: For 10 years I supervised Baylor Child Fellows at a “ghetto” school for pre-K through 6th grade. Through entitlement programs they got two meals daily when school was in session, but no food Saturday, Sunday, or during the summer. Who sets priorities? NASA and other space programs spend billions. Children go hungry. Many other social programs never get off the deck.

Racism: White supremacists got support from Trump at Charlottesville. Trump called Senator Elijah Cummings (now deceased) a “racist,” a colossal distortion.

Law: Reversing the verdicts of court marshals convened under the Universal Code of Military Justice is clearly tampering with the Law. Is it really Trump’s constitutional right to forgive murder?

Power: Trump is obsessed with power. Why? When will we Americans stop Trump from grabbing at the private parts of our Constitutional Democracy?

He should clearly be Impeached.

## **Reply to Peter Olsson, MD**

### **By Ronald Turco, MD**

The Trump Presidency is the product of a contentious election campaign in which the “establishment” candidate, Hillary Clinton, was sure she would win and, shockingly for her and many others, did not, although Trump lost the popular vote by a substantial margin. There has followed an unending polarization of opinions regarding the President. Donald Trump has sustained substantial media criticism and unpopularity with many segments of American society. His cabinet selections have often been unqualified and some are in jail. Others he has not been able to get along with, especially if they disagree with him. To be sure, Trump appears to be his own worst enemy with frequent twitter comments, many of which are hostile and critical of the press and his detractors.

There is sufficient “blame” and cause on all participants in this drama. During and before the election he had been crude, abrasive, demeaning to others, and significantly narcissistic, exhibiting behaviors lacking in decorum, characteristics many Americans do not expect in their President. At times, his comments are gross exaggerations of the facts at issue and border on or may be fabrications. He is an unorthodox President. Some of his verbalizations and criticisms likely have the goal of keeping him in the news, and the media “take the bait” and contribute to this phenomenon. His behavior and comments are often obnoxious. In this regard, his behavior is similar to that of Silvio Berlusconi, the multi-millionaire who has been Prime minister of Italy in four governments. Berlusconi has been accused of sexism, concealing his income taxes, conflicts of interest, and use of the media for personal political gain. He once referred to the Economist as the “Ecommunist,” is a good friend of Vladimir Putin (has given him lavish gifts and is known as Putin’s mouthpiece in Europe), and has insulted the Finnish Prime Minister and a host of others in an endless list of controversial behaviors. This is politics as usual, whatever the country.

Many with disappointment in the last election have projected their own hostility onto President Trump, feeding into his tweets and setting up an endless cycle of name

calling and criticism on all sides.

A number of psychoanalytic papers, as well as at least one book, have been written about his behavior, attempting to analyze his motivations and character without the benefit of formal psychoanalysis. These articles have been helpful in providing a degree of insight into his observable behavior. Almost all have been severely critical of the President and I cannot tell if the authors have a significant liberal political bias or if their work is based on an accurate scientific study. It is surprising to me that these psychoanalytic authors do not appear to have grasped their own counter-transference issues and their political bias. Of the material I have read, there is a decided lack of separation of feelings as well as social and political prejudices by these authors. To correctly understand character and leadership qualities we must stand back and allow our observing ego to operate effectively when opining on a President’s character as we would with a patient in the consulting room. One cannot honestly diagnose at a distance, however strongly one feels about a person. One can only describe. Anna Freud once mentioned “removing the layers” of personality traits and observable behaviors with the analogy of peeling an onion. It is difficult to judge a leader’s effectiveness when, for one reason or another, we do not like him or, especially with President Trump, have a strongly liberal political bias.

Many of our leaders have been successful in major foreign policy endeavors such as Richard Nixon’s rapprochement with China and the creation of the Shanghai Communiqué. Yet from a Shakespearean perspective he had substantial flaws which were destructive to him and the Presidency. History will judge the overall effectiveness of his Presidency many years from now.

Abraham Lincoln was referred to as “the baboon” by some of the members of his cabinet. Depending on one’s political spectrum he was disliked by a large percentage of Americans early on in his Presidency and thought to be inept. He suspended the rule of habeas corpus, ignored Supreme Court rulings, and was partially responsible for the death of over half a million Americans and the maiming of many more.



Had he not been popular with the soldiers in the army, he may not have had enough votes to win reelection.

Harry Truman was thought to be unsophisticated in leadership, especially after he was not successful with the China Policy, did not do well at the Potsdam Conference with Stalin and Churchill, involved the United States in the Korean War and later in firing General Douglas MacArthur, to say nothing of the early criticism of using the first atomic bomb ever detonated on civilians. These are major policy issues. His language and public decorum left something to be desired as well, although he was careful enough to never mail the angry hostile letters he wrote to people whom he disliked.

There are many other examples of leadership style in the United States as well as abroad that appeared to be lacking in substance but, with time, became relevant. In the last analysis, it is the substance of accomplishments that determines our judgement of effective leadership, not personality traits.

Historians and political scientists have the advantage of a comprehensive understanding of a political leader and his/her effectiveness partly because of the passage of time and partly because of their comprehensive understanding of domestic and geopolitical events. Most psychoanalysts have neither advantage, although some think they do. A few historians, for whatever reason, have given up their professional roles and become “talking heads” and television personalities—quick to judge, lacking the objectivity that comes with time and further scholarship.

Dr. Peter A. Olsson, in his essay letter “In Support of Trump,” clearly states that he is biased in favor of the President. Nevertheless, he writes with a novel and refreshing perspective, which is basically neutral in substance. His idea of Trump compensating is one found in most other successful leaders, including Lincoln and Churchill. He presents to us the idea of Trump’s reaction formation in terms of disavowing the need for anaclitic love and his ability to self-nurture in what Olsson calls the “vicious blood” of American politics. To this I would

add President Trump’s extreme defensiveness when he feels attacked. However, those few who know him on a more personal basis see beyond the defensiveness. Trump is popular with millions of Americans, who see a strong man who wants to protect them from terrorism, protect the borders, and enhance the military and police at a time when some of his political opponents are opposed to all of these issues, especially regarding the police and the military.

I agree with Dr. Olsson’s perspective of narcissism as it relates to Trump and his drive to be successful in a liberal political climate. I have spent my professional life studying strong world leaders and political figures and have never come across one who was not narcissistic, although most were quiet about it. Dr. Olsson notes that Trump’s strong external reality orientation to the “swamp” of Washington politics has been overlooked and ignored by most traditional politicians, academics, and the liberal media. His positive accomplishments in foreign and domestic policy have been ignored or berated. I note that this even includes, and is possibly because of, his Christian religious views and right-to-life stance. However, politicians I observe do appear to pander to their “base” by shifting views on the abortion issue, and Donald Trump may be no exception as he did not appear to be a religious person before he became President.

I agree with Dr. Olsson that Donald Trump is flawed but effective in spite of his character issues. Dr. Olsson offers a reasonable perspective of Trump without gushing melodrama. In my opinion, psychoanalysis has little to offer in opining on contemporary leadership figures other than to describe the personality traits of a leader which we already know about. Trump’s political base overlooks his shortcomings and looks at his accomplishments—and the hope he brings for the future. These accomplishments appear to be primarily in the area of economics and finance, although the national debt is increasing at alarming rates. All good leaders bring hope. Whether Trump accomplishes what he has set out to do only time will tell. History will be the judge.

## **Reply to Richard Friedman, MD’s Letter**

Dear Dr. Friedberg,

A colleague sent me a copy of the Academy Forum (Vol. 64, No.2) that has Dr. Friedman’s letter criticizing the American Psychoanalytic Association’s (APsaA’s) apology to the LGBTQ community. I want to remind your readers that APsaA continued its discrimination in training until the 1988 lawsuit made it illegal as restraint of trade. This was 15 years after homosexuality was removed from the DSM in 1973, making it no longer a practice based on

science. Also, it is important to keep in mind that an apology does not have to mean doing intentional harm, as in “I’m sorry about causing the car accident.” Lastly, I suspect that many of the physician analysts in APsaA who supported such discrimination may have felt they were protecting the public, but they were wrong.

Lee Jaffe, PhD  
APsaA President

# ***PSYCHIATRIST WELLBEING AND SUPPORT***

WWW.AAPDPP.ORG

***Coming soon: The Impact of Patient Suicide  
When Psychiatrists Face Their Own Mental Disorders  
The Immigrant Experience  
... and more***

Visit us on the Academy website.

## **Administrative**

Fees / Pivacy Policies  
Insurance  
Billing  
Medicare  
Practice Wills  
Treatment Consent Forms  
Patient Registration Forms  
HIPAA Privacy Booklet  
Mood Checklist  
PCL-C, GAD-7  
Adult ADHD Self-Report  
Beck's Depression Inventory

## **Aging & Retirement**

Stalking of Psychiatrists

## **Life-Threatening Illness**

Hodgkin's Lymphoma  
Anorexia  
Glioblastoma  
Prostate Cancer

## **Burnout**

Administratively generated  
Inherent aka 'soul sadness'  
Medical Students  
Burnout and Depression

## **Residency**

Suicide  
The Immigrant Experience

## **Litigation**

Tarasoff v. Pt Privacy

## **Patient Death**

Supporting Providers after  
Drug Death Overdose

## **Support Groups**

Bipolar Disorder

## **The Experience of Dying**

Glioblastoma- terminal  
At Death's Door – surviving

## **Losing a Child**

Childhood Leukemia – terminal

## **If You Need Help**

AAPDPP Membership Roster  
Medical Soc of the State of NY  
Comm of Physician Health  
MSSNY Physician Wellness  
and Resilience Resources

Amer Coll of Physicians--

Burnout and Wellness

Information Resources

Prof.Assistance Program of NJ

Federation of State Physician

Health Programs (with  
hyperlinks to each State)

## **Social Media and Selected Blogs**

Psychiatry Network

Women's Psychiatry Group

Women in Academic Psychiatry

Psychiatry for All Phsycians

Private Practice Psychiatry

President's Thoughts

by G. P. Perman, MD

Consider adding a narrative (anonymously) of your own experience. Check out "How to Contribute Personal Accounts, References, and Articles" on our site. Or, write to [DHIngramMD@aol.com](mailto:DHIngramMD@aol.com) and put "Wellbeing" in the subject line. We can help formulate and edit your story.

Also, if you happen across an article or reference that seems appropriate to our work, please let us know. Thank you.

# **“Psychodynamic Psychiatry and Relationships”**

## **AAPDPP Annual Meeting**

**April 23-25, 2020**

**Philadelphia 201 Hotel, Philadelphia, PA**

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

From April 23 to 25, 2020 the American Academy of Psychodynamic Psychiatry and Psychoanalysis will be holding its 64<sup>th</sup> annual meeting, in Philadelphia, PA. The Program Planning Committee, headed by David Lopez and Jessica Eisenberg, is putting together an enticing and innovative meeting that addresses the latest findings in **neuropsychanalysis** and in **attachment theory**. The title of the meeting is ***Psychodynamic Psychiatry and Relationships***.

We will begin our program with an enticing Opening Session titled ***Monsters! A Deeper Look at Vampires, Zombies, and Frankenstein and Their Relevance to Psychodynamic Work***. In this time when many political leaders are being compared to monsters, this session is aimed at looking back in-depth at the original monsters, and understanding why we classify them as such. The presenters will be three of our most engaging speakers: **Eugenio Rothe**, **Wynn Jackson**, and **Jeffrey Katzman**. Our multitalented and world-known **Clarice Kestenbaum** will be the discussant.

**Maria Muzik** will be giving the **Keynote Address**, which is titled ***Reflection in Action: Interventions to Foster Reflective Capacity and Promote Relational Health for Caregiver and Child***. Originally from the City of Vienna, Austria, Maria Muzik is a researcher at the International Psychoanalytic Association and at the Parent-Infant Program of the University of Michigan. Dr. Muzik focuses her clinical work on mothers suffering from anxiety, trauma and depression during pregnancy and postpartum, and on their infants or young children. Her research centers on the effectiveness of attachment-based mother-child psychotherapy for high-risk dyads.

The Annual Meeting will have two Plenary Sessions this year. The Committee on Psychoanalysis of the Academy has organized the **First Plenary Session**, ***Approaches to Integration in Psychoanalytic Theory and Practice***. **Norman Clemens** will be chair and discussant for presentations by **Elizabeth Auchincloss**, **Eve Caligor**, and **Jeffrey Katzman**. Dr. Caligor, an expert in personality disorders from Columbia University (New York), is an invited presenter in this plenary. She has published widely on several topics related to psychodynamics and personality pathology, and has received numerous teaching awards.

The **Second Plenary Session** will be a read-through by professional actors of the play ***Lake Effect***, by Academy member and multiple award-winner, **Richard Brockman**. In addition to his activities as a psychiatrist, Dr. Brockman's plays have been produced in New York, London, Chicago -- off-Broadway, off-off Broadway, Fringe, as well as at various national and international venues. This plenary was funded by an anonymous grant

by members of the Academy.

Our incoming President of the Academy, **Joanna Chambers**, will be presenting together with **Richard Brockman** and **Regina Sullivan**, the panel ***Good Memories from Early Trauma: Redefining Freud's Repetition Compulsion Through Neurobiology***. Dr. Sullivan is a Developmental Behavioral Neuroscientist from New York University who has authored over 100 journal articles and has lectured all over the world.

**Deborah Cabaniss** and **Yael Holoshitz** will be presenting an innovative approach named ***Differential Psychotherapeutics***, which includes a rubric created by collaborating with therapists who practice **23 different types of psychotherapy**. The rubric is jargon free, easy to use, and can help junior learners as well as seasoned psychotherapists to collaboratively make treatment goals with their patients. The panel is an extraordinary new way to conceptualize treatment tailored for the needs of each patient, instead of the old-fashioned one-size-fits-all approach that predominated in the first two decades of this century.

**David Mintz**, **Jessica Yakely**, and **Eric Marcus** will present on a panel named ***Psychodynamics and Doctoring***. Dr. Yakely, from the **Tavistock Clinic**, in London, and the **British Psychoanalytic Society** is invited to present at this Academy panel, together with Dr. Marcus, the immediate **Past Director of the Columbia University Psychoanalytic Center**. Dr. Marcus is known for his clarity as a teacher, for which he has won several awards, and has published widely. **Sherry Katz-Bearnot** will be the discussant for this panel.

The impact of suicide on the psychiatrist is the topic of two sister panels, which will be chaired by **Douglas Ingram** and **Kimberly Best**. These two panels, presented in consecutive days, are part of the ongoing efforts by our Academy to promote psychological wellbeing among our members.

**Maggie Zellner**, Executive Director of the Neuropsychanalysis Foundation in New York City and co-editor of ***Neuropsychanalysis*** will be the discussant of a presentation by **Ahron Friedberg** and **Terence Rogers** titled ***On an Integrated Model of the Mind and Its Clinical Implications***. Dr. Zellner will also be the discussant of a presentation by Lisa Piazza, titled ***The Social Neuropeptides and Cortisol in Social Neurosciences: Implications for Psychoanalytic Theory and Practice***.

The Annual Meeting will conclude with an engaging Presidential Address by Gerald Perman: ***Psychodynamic Psychiatry in 2020: An Open Letter to Sigmund Freud***.

Attachment theory, neuropsychanalysis, affect regulation, self-states, development, suicide, the importance of art and music for mental wellbeing, Lacanian theory, Jungian theory, and psychopharmacology are some of the other themes in the rich series of panels and paper sessions that will compose the final program.

---

We encourage you to reinvigorate the quality of your own neuronal networks and social connections by attending the 2020 Academy Annual Meeting in Philadelphia, PA.

**REMEMBER TO REGISTER!**

**64th Annual Meeting  
April 23 - April 25, 2020  
Philadelphia 201 Hotel  
Philadelphia, Pennsylvania**

**Program and Registration are  
available on the Academy's website:  
[www.AAPDPP.org](http://www.AAPDPP.org)**

**2  20**



# ARTICLES

## The Relevance of Clinical Autobiography

By Marco Bacciagaluppi, MD



In the autobiography of an elderly person like myself, who is 87 years old, there are always many things, and everyone can find something of interest. In my case, for example, there are some items of historical interest, like World War II and the Resistance movement against the Germans, and other areas of scientific interest.

I shall start with the latter of clinical science. One item is already to be found in the title of my autobiography (Bacciagaluppi, 2018), where I describe myself as a “relational psychoanalyst.” I refer here to the fundamental distinction made by Greenberg and Mitchell (1983) between drive model and relational model in psychoanalysis. The drive model is that of the later Freud, after he denied, in September 1897, the traumas of his patients and ascribed their symptoms to “fantasies.” I stand squarely with the earlier Freud, who upheld the reality of traumas. This reality was confirmed by the notion of PTSD, observed in Vietnam veterans and in women who had suffered sexual abuse, and incorporated into DSM-III in 1980. Soon after, in 1984, Jeffrey Masson published Assault on Truth, in which the title itself of the book describes the abandonment of seduction theory on Freud’s part. In the same year, John Bowlby gave a paper on “Violence in the Family,” which was republished in his 1988 book, A Secure Base. In this paper he defines Freud’s abandonment of the seduction theory as a “disastrous volte-face.” After denying the reality of traumas, and therefore also of his own, which he had revealed in a letter to Fliess on February 8, 1897, Freud developed cancer of the jaw. The pain was such that in London, 1939, he asked his doctor, Schur, to give him a lethal dose of morphine. As Alice Miller says, in the title of one of her books, The Body Never Lies.

Turning to my personal history, my life has been characterized by multiple cultural identities. My father was Italian but also spoke English, and my mother was half British and half American. My parents agreed to speak to me in English, which is therefore my mother tongue. On the other hand, since I grew up in Italy, I also learned Italian, and I am bilingual. Furthermore, I was born in Bozen, the capital of South Tyrol, which is a German-speaking part of Northern Italy bordering on Austria. Before the war, the Italian Fascist government was trying to force an Italian identity onto South Tyrol by inventing Italian names for places and by encouraging the emigration of the German-speaking population to Austria, which, in 1938, had been incorporated into Nazi Germany. My parents were against Fascism and firmly on the side of the local population. I therefore acquired there a third, German-language identity. Finally, in 1938 I was enrolled in the Swiss School of Milan, in order to avoid the Italian Fascist school, and there I acquired a fourth, equally German-language, identity.

After the outbreak of World War II in September 1939, Fascist Italy joined Nazi Germany in June 1940. In October 1942, I witnessed the first air raid on Milan on the part of British bombers, after which we moved to our country house. In July 1943, Mussolini was forced to resign. In September 1943, the Italian government signed an armistice with the Allies, after which the Germans started pouring down into Italy and Mussolini set up a puppet government allied with the Germans. This was a very adventurous period for me. My father joined the Resistance movement against the Germans and set up an organization to help the Allied prisoners of war escape into Switzerland. In April 1944, my father was arrested by the Fascist police and my mother and I sought refuge in Switzerland. Then my father escaped from prison and joined us in Switzerland. This was the definitive confirmation of my fourth, Swiss, identity.

After the war, in high school, an important experience was my participation in the New York Herald Tribune World Youth Forum in 1949. Our group was received at the White House by President Truman.

At University, my father obliged me to enroll in medicine, whereas I would have preferred architecture. I tried to avoid medicine by doing research in biochemistry and genetics, but I did not succeed well.

At the end of that period, I was conscripted into the army as the medical officer of an infantry battalion. I was involved in a very severe accident, in which ten soldiers were killed, and I suffered a head injury and lost the sight in my right eye.

At the end of my convalescence, I succeeded in avoiding medicine when I had the inspiration of training in psychiatry and psychoanalysis. In this field, I had a fundamental experience when, in 1963-64, together with my first wife, I stayed for one year in New York and studied with Silvano Arieti, an Italian Jew who had escaped to the United States in 1939 and then became a great specialist in schizophrenia. He trained at the William Alanson White Institute, the center of the interpersonal-cultural school, oriented by Sullivan and Fromm. It was an unforgettable year also because of multiple cultural events. We saw Shakespeare’s King Lear and heard Handel’s Messiah at the new Lincoln Center. Together with my wife, I then translated three of Arieti’s books into Italian: The Intrapsychic Self, Creativity, and Severe and Mild Depression, co-authored with Jules Bemporad.

On the other side of the Atlantic, I was much influenced by John Bowlby, with whom I corresponded for eight years. Bowlby described attachment behavior of the young to the mother in all mammals and in many birds. This behavior is independent of the need for nourishment and has as its aim the defense from predators. For instance, chicks do not follow the hen in order to be nourished, because they peck their food by themselves. This behavior, in common not only to different species, but even to different classes of animals, has a time dimension of millions of years and is by far the most powerful theory at our disposal in psychoanalysis. There was mutual regard between Arieti and Bowlby. Bowlby contributed a chapter to the second edition of the American Handbook of Psychiatry, of which Arieti was Editor-in-Chief.

Another author to whom I often refer is Alice Miller. A Polish Jewess, she suffered severe traumas during World War



II. She escaped from the ghetto of her native city and sought refuge in Warsaw under a false “Aryan” name. After the war she moved to German Switzerland, studied philosophy, trained in psychoanalysis and wrote all her books in German, but they are all translated into English. In all her books she is constantly concerned with childhood trauma. One of her most important books, which I mentioned above, is The Body Never Lies, in which she says that if childhood traumas are not addressed, they will be expressed in the body.

Unlike Freud, and following Alice Miller, in my autobiography I constantly address my traumas. In order to understand the traumas of our patients, we must first look at our own. I describe childhood traumas, both at the hands of my mother, who started to beat me, and at the hands of my father, who was very competitive towards his younger brother, and then transferred this competitiveness onto me. These traumas were compensated for by positive experiences: my mother had previously breastfed me for one year, and my father during the Resistance was a very positive model. I then had traumas at an adult level: the illness and death of my first wife, and later my pathological mourning for the death of my father. I turned to two therapists, one after the other, but it was to no avail. In Free from Lies, Miller warns against inadequate therapists. Since then, I carry out a constant self-analysis, which is much more effective.

By cooperating with an increasing number of colleagues who shared my relational view, in November 1996 OPIFER was founded, and in 1999 we started to collaborate with the AAPDP in our Joint Meetings. These meetings take place “In the Footsteps of Silvano Arieti.” They therefore refer to my foundational meetings with him in 1963-64, and confirm my American identity with its multiple roots.

After overcoming my mourning for my father, in 2012 I published my most important book, Paradigms in Psychoanalysis, at first in English, then in Italian. In 2013 I edited The Milan Seminar by John Bowlby in English, and in 2015 in Italian. It contains my correspondence with Bowlby. This is a seminar which Bowlby gave in Milan in 1985. Finally, in 2018 I published my autobiography.

To conclude, the benefit of an autobiography which examines traumas is that it also highlights the positive experiences that compensate for them.

## References:

1. Arieti, S. (1967). *The Intrapsychic Self. Cognition and Creativity in Health and Mental Illness*. New York: Basic Books.
2. Arieti, S. (1976). *Creativity. The Magic Synthesis*. New York: Basic Books.
3. Arieti, S. and Bemporad, J. (1978). *Severe and Mild Depression. The Psychotherapeutic Approach*. New York: Basic Books.
4. Bacciagaluppi, M. (2012). *Paradigms in Psychoanalysis. An Integration*. London: Karnac.
5. Bacciagaluppi, M. (2018). *Appunti autobiografici di uno psicoanalista relazionale*. Milano-Udine: Mimesis.
6. Bowlby, J. (1988). *A Secure Base. Parent-Child Attachment and Healthy Human Development*. New York: Basic Books.
7. Bowlby, J. (2013). *The Milan Seminar. Clinical Applications of Attachment Theory*. Edited by Marco Bacciagaluppi. London: Karnac.
8. Greenberg, J. R. and Mitchell, M. L. (1983). *Object Relations in Psychoanalytic Theory*. Cambridge, MA: Harvard University Press.
9. Masson, M. M. (1984). *The Assault on Truth. Freud's Suppression*

- of the Seduction Theory. New York: Farrar, Straus and Giroux.
10. Miller, A. (2006). *The Body Never Lies*. New York: Norton.
  11. Miller, A. (2009). *Free from Lies*. New York: Norton.

Based on a presentation at the Seventeenth AAPDPP-OPIFER Joint Meeting in Florence, Ospedale Santa Maria Novella, October 19-20, 2019.

## Patient Suicide: Impact on the Psychiatrist and the Health Care System

By Kimberly Best, MD and Douglas H. Ingram, MD



I was in the 4th month of residency working with homeless and severely ill patients – alcoholic, schizophrenics, bipolar, and all else. A new admission arrived with the startling complaint that she was deeply depressed because she was unable to reconcile the notion of Freudian psychic determinism with that of an existential will. Apart from my inability to understand the problem, I could not help noticing that she was incredibly beautiful, refined, and well-spoken.

When the media announces a death by suicide, the thoughts of psychiatrists in the audience turn to the treating psychiatrist. Was the deceased in treatment? Who was treating him or her? We wonder and express concern for the treating psychiatrist, as well as for bereaved family and loved ones. We understand that the loss of a patient to suicide is a distressing event in the career of a psychiatrist. We sometimes speak of the ripple effect of suicide, with the intensity of impact more significant for those close to the lost individual, and less intense as a circle widens. In fact, it might be more fitting to think of the effect of suicide as a matrix, with each individual affecting many others, so that those left behind are embedded in a complex web of interactions and reactions that expands and reverberates.

My heart pounded as I learned more about her, her struggles with apathetic parents and an abusive boyfriend. As we worked together, I became delighted by her intelligence, her carefully constructed English, and the remarkable way she contorted her face while thinking. I adored her. We talked and talked, and I felt sure that I was the best person to provide the empathy and insight she deserved. I fantasized that we would work together in therapy for years. Though I had no erotic desire for her, I felt a strong need to be a vital force in her emotional growth.

The Task Force on Psychiatrist Wellbeing and Support of the American Academy of Psychodynamic Psychiatry and Psychoanalysis is building a collection of support materials and resources to help those who have encountered a variety of stressful events in the professional life of a psychiatrist. See the website: <http://www.aapdp.org/index.php/Program/>. Suicide death is one of the major topics the Wellbeing Task

Force is addressing. The group will sponsor two separate presentations, a panel and a workshop, at the annual meeting in Philadelphia in 2020. We hope you register and attend these events and add to the discussion.

Supervisors suggested that perhaps I was too inexperienced, that I should avoid seeing her because she had a Borderline Personality Disorder. I felt differently. We were progressing in our sessions on the in-patient unit, and she valued my observations and interpretations. Her anxiety diminished. She had no apparent suicidal thinking and showed no evidence of psychosis. When discharge discussions began, she stated to the treatment team that she was unable to speak openly with other therapists and only wanted to speak with me. She stated she was able to laugh now, to enjoy her days more, and felt she could cultivate new relationships. The administration approved my continuing to work with her as an outpatient.

At our upcoming Academy meeting, our panel, "The Impact of Suicide on the Health Care Community" will increase awareness of the breadth of the impact of suicide. When suicide occurs in a hospital setting, many people are directly touched by the event. These include the nurse who finds the patient, the code team who rushes to intervene, medical students who met the patient, and many more. Each of these individuals brings a personal history to the event. There are members of various disciplines, and these individuals are at various stages of their careers. All these factors affect the reaction to the death. In addition to individual responses, they bring a group history and group processes to the event. They influence one another in real time at the work site as they process the multiple meanings of the unexpected death of someone being cared for on their unit. This panel will explore issues that arise in group settings in response to a death by suicide. Psychiatrists who attend this panel will be more prepared to understand their own reactions and to support the rest of the team when a suicide death occurs in a clinic or hospital setting.

She was soon seeing me 3 times weekly, arriving punctually, showing livelier affect, and feeling less vulnerable to victimization. But one Saturday, after seeing me that week without trouble, she missed a session. She had never missed a session before. I called several times, left messages, and waited. Then I received a call from the police.

This panel is co-presented by the Wellbeing Task Force and the Department of Psychiatry at Einstein Medical Center in Philadelphia. Dr. Kimberly Best, Associate Chair and Residency Training Director, will moderate the panel and offer opening remarks. Dr. Ajita Mathur, Chief of the Consultation and Liaison Division and Associate Training Director, will discuss the response of a medical unit to a death by suicide on the unit. Such a death has multiple meetings in the immediate moment, and additional meetings as individuals in the group discover that administrative tasks combine with personal reactions to create meanings as they process the impact of the death. Dr. Sarah Noble, Medical Director of Outpatient Services, will discuss death by suicide in the outpatient setting. Dr. David Greenspan, Chair of the Department of Psychiatry, will discuss the Chair's perspective on death by suicide. The Chair is responsible for supporting the wellbeing of the psychiatrists in the department and for the functioning of the department as a whole. A Chair who is effective in this situation must

develop an understanding of the meaning of suicide at both individual and group levels. The panel will provide opportunity for questions and audience comments.

The workshop, "The Impact of Patient Suicide on the Psychiatrist," will be chaired by Dr. Douglas H. Ingram, Chair of the Task Force on Psychiatrist Wellbeing and Support for those who have experienced patient suicide.

I was asked to go to her apartment and identify her body. I was shaking, terrified, and devastated. I walked up the four flights and found her lying face down on the rug, an empty bottle of pills next to her. I was notified because the suicide note was to me, saying that the only reason she felt bad about killing herself was that it might cause me grief, and that pained her. But her hatred of her parents was so strong that even my kindness could not stop this. I returned home, shaky and woozy. I also was terrified of facing her parents, who were flying in from Ohio. My analyst coached me: speak caringly, avoid suggesting they were in any way to blame. Although her parents felt her loss, they were curiously indifferent. At the end of the session, they paused to ask one final question: Where did I think they might be able to sell her things to at the best price?

I nearly left the field as a result of my desolation. Eventually, I was able to acknowledge a deep feeling of love for her, perhaps something of chivalric purity, and that I could reconcile with notions of "clinical detachment." I decided to memorialize her in my work with subsequent patients by holding true to empathy, insight, acceptance and warmth that were the hallmark of my work with her.

In my forty years of clinical work since that tragic event, she remains a reoccurring and sustaining presence. I have had no further patient suicides...not yet. [The authors thank the anonymous contributor of this clinical vignette.]

## **Lessons from Lacan: How His Ideas Can Help Your Psychodynamic Psychotherapy Practice**

By Gerald P. Perman, MD

Jacques Lacan was an enigmatic psychoanalyst born in 1901 and who died in 1981. He gave weekly lectures in Paris for almost 30 years and is better known in the French, Spanish, Portuguese and Italian-speaking psychiatric world than in the English-speaking world, where he is still mostly viewed as a dissident psychoanalyst. He is also better known in departments of humanities including comparative literature, literary theory, media studies, feminist theory, philosophy and intellectual history than in departments of psychiatry. His lectures and writings were complex and oracular, his theories changed over time, and he created his own words (neologisms), and devised strange-looking formulae (mathemes) in an effort to more precisely define his ideas in an attempt to make them closer to science.

Lacan based his work on the linguistic aspects of Freud's writings and he called his life's work "a return to Freud." While he acknowledged the existence of biology and genetics, he left these influences on human mental functioning to others. In my experience, it is more useful at first to read knowledgeable authors who have written about Lacan's ideas, than to attempt to learn about his work directly through his *Ecrits* and *Seminaires*. (1-7) The latter approach is a surefire way to quickly dismiss Lacan and view

him as not having much to contribute to the psychoanalytic discourse.

In 1936, Lacan presented a paper to the International Psychoanalytic Association in Marienbad, Germany on what he called the “mirror stage” of development. Since human beings are born in an immature state, and only gradually acquire mobility and language, Lacan wondered how children developed a relationship to their bodies. He postulated, based on animal studies, that between six and 18 months of age, children identify themselves with the image they see in the mirror, and have the jubilant perception of themselves as being whole and complete, in contrast to their inner experience of being fragmented and disconnected.

Lacan then made a profound leap. He postulated that the child’s false perception of itself in the mirror is characteristic of one of the three registers or orders by which human beings experience the world. Lacan called this false perception seen in the mirror the ego, and this visual image is the basis of our initial impression of all other people we meet in life. This is, indeed, how we “judge a book by its cover.” The Imaginary Register is the basis of our gut reaction to meeting others for the first time, of prejudice, and for much of the advertising industry.

Later, in the 1950s, Lacan described what he called the Symbolic Register that includes the more enduring qualities that makes each of us the person that we are: our language, culture, family history, religion, rituals, the laws of our society, and so on. The Symbolic Register is waiting for us before we are born: our parents often have a name chosen for us, we are born into a language, a religion, and are usually given a gender identification.

According to Lacan, if the Paternal Metaphor, i.e. the father’s role in the Oedipal drama, also called The Name of the Father, in the Symbolic Register is absent, the child will remain in a dyadic relationship with its mother, with resulting grandiosity, paranoid terror, and the language deficits characteristic of schizophrenia. The child is unable to differentiate from the mother and establish functioning human bonds.

Finally, Lacan identified a third register of human existence, the Real, that includes all that is not a part of the Imaginary Register – it is not experienced through perception – and it is also outside of the Symbolic Register such that there are no words with which to conceptualize it. The Real lies in Freud’s dynamic unconscious and when we give words to previously unnamed experiences, we say that the Symbolic Register makes a cut in the Real. To paraphrase Freud: “Where the Real was, the Symbolic shall be,” but for the subject to experience the whole truth about itself, it must confront and accept its symptom as being part of itself. According to Lacan, each of us has a “symptom” and there is no “normal” person.

I will now briefly discuss a second major innovation of Lacan. Lacan became interested in the structural linguistics of Ferdinand de Saussure in the second decade of the 20th century. De Saussure called the sound of the words we hear signifiers and the concept that the signifier points to, a signified. A signified is not a particular object, but instead the concept or category of an object, such as “car,” “cow,” “pencil,” and so on. Lacan postulated that our unconscious consists of chains of signifiers, or words, and that the work of analysis is to facilitate the verbal expression of these signifiers by the analysand.

Lacan believed that the subject literally consists of chains of unconscious signifiers. Otherwise put, we are our words, and that by facilitating verbal free association, the analysand will be freed up of the symptoms and the pathological character formations for which he or she is seeking treatment. Therefore, we are more interested in what our patients actually say than what they tell us they meant to say. Their slips of the tongue, their associations to their dreams, their mistaken actions, and their neurotic symptoms is their unconscious speaking the truth about who they are.

Lacan’s approach to psychoanalysis was to raise more questions than to provide answers, creating an atmosphere in which the patient would come up with the answers to their own questions. This, in my view, is the essence of Lacanian analysis: to engage the analysand’s curiosity about him or herself. What follows are a few seminal concepts in Lacanian psychoanalysis that I believe can have applicability to your practice.

### 1. The unconscious is structured like a language.”

This is Lacan’s most well-known aphorism and is central to his theory of how the mind works. As described above, Lacan believed that the unconscious is made up of “chains of signifiers” (repressed words) and that these signifiers relate to one another using the rules of language found in poetry and song, such as metonymy, in which the part represents the whole, and metaphor, when we say that something is similar to something else.

For example: “I’m taking my wheels out for a spin” uses both metonymy with “wheels” standing for a car, and metaphor, with “spin” having similarity to taking a ride in a car. If we look closely at all of our spoken and written sentences, I believe that we will find rhyming, metaphor and metonymy all the time. For example, in my previous sentence: the words “look closely,” “we will find,” and “all the time” have letters and sounds that are repeated and sound good together: our language is more beautiful than we usually appreciate. Paying attention to the metonymy and metaphor in our patients’ speech uses the patient’s innate poetic creativity and will help lead to the relief of their psychiatric symptoms.

An obese patient, speaking metaphorically, remarked: “I have so much on my plate at work!” I replied: “Too much on your plate at work, and too much food on your plate at home.” This led her to reflect on how she had been off her diet and gaining weight, the reason for which she had sought treatment in the first place.

### 2. “Language is meant to be misunderstood.”

Part of the attraction of Lacan was his ability to turn what seemed to be a commonly accepted idea – in this case, that language facilitates understanding – on its head in a way that surprises us with unexpected truth.

Whenever we speak or write, we use words that the other person claims to understand, but there is always an enormous amount of misunderstanding built into our communication. This was expressed well in a line in a Western movie: “There’s many a slip, twixt the cup and the lip.” But because there is sufficient overlap between the shared meaning of words, we are still able to communicate with one another. The misunderstanding about what words mean to each person, however, is often a source of conflict and argument



between individuals, as well as sometimes between nations leading to war.

A man calls his wife and, wanting to please, asks her what she would like him to make for dinner before she gets home. She replies, "Seafood with pasta would be great!" When she gets home, he has a hot bowl of capellini with white clam sauce on the table. She yells, "how could you – you know I'm allergic to clams and I only like rigatoni!" To have avoided this train wreck, the husband needed to have asked "what kind of seafood" and "what kind of pasta." Either he was unaware of his wife's culinary tastes—unlikely—or he was being passive aggressive to make her angry.

I tell my psychiatric resident supervisees that the three most important words in psychotherapy are "tell me more..." to encourage their patients to elaborate on what they are saying so they can get closer to what the patient has in mind.

### 3. "Our greatest misery gives us our greatest pleasure."

TMS (transcranial magnetic stimulation), CBT (Cognitive Behavioral Therapy), and other brief treatments, can sometimes provide rapid symptom relief, but have relative limited ability to change long-standing unhappiness or enduring patterns of self-defeating behavior. Patients' compulsive rituals, excessive alcohol intake, self-mutilation, repeated academic failures and so on, cause enormous psychological pain and can interfere with the achievement of important life goals, and yet these symptomatic behaviors serve a homeostatic purpose and defend against unconscious psychological threats that would cause even greater psychic pain.

In the vignette I gave above, the greatest pleasure of the obese patient, eating, also caused her greatest misery, her obesity, and was a way for her to defend against other anxieties, such as a fear of sexual intimacy.

A patient consulted me because alcohol binges associated with gambling and financial losses were threatening the stability of his marriage. When I suggested that he consider taking disulfiram (Antabuse) that would make it impossible for him to drink alcohol without feeling ill, and might help him save his marriage, he immediately rejected my proposal. He said he wanted to be in "control" over his life and not be controlled by a drug – even though alcohol (a drug) made him lose control. This man obtained more pleasure from drinking and the thrill of gambling than the misery that these activities caused him. He also unconsciously wanted to find out how much his wife loved him, and for how long she would put up with his risky and self-destructive behaviors.

Lacan called the pleasure that patients get from their symptoms "jouissance," but it is a painful pleasure, an excess of pleasure, sometimes equated with the exquisitely unbearable sensation immediately before sexual orgasm. In a 1974 lecture in Louvain, Belgium, Lacan remarked that the only way we can bear the unbearable jouissance of living is because we have the certain knowledge that one day it will all be over and we will die.

### 4. "Our desire is the other's desire."

How often do you make a food choice at a restaurant based on what your dining companion, or someone at another table, has just ordered? This is the basis for advertisements that suggest that you too would enjoy driving, eating, wearing, or whatever the attractive model in the picture is doing. In order

to facilitate all of our relationships—romantic, academic, occupational—we strive to find out what the other person wants and then to fulfill their desire. Thus, our desire is the other's desire.

A young adult patient, newly living on his own, complained that he never heard from his parents. When I asked if he called them, he replied, "of course not, if they really cared, they would call me!" His narcissism was showing and, thinking about Lacan, I said, "perhaps if you were to let them know that you'd like to hear from them, they might be more inclined to give you a call." Otherwise put, his desire would then become their desire. The problem was quickly resolved to the benefit of both the patient and his parents.

When new patients used to call for a first appointment, I would tell them times I had available and asked that they choose one. Now, instead, I ask what the best times would be for them to meet with me. Thus, I let them know that my desire is to fulfill their desire, and not the other way around. Of course, if I don't have availability that meets their request, I let them know. But I have first taken their desire into consideration, and only then my own.

The goal of a Lacanian analysis is for the subject to discover the origin of and become responsible for his or her own desire.

### 5. "The patient knows everything and the analyst knows nothing."

I love this Lacanism! We would all like to make our problem someone else's

problem. Patients see their psychiatrist, in Lacanian terms, as "the subject who knows," just as small children imagine that their parents know everything. As adults, we "turn to the experts" – nowadays to Google – to get the answers to our questions and, in general, this is not a bad thing.

On the one hand, yes, we psychiatrists do know a thing or two, but on the other hand, the psychological conflicts that create the symptoms that our patients come to us for help with reside in their unconscious and speak to us and to them through their symptoms, slips of the tongue, dreams, bungled actions, and character styles.

When we take the position that "the patient knows everything and the analyst knows nothing," we give the responsibility of the analytic cure to the patient who will benefit from doing most of the work in treatment through discovering what is in his or her unconscious.

### 6. "Objet petit (a) is the object cause of desire."

Lacan claimed that "Objet petit (a)" is the driving force that causes us to seek out what we desire, although this "object" does not exist in reality. Instead, as soon as we get what we want, we immediately want something else, and then something else.

In their recent book, "The Molecule of More: How a Single Chemical in Your Brain Drives Love, Sex and Creativity – And Will Determine the Fate of the Human Race," (8) my colleague, Daniel Lieberman, and his co-author Michael Long, describe how dopamine, the reward neurotransmitter, is only released in the anticipation of receiving a reward, but shuts off abruptly as soon as the reward is obtained.

A former supervisor of mine, Louis Conte, gave the example of the opera singer who feels disconsolate after the final curtain has gone down, and the audience is filing out of the opera house. The same happens when a cocaine addict “crashes” after a binge and has depleted his or her brain of dopamine.

The perpetual search for the next new thing, or exciting sensation, according to Lacan, is due to “Petit Object (a),” and gets out of control with people who are hoarders and who collect more things than they can ever use, and those with other addictions who are perpetually seeking their next high. A recent newspaper headline about people no longer lining up around the block for the newest iPhone was: “The iPhone has Lost its ‘Wow’ Factor.” Salman Akhtar’s book, “Objects of Our Desire: Exploring Our Intimate Connections with the Things Around Us,” provides a more classical psychoanalytic point of view. (9)

7. “The sentence completes its signification only with its last term.”

We never know what a patient has in mind until we hear the last word in his or her

sentence. This idea helps us “hold our horses” when listening to patients. As much as we may think that we know where the patient is going with his or her story, it behooves us to listen until the patient has completed his or her thought.

There are an infinite number of endings to any interrupted sentence, and this changes as you get further along in the sentence. This is the rationale behind the well-known “Sentence Completion Test.” We could also say that that a person doesn’t know the full meaning of his or her life until life itself has come to an end and can be examined in its entirety.

8. “There is no sexual relation.”

I will finish my “Lessons from Lacan” with Lacan’s provocative statement that “there is no sexual relation,” also translated as “there is no relationship between the sexes.” What could Lacan possibly have meant, since we all know that people “have sex” and that many people are “in sexual relationships” with one another?

By this Lacan meant that sexual relationships among humans, like all aspects of human relationships, is established and mediated through language. According to Lacan, when we are in a relationship with another person, including a sexual relationship, we are relating to the other person through the three Lacanian registers: The Imaginary, The Symbolic and The Real, but not to a whole, integrated, person. In this sense, “there is no sexual relation.”

A woman had been in a romantic relationship with a man for several years toward whom she felt extremely ambivalent but could not bring herself to leave. On the one hand, her boyfriend was handsome, a good lover, and gainfully employed, and they both usually enjoyed each other’s company. But on the other hand, he was obsessed with motorcycles about which he frequently talked, both with her and in social situations. She found his obsession to be tiresome and, when among friends, disrespectful to their sensibilities. She feared, however, that if she left him, she would be alone, she would never find another boyfriend, and that she would hurt his feelings. Therefore, it was not “him”

with whom she was having a relationship, but instead to his various attributes, some of which she liked and another that she found intolerable.

When a new patient tells me that he or she was dissatisfied with his or her previous psychiatrist, I always ask what it was about this psychiatrist that my patient did not like. I am inquiring about the attributes of the previous psychiatrist and to anticipate the qualities that the patient might soon find lacking in me, based on the developing transference.

## Conclusion

Jacques Lacan developed many clinically interesting and engaging ideas that continue to capture the attention of tens of thousands of psychotherapists across the world. In this article I described a number of Lacan’s seminal ideas and a few of his concepts that I believe have great clinical utility and that I hope will encourage you to learn more about the work of this enigmatic psychoanalyst.

## References:

1. Introducing Lacan: A Graphic Guide by Darian Leader, Richard Appignanesi, Judy Groves, Icon Books Ltd. 2005
2. Lacan: A Beginner’s Guide by Lionel Bailey, Oneworld Publications 2009
3. Against Understanding: Commentary and Critique in a Lacanian Key, Volume 1 by Bruce Fink, Routledge Taylor & Francis Group, London and New York 2014
4. Against Understanding: Commentary and Critique in a Lacanian Key, Volume 2 by Bruce Fink, Routledge Taylor & Francis Group, London and New York 2014
5. Let’s Keep Talking: Lacanian Tales of Love, Sex and Other Catastrophes by Yael Baldwin, Karnac Books 2016
6. A Clinical Introduction to Freud by Bruce Fink, Norton Books 2017
7. A Clinical Introduction to Lacanian Psychoanalysis: Theory and Technique by Bruce Fink, Harvard University Press 1997
8. “The Molecule of More: How a Single Chemical in Your Brain Drives Love, Sex and Creativity – And Will Determine the Fate of the Human Race,” By Daniel Z. Lieberman, MD and Michael E. Long, BenBella Books, Inc., 2018, Dallas, TX, 225 pp.
9. “Objects of Our Desire: Exploring Our Intimate Connections with the Things Around Us,” By Salman Akhtar, MD, 2007, Crown, pp. 224

## Long Term Individual Psychoanalysis: do we still need it for therapy?

By Reimer Hinrichs, MD

### Overview

“We believe that psychoanalytic ideas may be helpful in understanding the details of how someone becomes ill, but it is not psychoanalysis as such that will cure the disease.” (Leader, Cornfield, 2007: 8f.)

Recently, we did and currently, we do find a renaissance of psychoanalytic theory. One example is neuro-psychoanalysis (Mark Solms), in which metapsychology is connected with brain morphology. Others are Attachment Theory (John Bowlby) and mentalization (Peter Fonagy). This all is respectable and good, but we find not directly important in therapeutic matters.

Analytic technique was interpreted by Juergen Koerner (2016) lately down to the thesis, that not the classic theory is important for success in therapy, but instead the patient’s



psychic structure. This has led to many eclectic concepts of “integrative” and “modular” pieces of therapeutic approaches, especially in the inpatient setting, all of which settled under the roof of “psychodynamic psychotherapy.” Classic analytic abstinence (vertical cooperation) is losing ground in favor of pragmatic cooperation for help in life (horizontal cooperation). Through this approach, behavioral aspects and non-verbal therapeutic techniques were introduced into psychodynamic therapy.

In therapy, all new paradigms are circled by a change from a vertical to fair and transparent patterns of relationship between therapist and patient. All is transparent, personal and especially respectful. The therapist’s reliability as a source of the patient’s trust became more relevant than classic structures of standard psychoanalytic techniques like abstinence (of the therapist) and associations (of the patient). All of what the patient may be saying is a twisted narrative, followed by the second narrative of the therapist’s interpretations. Both narratives can be biased by false memories, a fact that for a long time has been neglected in analytic research. False memory is a trivial and common phenomenon in everyday life.

This means that the best way of “understanding” the patient is the appreciation of intrinsic or implicit knowledge, both of which are unsaid and shared by both participants in the individual process of dynamic psychotherapy. One example of the need for this shifting is the patient’s morbid gain. A therapist who is not able to recognize primary, secondary, and tertiary morbid gain in his patient is bound to fail in therapy of this patient. Primary morbid gain = private protection by family and peers; secondary morbid gain = public and social support in matters of rehab, housing, and money; tertiary morbid gain = all advantages for the therapeutic people and industry connected with therapeutic work. We have a zoo of therapists with all forms of qualification. A lot of money is involved in all three forms of morbid gain. We could also say that the patient is the therapist’s employer.

### **The System of Outpatient Psychotherapy in Germany**

In Germany, the public system of insurance-based outpatient psychotherapy consists of four branches, which exclude each other in the way of applying for being paid by the patient’s insurance. The therapist can only apply in the patient’s name for one at the same time of the following.

Analytic PT (APT), dynamic PT (TPT), and cognitive behavioral therapy (CBT) are well established. Recently, in November 2018, systemic therapy (ST) was added. All these forms are covered by insurance. The therapist is paid with \$90 USD before taxes for a session of 50 minutes. Analytic psychotherapy was introduced in 1967 by a study of German MD and psycho-analyst Annemarie Duehrssen (1962); in her study, she investigated two groups of 1004 patients each with neurotic symptoms. Her question was: Does outpatient analytic psychotherapy (150 sessions) reduce the inpatient admission days of patients per year?

The main point was how many days of inpatient care each participant had had the year prior to the study; the average was 20 days of inpatient stay, no matter in what field of medicine. One group received 150 sessions of outpatient analytic psychotherapy, the other received nothing. In a follow-up study, Duehrssen found that the group which received analytic PT reduced their yearly days of inpatient

hospital admission from 20 to an average of 3, whereas the control group without APT stayed with 20 days of inpatient medical care per year. That was the breakthrough, and the German medical system included analytic psychotherapy in its catalogue of available outpatient therapies without the patient’s cost. The authorities concluded it was cheaper for the insurance to pay for outpatient AP rather than for inpatient care.

Today, the situation is different. In a recent study (Doering, 2018), it was investigated how many days patients with different outpatient forms of psychotherapy have been written sick by MDs before and after outpatient therapy. Epping, et al (2018, as quoted in Doering, 2018b: 411) additionally showed in a very large and solid recent study which was mentioned above (n = 9916 in the years of 2003-2015) that the day of written sick in one year dropped after dynamic PT (TPT) and Behavioral PT (CBT) from 20 to 6, whereas no reduction was seen in cases after analytic therapy (APT). It stayed as 4 days written sick before and after analytic therapy. We should add that their days off work were low even at the beginning of analysis (4) and stayed on that level after analytic psychotherapy. It may be that a lot of YARVIS-patients have been in this group (young, attractive, rich, verbal, intelligent, social).

CBT and Dynamic Psychotherapy reduce the days of being written sick per patient per year from 20 to 6, whereas patients undergoing psychoanalysis stayed with 8 days sick per year, which is the same number as they had before analytic psychotherapy. Nothing changed here, but the days of being written ill per patient with analysis were low (7 or 8) anyway before the beginning of analytic therapy (Doering, 2018b: 411).

### **Current Aspects**

Today, “dynamic psychotherapy” is the main word for all kinds of psychotherapeutic techniques derived by analytic standards or theories. The classic psychoanalytic theory has lost its leading role since the 1970s to CBT and systemic approaches, which influenced academic psychotherapy in our universities. Statistics, lab tests, and short therapies have become more prevalent. Efficiency is considered to be crucial, but the definition of efficiency has changed over the decades. Outpatient individual analytic psychotherapy as a long-term therapy has become more of a luxury.

### **Epidemiology**

It has been said that at a given time in Germany, 32% of the adult population suffer by mental or psychogenic symptoms; (n = 8 million), 64% receive no support at all. 36% receive unspecific help of nonprofessional, advisory or blurry kind (2.8 million). In this connection, 10% out of this 64% (n = 280,000) will receive “interventions” of some kind. And 36% out of this 10% (n = 100,000) get specific psychotherapy outside psychiatry and paid by insurance. This is the outpatient situation. However, more than 50% of this group will get cognitive behavioral therapy (n = 60,000), and the rest (n = 30,000) gets either eclectic dynamic therapy in short or longer form or analytic therapy.

Since dynamic psychotherapy covers 90% of this group (n = 27,000), less than 3,000 patients will get the luxury of individual, analytic outpatient psychotherapy per year in Germany. Given the fact that many of these are YARVIS

patient cases, there is not much room for patients with a psychogenic pattern of symptoms left for outpatient analytic psychotherapy. The running joke is that analysts prefer to accept healthy patients for analytic treatment.

Only less than 0.05% of all individual outpatient psychotherapies in Germany are analytic and long term; that is 2000 in a group of 8 million mentally ill persons in Germany. And these 2000 analytic patients are the easy ones.

The number of applicants for training in psychoanalysis has decreased immensely. The institutes are now accepting candidates older than 50, whereas in the 1970s nobody above age 40 was admitted.

### **Research in Psychoanalysis**

Markus Faeh (2002: 114) summarized the dilemma in one sentence: "In psychoanalysis the systematic research of failing factors is missing." This may be one reason for losing ground of psychoanalysis in outpatient psychotherapy, that many analysts still are immune to criticism (Schaefer, 2016), because of the long and expensive education they have received. They don't want to question the method. It is still an open question, how research and evaluations in psychoanalytic therapy can be conducted.

One way is the hermeneutic and heuristic case study, which has a long tradition; the other way is the statistic survey of "evidence-based" psychotherapy, or the meta-analysis of literature. Lately, two authors, who could not find an answer, voted for a blurry "plural" way (Sell, Warsitz, 2018). In 2010, Jonathan Shedler, stated that there is no evidence at all in evidence-based research.

### **The Institutional Side**

It is an open secret that the internal dynamics of psychoanalytic institutions are not transparent. Envy and power are handled almost like in any political party. The education is not free; the candidate has to be qualified before applying as candidate as a specialist in medicine or an approved clinical psychologist. Then the analytic training takes 5 years and the costs are about \$100,000 USD, and the outcome of passing the final examinations is uncertain. Especially the matter of training analysis is difficult to handle for the candidate. His or her training analyst may be the supervisor of other candidates, and rumors are the rule.

The leading group of teaching and training analysts and supervisors are heading the institute in a manner which is often blurry for the candidates. The leaders have secret circles of meetings; decisions are made about any candidate behind closed doors. The analytic training is performed as a "ritual of stones" (Beamtenkredit, 2017). Shmuel Ehrlich from Jerusalem says, "the intergenerational problem, which supposedly was solved on an individual basis, is shifted and projected in the field of the organization and institutions, and there it is heavily acted out." (2017: 227)

### **The Therapist's Side**

In Germany, a candidate for psychoanalytic training can only apply either when he is already a specialized MD or a clinical psychologist. He must have successfully passed 5 years of college as well as clinical experience of another 5 years, then the analytic training starts, with a minimum of another 5 years until final examination. That makes 15 adult years of training. Then, if approved as analyst, he gets \$90 USD for 50 minutes of analytic session before taxes.

For many, this pattern does not sound promising, given the fact that his past time in college together with the coming training in psychoanalysis did and will cost him at least \$150,000 USD along the way.

And then this is only the beginning of the rat race to become a training and teaching analyst against established leaders of his institution, who decide out of any transparent control.

During this process of analytic training, the candidate never will get a glimpse of the decisions of the head corpus of the institute. The candidate also never can be sure if he will finish successfully.

### **The Patient's Side**

For the patient, the market is the problem. Every analytic office which works with 10 patients at 3 hours each week is full for the next coming 3 years. That means that the patient must take any place and any analyst he can find. Whether the chemistry between the two of them fits does not matter for getting a place in analytic therapy. If the patient does not take the one place he is offered, he must start a new search and wait at least another year to find a place.

This is true for Berlin, which has 21 analytic institutes and is Germany's psychoanalytic center. In smaller towns or rural areas, the market situation is much worse. And it is an open secret that analysts try to find a YARVIS patient so that the offices are blocked by healthy upper-class patients for a long time.

Another dilemma in psychoanalytic therapy is morbid gain, which means that patients use their symptoms to gain private or public and social support by keeping the suffering patient's victim status. The classic regressive situation of analytic therapy very well can work as a spoiling factor for the patient. And medical authorities in Germany have decided that a patient who has received 300 hours of analytic therapy and is not satisfied with the results just has to wait two years, and then he can start a new psychoanalysis at the cost of his insurance. The patients also can change the therapist in the middle of a running therapeutic process by applying to their insurance.

### **Spirit of Time (Zeitgeist)**

The German-Iranian neurologist und psychotherapist Nossrat Peseschkian (2017: 609), who established positive Psychotherapie, shows us which components of the current time spirit are standing against the work of classic-analytic solving of conflicts. He says the current situation of society is like a crisis of a relationship: "The main symptoms of this inter- and intrapsychic crisis are low tolerance of frustration, a huge readiness for aggressive arousal, individualism, hatred, egoism, prejudice against others, feelings of senselessness, and a poor culture of communication, especially in the social networks." I would call his words a summary of digital dementia, leading to a multiform shaping of isolation. This involves not only patients, but analysts as well. The climate is no longer analytic. This was stated as early as 2008 by Eizirik, but his thesis had no public consequences within the scientific community.

### **Nosology**

Since every analytic therapist has to apply in a written expertise to an expert (Gutachter) if the analysis will be covered by insurance, it is common that even YARVIS

patients are described by their analyst as being severely neurotically ill with a very complicated psychodynamic pattern in their past. The problem here is that YARVIS patients are constantly blocking analytic places on the outpatient market of psychotherapy. To write this expertise before being allowed to start with the therapy is not an easy task because DSM-V has eliminated the term of neurosis and has put the huge group of “personality disorder” in that place, which describes any mental disturbance in a linear way and not in a dynamic one. This makes the analyst’s job harder to explain why just this patient needs analytic therapy. As we know, there was no quality control in establishing DSM-V (Frances, 2013).

### **The Efficacy of Long-term Analytic Individual Psychotherapy**

Nobody can be sure that long term psychoanalysis will change the patient’s internal structure, especially if the phenomenon of morbid gain is involved on the patient’s side. He won’t tell the analyst. Even the persistence of a symptom complex is described as a “progress” because it can be interpreted as an accomplishment to avoid dangerous insights. Analytic therapy also can fail when the therapist’s and the patient’s structure do not match. I already have pointed out that the patient has to take any analytic place he can get.

Chances of healing are low when patient and therapist have a very similar or very different personality structure. Analysis also is at risk if the gender pattern of patient and analyst do not fit together, as far as the patient’s primordial psychodynamics are concerned. Again, the market allows no chance for choosing on the patient’s side. As said above, a recently published study (Leichsenring et al., 2008: 195) shows that neither the changing of internal conflicts nor a helpful influence on the patient’s deficits could be proven after long-term psychoanalytic therapy.

### **Conclusion**

Analytic long-term psychotherapy has lost its therapeutic importance, which it had in the 1970s and 1980s. Long-term individual analytic psychotherapy is obsolete now, because there are effective alternatives which include analytic principles. However, beyond the therapeutic sector, psychoanalysis is still a very intelligent theoretical system in painting a picture of unconscious components in our daily life in art, society, relationships, and culture. But this capability is not therapy.

### **About the author:**

Reimer Hinrichs, MD, born in 1949, supervisor, teaching and training psychoanalyst at the German Academy for Psychoanalysis, Berlin and Munich, Germany; office in Berlin; specialties include Neurology, Psychiatry, Psychoanalysis, Psychotherapy, Psychosomatic medicine, Acupuncture.

## **The Fisher King**

By Greg Mahr, MD and Jamie Sweigart, DO

### **Introduction**

Like all living beings, we suffer from both injuries and wounds. Injuries are those injuries that heal completely, wounds are those deeper blows to the psyche and the body that never fully heal but change us forever. Serious illnesses are wounds, as is grief, abandonment and trauma. While we are culturally conditioned to view mind and body as distinct entities, psychic pain and physical pain are inseparable, and together form a pain complex that can dominate a person’s life.

Chronic pain is a major current health problem, and there are no easy strategies to help patients manage chronic pain. Although pain clearly has a psychological dimension, pain patients are particularly challenging to treat in psychotherapy. In a 2014 review article, Pillay, van Zyl and Blackbeard outlined the complex cultural factors involved in the pain experience. Among many indigenous peoples, chronic back pain is simply unheard of. While this may relate to issues like obesity and exercise, it may also relate to the way that pain is experienced and the meaning that is ascribed to it culturally.

The wound of chronic pain is a challenging clinical issue that our health care system has failed to effectively address. A few short decades ago, our health care leaders were sure that pain was being under treated. Pain was felt to be a fixable injury that a strong enough pill could eliminate. This conviction contributed to the current opioid crisis. Opiate drugs seemed to offer a solution, especially when long-acting opiates were developed more than 20 years ago.

In 2013, 523 tons of morphine were produced worldwide. Yet opiates are only partially effective in the treatment of chronic pain, and the massive increase in opiate production and consumption that has occurred over the last two decades has led to addiction, diversion, overdose, and death. In our misguided efforts to help, healthcare providers may over treat or under treat pain, or treat pain in an incomplete way that does not include the psychic dimension of chronic pain. The medical narrative describing chronic pain is incomplete and insufficiently nuanced.

### **Narrative aspects of chronic pain**

Arthur Frank identified three kinds of medical narratives: (1) the chaos narrative, (2) the restitution narrative, and (3) the quest narrative (Frank 1995). The chaos narrative is the disorganized emotional turmoil that is the first response to woundedness. The restitution narrative is that shown on every television advertisement for a new medication: There is a problem, one takes a pill and the problem is gone. In contrast, the quest narrative includes the dimensions of meaning that arise in response to serious illness.

Modern medicine, which partakes of the materialist ethos of modern culture, is most comfortable offering restitution narratives. I was once told a story about a Western physician working in the African bush. He recounted that he had treated and cured a tribesman of malaria, and he told the story of the native tribesman that he cured of malaria. He noticed the tribesman waiting to see the village healer. The



physician, caught up in his restitution narrative, asked the man, "Why are you waiting to see the healer, your malaria is cured?" The villager answered, "Yes, you cured what the mosquito did, and I am grateful to you. But I still need to know why the mosquito bit me." For him the restitution narrative was inadequate, and he sought a quest narrative.

We and our patients often lack the wisdom to seek quest when quest is needed. Our patients with chronic pain want to experience a restitution narrative, but restitution sometimes does not come. Extending the Frank model, a failed restitution narrative can easily become a victim story. Caught up in restitution/victim narratives, our chronic pain patients seek and demand intervention after intervention, then grow angrier and more bitter as each intervention fails. But they are not injured, there is no simple restitution; they are wounded. Their current wound attaches itself to ancient wounds they are not even aware of and are not readily healed. The restitution narrative must, painfully, be rewritten as a quest narrative.

With our modern Western bias towards cure, we have difficulty viewing illness and suffering as quest. Ancient myths and stories, because they constellate timeless psychic structures and complexes, can guide us in contemporary situations. We are not alone, the problems we face have been faced by our progenitors, and perhaps solved by ancient heroes.

The medieval Fisher King myths and stories describe a recovery narrative of chronic pain. They even directly connect the experience of illness with the idea of quest.

### **The story of the Fisher King**

The Fisher King is wounded by a symbolic injury to the groin. His kingdom is laid waste. He can barely manage his central purpose in life, caring for and protecting the Holy Grail. He waits for a healer, who by asking the right questions, can make him whole again.

Let me retell this powerful ancient tale in modern psychodynamic language. Most of the details of the story will be based on the Chretien de Troyes' story of the Grail and on von Eschenbach's Percival story, but will include elements as well from other sources: de Troyes, Chretien [1991] *The Story of the Grail*. In *Arthurian Romances*, translated by WW Kibler. Penguin Books, Von Eschenbach, Wolfram (2004) *Parzival*, translated by C Edwards, Anthony Rowe, and *The Quest of the Holy Grail* (1969) translated by P. Matarasso. Penguin Books.

The Fisher King is wounded by a blow to the groin from a sacred lance that penetrated his scrotum. This wound, called the Dolorous Blow, was incurred in a battle with another knight. Both and neither were at fault, both acted impetuously from pride, but with good intent and, in their own minds, justly. This magic wound would never heal. The King could neither ride nor hunt, nor effectively rule his kingdom. He was nourished by the Grail, drinking from it while lying in pain. He could only fish, thus his name, The Fisher King.

The young knight, Percival, has the power to save the Fisher King. Percival is wounded as well, but in a different way. His father was a great knight who was killed in battle. Traumatized by his loss, Percival's mother hid with Percival in the depths of the Waste Forest. There she hoped that Percival would never see a knight, and thus would never want to become a knight.

Thus Percival, like all of us, grew up in the shadow of his parents' woundedness. His mother tried to protect him from the very destiny that he must follow to fulfill his life's purpose.

One day, a group of three of King Arthur's knights strayed into the Waste Forest. Percival heard the sound of their armor and saw their beautiful shields and swords. He called after them, "Who do you serve?" They answered, "King Arthur."

Percival had found his destiny and decided immediately to serve King Arthur. But he was naïve and not ready for a true quest. His mother delayed him, gave him bad advice and the poorest of clothes, hoping that "if he is roughly handled, then he will come back to me." Among other things, she told him to never ask questions. As wounded mother, she set him up for failure. Then she begged him to stay, finally collapsing on the path behind him (a nice medieval example of a conversion disorder). Percival rode away bravely, yet burdened by guilt, worried about his mother's collapse, not sure if she was alive or dead.

In a series of adventures, Percival proved to be a brave and capable knight, invincible in battle but naïve. His thoughtless compliance with his mother's advice leads to misfortune for him and others. He decided to go home to check on his mother, but he lost his way and encountered a river that he could not cross. He asked directions of an angler in a boat, who gives him directions to his castle. Unknowingly, he has encountered the Fisher King and arrived at the mysterious Grail Castle.

Percival is received warmly at the great castle. His host, the Fisher King, begs his pardon that he must greet him lying down because of his wound. Dinner is served, accompanied by a great pageant. The pageant involves multiple hosts and attendants, a lance that drips blood, and finally, with great majesty and respect, the Holy Grail itself. Percival witnesses all this, is amazed but remains silent. He has been coached by his mother not to ask questions.

When Percival awakens, he finds that the castle and all the hosts have disappeared. He encounters a woman who tells him the ruin he has wrought by not asking the right questions.

The Grail questions that Percival should have asked are: (1) What ails thee?, (2) How can I help?, and (3) Whom does the Grail serve?

Percival wanders for many years in despair, eventually ending up in Arthur's castle, and finally forgetting the Grail quest altogether. The witch Cundry reminds Percival, as he is drinking and carousing in Arthur's castle, of his true quest. Ashamed, he sets out again to find the Grail Castle and the Fisher King who protects it. Now the Grail Castle, which Percival discovered so easily in his youth, is extremely hard to find. It is everywhere and nowhere, and it appears when you least expect it, when you are not looking for it.

The Grail story does not have a simple ending. The oldest version, by de Troyes, ends abruptly, in mid-sentence, probably interrupted by the death of the author. In other versions the Grail is recovered, the King is healed and, in some, Percival becomes the new guardian of the Grail.

### **Lessons of the Grail Myth**

1. Recovery from woundedness takes a long time; the quest journey is a tedious and painful one. This certainly fits our experience of the treatment of chronic pain patients. Solutions appear unexpectedly, like the Grail Castle.



2. The proper attitude is crucial to recovery for the Fisher King. He never complains, never laments his fate, never asserts his victimhood. He does all he can, he fishes and he waits. Fishing is an important symbolic act. To fish is to seek nourishment from the unconscious, to seek and accept its gifts.
3. The right attitude is crucial in the healer as well. When Percival is naïve, unconscious and under the sway of his maternal introjects and his mother's woundedness, he cannot heal the Fisher King. As healers, the pain of our own woundedness can interfere with our attempt to help those suffering from frustrating disorders like chronic pain.
4. Failure is part of the quest. The quest does not end with Percival's failure, for only then does the real quest begin. In therapy with the chronic pain patients, the real work often begins only when the failure of the restitution narrative is recognized and grieved.
5. The wound relates to the masculine. In the Fisher King's case, the lance and the pierced scrotum symbolize his failed masculinity and his neglect to protect the Grail and instead fight another night with false masculine bravado. In Percival's case, he is naively bold in some conflicts, but in the face of the Grail King, he is timid and does not ask the natural and instinctive questions he is meant to ask but is instead swayed by his mother's self-serving advice.
6. Cure begins with the feminine, the call by Cundry. This hideous witch calls Percival back to his true destiny and gives him the courage to ask the right questions, to nurture, to recognize the pain of the other. True cure involves a complex harmony of masculine and feminine roles. Percival must recognize his independence and masculinity, reject his mother's woundedness before he can be open to his own latent capacities to nurture and care for. Those non-traditional knightly virtues turn out to be exactly the ones he needs. His battlefield skills will not help the Fisher King.
7. Percival's maturation involves a development of consciousness and awareness, but in a complex way. It is interesting that two heroes who can be considered central to Western culture, Percival and Hamlet, both suffer from a hypertrophy of consciousness. They are cut off from connection to the instinctual life and its natural balance. Hamlet's "conscience makes cowards of us all" is very similar to the first line of Eschenbach's Percival, "If vacillation dwell with the heart, the soul will rue it." One must be aware and conscious, but also remain connected to instinctual truths.
8. The final Grail question, "Whom does the Grail serve?" introduces a spiritual dimension to the Grail quest. A true quest narrative always has a spiritual dimension and addresses the deep questions of meaning and purpose that our tribesman faced in dealing with the aftermath of his malaria. The first two Grail questions are natural to us as therapists, the third is the most challenging and forces us to face our own issues of meaning and purpose.

### Summary

Chronic pain is a woundedness of mind and body that our current medical narratives do not effectively address. The Fisher King's wound is an ancient model of chronic pain that helps illuminate certain aspects of the chronic pain

experience. To help others with chronic pain we must heal our own woundedness and be brave enough to ask the right questions.

### References:

1. Frank, Arthur (1995). *The Wounded Storyteller: Body, Illness and Ethics*. University of Chicago Press, IL.
2. Macy and Beth (2018). *Dopesick: Dealers, Doctors and the Drug Company That Addicted America*. Little Brown, NY.
3. Pillay TK, Van Zyl HA, Blackbeard DR, *J Psychiatry* 18, 234-9 (2014) from *The Influence of Culture on Chronic Pain: A Collective Review of Local and International Literature* (2015).

## On Resilience in Psychodynamic Psychiatry

*The study and use of resilience is highly important for psychodynamic psychiatry and psychoanalysis. Yet its efficacy is underutilized in clinical practice. This article, based on a panel at the Academy meetings in May, 2019, will help point the way to its greater application in psychiatry and mental health with more informed approaches.*

*The subject of resilience has historically involved trauma and PTSD. Dealing with loss and suffering are certainly a part of life. But sometimes these events or stressors are so excessive that they disrupt psychological functioning, and a person loses his normal mediating capacity. Resilience is a potential in all of us that can be harnessed therapeutically. There are various factors that influence resilience such as genetic and epigenetic, neurochemical, developmental and psychological and psychosocial. The basic idea of resilience relates to an individual's ability to adapt positively in response to a trauma or significant adversity.*

*The scope of resilience is quite broad. It encompasses the trials and tribulations of being human as well as its tragedies: loss of a loved one, disease, natural disasters, poverty and homelessness, war. It includes other social issues such as immigration, child abuse and bullying. One relevant question is what are the factors that enhance resilience and how do we harvest them? Resilience can be found within each of us and developed, so that we can better cope and become stronger as individuals.*

*In the article that follows, two superb clinician-scientists, who have made significant contributions to the study of resilience, discuss their work. Dr. Nathan Szajnberg, the first presenter, is a Clinical Professor of Psychiatry and formerly the Freud Professor of Psychoanalysis at the Hebrew University in Jerusalem. He is a leading author with three landmark books and numerous articles on resilience. Dr. Vladan Novakovic, the second discussant, a professor of Psychiatry at Mount Sinai, is Director of the Outpatient Department at the Zucker School of Medicine at Northwell Health and a certified psychoanalyst.*

Ahron L. Friedberg, MD

## Role of Resilience in the Treatment of Complex Neuropsychiatric Disorders: A psychodynamic case review

By Vladan Novakovic, MD

Advances in neuroscience and increasing complexity of neuropsychiatric disorders pose nowadays a significant challenge on the contemporary practice of psychotherapy.

Complex presentations such as this case of a patient with autoimmune encephalitis with its extensive workup and multidisciplinary treatment approach often requires prioritizing our psychotherapeutic methods with focusing particularly on fostering resilience through intense therapeutic engagement, providing safe and secure environment and rediscovering hope for the patient.

Autoimmune encephalitis is an autoimmune, inflammatory condition with no particular prior cause found in 90% of cases, but when found, paraneoplastic syndromes are usually present in the past history. The criteria for the possible autoimmune encephalitis are: subacute onset of cognitive deficits with memory decline, diverse psychiatric symptoms, and change with mental status with at least one positive finding on MRI, CSF, focal CNS findings, and unexplained seizures. Patient's repeated experiences of dread and threat to his life by the disease process are frequently accompanied by the sense of lost identity and confusion.

We find it critical while intensely focusing on coordinated and integrated care with other health care professionals to exercise the treatment plan consisted of resilience work with rebuilding the patient's capacity to rebound, providing cognitive-remediation exercises for patients at home, using patient's positive transference, and serving as a container offering the holding environment for the patient.

### **Patient**

These were the words of my patient, a 65-year-old man recovering from the "crisis of his lifetime," namely an episode of autoimmune encephalitis. He presented to me in chaos, and I came upon his despair. The door to my office opened and the man wearing the EEG cap accompanied by his sister spoke. He was frank about his illness and was taking the chance to pursue whatever cure he might find. Self-pitying and perplexed, his illness put him in a very difficult spot. He was trying desperately to get away from it and be "normal" again.

Noting his calamity and ruin, he asked what has become of the self-sufficient man he once was. Being physician himself all his life, he imparted great care, thoughtfulness and concern to everyone around him and especially to his patients. And now, the role has reversed. He was no longer in the center of the problem needing to be solved but on the receiving end of it. He thought the image of himself functioning independently was now too far gone to salvage. His lightheadedness was interrupting the daily tasks he liked, and he described several things he would still like to do but was not in position of doing. His nightmares, which he could not easily reconstruct in the sessions always involving "different persons and plots," frequently interrupted his sleep and caused severe distress.

In one of these night terrors he did remember, two strangers were invading his house. They appeared to be father and his young son. He is calling the police. The father is tall, handsome, and wears the huge star of David on his chest. He is offering him a glass of wine. He feels more comfortable. In another he is singing in the synagogue while seeing a man in distress in need of his professional help.

His nights and early mornings were frequently marked by awakenings. He described "waves of anxiety" then coming over him and lasting not more than a few seconds, which were particularly terrifying. In our initial sessions, he was at one moment chatty and cheerful and at the next prey to

horrific dreads that I witnessed firsthand.

Yet in relation to his illness, he wanted to remain the "doctor in charge." He wanted to have an upper hand in it; to become intimately familiar with it and make changes in treatment as he wanted to while often not readily complying with recommended medications.

My early efforts to help him were filled with temptations to be sorrowful and overly empathic, to bear his pain but also to acknowledge him as a contributor to our extensive treatment plan that often involved the coordination of care necessary for a good risk management. He was deemed by staff as "one difficult patient" by many of our colleagues. It seemed I had passed whatever test he set for the safety of our relationship. He would advise others to call me as "I knew him the best," which ordinarily would alarm me to his sense of dependence, while at the same time being aware of the grave scenario of letting him down as his psychological distress was immense.

"Could my life emerge through so many signs of death?" he reflected while contemplating on the meaning of his life. "Do I have a past or future?" We both questioned his current situation as we were looking closely into the new world he was living in.

### **Conviction that he was damaged**

What I had to offer psychotherapeutically was initially limited to our once-to-twice a week hospital sessions, and it came up repeatedly as a subject in our conversations. While all along having intense psychotherapy sessions, I became involved in his care in great many other ways: from proactive communication and discussions with other specialists to recommendation of daily cognitive remediation home exercises. I recall asking myself: Can the psychoanalytically informed therapy stand against a life crisis of this extent? Can the therapy stand against the threat of death? Was I ready to accept the patient as he was and whether his life has a chance through therapy?

I felt certain about my refusal to be futile and determined in my desire of not wanting to fail him. I recounted this notion of failure and rejection as he expressed the following material: "My optimism is about not killing myself because of my stubbornness in holding on to hope that I can be normal again." He described how during his life he had pushed through adversity despite not wanting to. He persevered with his sexuality and acknowledged this aspect of himself with his family and religious community growing up. He tried to have a sense of humor about the situation and cared for people; had a moral compass and lead a "clean life" in the sense of being a decent person.

I was moved by his perseverance and relentless efforts to be himself all these years and asked him about his thoughts about his work with me. He became relaxed, turned his face toward me, and spoke about how he felt closeness and acceptance here, and how he was trying to learn to live again. My first response was little more than a nod as I was awaiting the impressions germinating inside of me while I was becoming aware of the daunting task set before us.

### **Resilience in family and community**

The broad spectrum of the patient's sensitivity was revealed in his report about his life development and perceptions while growing up amid apparent disapproval and blame by his family and religious community. During his

school years in Brooklyn, he tried to do good work and was always eager to please teachers and friends while at the same time remain “hidden” because the concept of a “gay man” then was not acceptable and talked about.

He thought of it as his “ineluctable fate” and let other people deal with it at the time and chose to relate to people in an asexual way. When taken by his mother to see psychiatrist, he received subsequent therapy; he faced a pronouncement that sounded more like “a dictum” to him. “You are not a gay man but just have the fear of becoming one,” his doctor authoritatively noted, upon which my patient lightened up and his face turned into a glaring smile.

As the years passed, he could easily see himself steadily being pulled down by the feeling that others have more grounds for their complacency and how their opinion was paramount. “I tried to emulate and follow,” he said. “But I did not want to put myself in a cave and place a rock in front of it but tried to find my way through the world so people can’t hurt me.”

Being a solid student, he found studying medicine was his “way out,” and he did it admirably. I became steadily more captivated by his perseverance and found his determination commendable. As a medical student and later a doctor, he could be skeptical without being bitter. With me he was able to share his personal treatment failures and misgivings in care. In those moments of sharing in our work, I felt I needed to make his treatment a safe place and not to impose any unnecessary demands on him, but carry myself lightly with what I knew—not losing sight of pertinent medical issues while modeling my hope for him.

I thought a kind of paradox illuminates his tragedy. He would say, “I am living a scary movie,” and yet through his actions, he tried to disapprove and overpower the “scary reality” he was living. His newfound passion, caring, and feeling for others were all evidence of health, and his openness to a new ideas and perspectives has started to get a hold on his emotions more and more. He had a “role model” neighbor friend and while taking care, gradually found caring for himself more independently. He rejoined our medical community on a voluntary basis and felt joy when talking to his former patients.

As I was witnessing his improvement, I thought of how illness can lead to positive growth and resilience—as it happens sometimes in life—and would conclude that this was neither a relationship of domination nor submission but of genuineness and trust. We both felt it to be so. The relationship in which we looked outward through similar attitudes and perspectives and in which even the gloomiest communication, while taken with utmost seriousness, seems to have more life than ever.

## **Resilience: From Birth to Thirty; From Soldiers; From Ethiopian Children, to the Biblical Joseph and the Ego Ideal and Attachment**

By Nathan Moses Szajnberg, MD

Resilience can be defined as “the capability of a strained body to recover its size and shape after deformation caused especially by compressive stress.” It derives from “the present participle of the Latin verb *resilire*, “to jump back” or “to recoil.” *Salire*, a verb meaning “to leap” as in “sally

and somersault”. (Merriam Webster) It relates to the idea of a secure attachment: the balance of security and exploration, the capacity to seek both safety and comfort in the face of fear or anxiety. There is a logarithmic rise in the use of Resilience in literature starting about 1978.

I became first aware of my conscious interest in this topic thirty-five years ago, when Hank Massie and I studied 76 children from birth to thirty, which was published as *Lives Across Time* (2008). We studied their early life records and films of mother-infant feeding and play as well as their evaluations up to 18 years old. We classified the infancy studies in attachment terms and other criteria for robustness. Then, we compared early life to outcome at 18 and 30. We did find many infants with good or good enough mothering continued to robust adult emotional health; many with poor mothering continued to troubled emotional health. But there were crossover groups: those who had good mothering but had at least two profound traumata in childhood, dropped their emotional health functioning by thirty; and some with troubled mothering in infancy, somehow crossed over to robust emotional health in adulthood. What about that latter group, those we might call “resilient?” What can we learn from them?

I’ll give a striking example. In her feeding film, “Baby Sue” showed a mother who was so distressing that professional audiences asked us to halt it. While Sue was bottle feeding, her mother would suddenly decide Sue needed to be burped, as Sue kept rooting desperately. Then, the mother held her upright and would slap her baby so hard on the back that the baby’s head whiplashed.

Now, at thirty, we could film Sue as a mother feeding her 18-month-old daughter. This scene brought smiles to our audiences. As her daughter sat on a highchair, fingering a new food, broccoli, Sue exclaimed, “Yum, broccoli!” took a nibble, then smacked her lips. Most of us would want to have dinner with Sue. How did she get that way? Since we had records in early childhood, at age 7 and at eighteen, we have some hints. As an infant and toddler, while mother’s relationship was problematic, when father returned from work, Sue would be trembling with excitement and bouncing in her playpen upon hearing his voice. In her prelatency and latency era, she teamed up with her two older sisters. On one long car trip, the girls voted father to become the next President of the USA (over JFK, mind you), and at seven, when Sue is asked who her favorite family member is, she said, “my puppy.” (To our knowledge, no one has studied the attachment relationship between human infant and dog.) While she had multiple allergies and eczema in childhood through adolescence, after her marriage to a darling man, these disappeared.

This subgroup of “resilients” launched me to my next study and book on elite Israeli Combat soldiers (*Reluctant Warriors*, 2011). In Israel, one cannot apply for elite units and officers are promoted from within (no West Point, as such). In the book, I chose nine paradigmatic citizen soldiers—that is, those who chose not to continue to the professional track, but all of whom had been promoted to officer. My question was how did their combat experiences affect them when I studied them in their late twenties, after they finished their active tours of duty (although, as you know, they remain in reserves and therefore, I studied them through the almost catastrophic second Lebanese War).



Most of these soldiers describe idyllic childhoods, or as idyllic as one can have in a country with episodic wars and almost continuous wars of attrition, such as busses being bombed or missiles fired from Iraq and later, Lebanon and Gaza. Nevertheless, a few had significant childhood adversities, personal ones, such as parental battles or deaths. Perhaps, one example may suffice. One boy saw his mother immolated in an accident; his father became a ghostly presence for the next few years, until he remarried. Being on kibbutz, however, permitted this boy, the eldest, to both ‘mother’ his brothers and to be cared for by an extended family of parents. At fifteen, he became an expert in irrigation, being called out of class to handle emergencies. In the army, he quickly took to fostering the wellbeing and safety of his peers, often leading them into battle (as is expected of Israeli officers). He was quickly promoted. Upon discharge, he invited his younger brothers to room with him, after the father’s remarriage, and oversaw the boys until they entered army.

My next inadvertent study of resilience came with my three-year study of Ethiopian/Israeli children and families, *Sheba and Solomon’s Return* (2013). I worked with (“studied” is too emotionally distant a term) 42 six-year-olds over three years in their after school enrichment program funded by Elie Wiesel, in their homes and neighborhoods, including during the Gaza War, as they were in bombing distance of the border and kept home from school that week. (Schools were targeted by the Gazans.) Here, our results were more startling. Every mother had been born in Ethiopia, most married by thirteen years old, and almost every one faced profound traumata/loss in childhood/adolescence (including being kidnapped/held hostage, raped, etc. in Ethiopia). Of the children, almost seventy percent showed Insecure, Anxious attachment associated with Unresolved Trauma/Mourning. This is the highest incidence of Insecure attachment among any culture that had been studied until then. Yet, most of the children showed robust functioning in other parameters, including good academic functioning, although in general, girls did better than boys. What was the “magic sauce” for resilience here? At best we could find, there were several ingredients. First, being moved to Israel from war-torn, genocidal Ethiopia. Second, having an Israeli society that substantially supported these families and welcomed them. Third, the large families (5-8 children) offered sibling caregiving (most of our target children were the youngest of the family). For instance, one fourteen-year-old boy would collect his six-year-old sister from our after-school program, shouldering his bag, her bag and holding her hand, while chatting with her about what she had done that day. Most children all lived within walking distance from the after school program, permitting a more organic peer-play neighborhood than those who must be bussed. Finally, the dedicated teaching at Wiesel’s Beit Tziporah was some of the finest pedagogy I had seen. Most of the teachers were either kibbutz/moshav members or Orthodox women. The director of the program, a kibbutznik, considered their jobs to be the essence of Zionism, helping the forlorn Jews of the world integrate into modern and welcoming society. These factors mitigated the profoundly traumatic life experiences of both parents.

This brought me to exploring what is an intrapsychic ingredient that one builds as a factor for resilience. Preconsciously, I turned to study in Hebrew the Jacob and

Joseph father-son story. It resulted in my current book, *Jacob and Joseph, Judaism’s Architects and the Ego Ideal*. We have three major father-son myths in Western literature: Abraham/Isaac (near-filicide); Laius/Oedipus (patricide and incest); God/Christ (successful filicide and alleged celibacy). The Jacob and Joseph story differs profoundly: father doesn’t try to kill Joseph, Joseph doesn’t try to kill his father. While his brothers try to kill Joseph, then sell him into slavery, Joseph doesn’t retaliate with a *lex talionis* towards his brother. In fact, when they fear that Joseph will finally retaliate after Jacob’s death, Joseph responds that he will care for them, their children, and children’s children.

In the story, I discovered the first description of the psychic structure of Ego Ideal in the Bible, in Joseph. I will first review what we know of the Ego Ideal, then describe how Joseph developed this and close with implications for resilience and contemporary parenting. I will outline the features of the Ego Ideal, but much of what I will say comes from Peter Blos Sr., who was my supervisor as he was writing his final book, *Son and Father: Before and Beyond the Oedipus Complex* (1985). I was not consciously aware how much his supervision initiated and crystalized my clinical technique around the Ego Ideal’s influence upon both development and technique.

Briefly, Blos, that explorer of adolescence, along with his good friend from Vienna, Erik Erikson, demonstrates that there is a parallel building of psychic structures at two different ages. Around seven plus or minus one, we develop our Superego, the heir to the Oedipus, as we sort out our love for the parent of the opposite gender (while balancing our love/rivalry for the parent of same gender). And, the heir to adolescence is the Ego Ideal as we resolve our love for the parent of the same gender. This Ego Ideal prepares us to carry on the work of our parent and, poignantly, prepares us for the work of mourning.

What is this Ego Ideal? Before turning to the Jacob and Joseph tale, let’s remember much of the work initiated by Freud as he began to differentiate Superego from Ego Ideal, but developed more clearly by his own descendants, including Blos, Erikson, Bettelheim and later, Giovacchini, Ekstein, Chassaguet-Smirgel and others. For brevity, look at definitions of Ego ideal:

“The agency that works for the object who is loved rather than dreaded” (Laplanche and Pontalis p 145)

I would revise this: the Ego Ideal follows by admiration; the Superego reigns by fear.

“The repository of depersonified values of morals...” (Auchincloss and Samberg, p. 72-3).

Chasseguet-Smirgel suggests that the Ego Ideal has a forward-looking quality, projection of the Ego Ideal, before him “rather than behind him.” Giovacchini (2000) adds creativity as an element of the Ego Ideal. That is the Ego Ideal carries values, but without the ominous punitiveness of the Superego. It is more encouraging, hopeful, and it fosters creative solutions. It is the “Dutch Uncle” who pats us on the shoulder after mishaps and points to hope.

Now let us return to the Bible. Joseph portrays evidence of an Ego Ideal, the first portrayal in Biblical characters, who until him showed profound, even harsh Superegos. (I include God among the characters, a chief of Superego punitiveness.)



We can ask at least three relevant questions:

1. How do we know Joseph possessed an Ego Ideal?
2. How did he develop this psychic structure?
3. What can we learn from him about the Ego Ideal's contribution to resilience?

Our evidence, like that of archeology, is assembled from fragments that we try to fit together, so that they make sense in relation to each other (and in relation to other artifacts of the time, if we consider the Biblical characters as artifacts). A brief survey of the Jacob-Joseph story shows this is the longest series of chapters on the relationship between father and son in the Bible. Jacob is the youngest of twins, the brother of Esau. Jacob's name, Yaakov, has meanings such as "heel grabber" (as he appeared to grab his first-born brother's heel in order to precede him), or "crooked" (or devious, like wily Oedipus). He yearns for others' blessings. He buys Esau's blessing with a bowl of red soup. Later, with his mother's help, he deceives his blind father, Isaac, into blessing him, Jacob claiming he is Esau. Jacob escapes his brother's wrath for over two decades, living under his Uncle Laban's domain, who in turn deceives Jacob into marrying Leah, before Jacob can marry his beloved Rachel. He returns home in time to bury his parents, but only after burying Rachel at the roadside. He has twelve fractious sons and a daughter, Dina, who is raped as they almost reach his Hebron home.

Jacob changes profoundly. He begins as a go-getter, a schemer, an expert animal breeder (and children breeder). But, after Rachel's death, Dinah's rape and particularly following his sons' deception of Joseph's death, Jacob descends into a despair from which he never fully recovers. Even when he sees that Joseph is alive and now vizier of Egypt, Jacob speaks to the Pharaoh of his own miserable life. And on his death bed, he delivers a screed of curses to his older sons (of Leah's loins), tempering only as he approaches his last two, Joseph and Benjamin (of Rachel's loins).

Now, Joseph, the eleventh son, shows not only different but also developing character. He presents to us at seventeen, enthusiastic about his two dreams and apparently tone-deaf to his brothers' envy and hatred of him. He is decorated by his father with a multi-colored cloak, that same cloak that his brothers return blood-stained to Jacob to imply Joseph's death. That is, we have the portrait of an adolescent who behaves as if favored, dreams as if gifted and as a leader-to-be. Then, in the text, we are told he descends into "pits" twice: first the pit into which his brothers throw him as they first plan to kill him, then sell him into slavery to a passing caravan of Ishmaelites. Then, in Egypt he is thrown into a "pit" (this word is used for the Egyptian prison), first as a slave, then after his master's wife accuses him of attempted rape, as she bears a torn piece of his clothing to "prove" her lies.

But what kind of man do we see emerge from these two descents? When Pharaoh is plagued by two terrifying dreams that his soothsayers cannot interpret, Joseph is called from prison to interpret, as he interpreted accurately for two prisoners' dreams. Joseph is quietly self-assured. When the Pharaoh is impressed by his interpretations, Joseph demurs, saying that God has given these. And when Pharaoh accepts Joseph's dream interpretations that seven years of good harvest will be followed by seven years of famine, the Pharaoh is convinced by Joseph to appoint him vizier

in order to prepare for the years of famine. Joseph shows creativity in setting up warehouses and filling them in the years of plenty. When famine strikes, the distant Jacob sends his sons to get provender from wealthy Egypt.

Here we have richer evidence of the Ego Ideal within Joseph's character. One example is he doesn't show the need for vengeance with his brothers. Instead, he restrains his tears five times before he reveals himself to them, bawling loudly on the sixth occasion. After Jacob's death and his brothers approach him fearfully that without Jacob, Joseph will unleash retribution, Joseph assures them that he will care for them, their children and children's children. The next four hundred years of exile prove fruitful for the sons of Israel and the descendants of Joseph's largesse.

We can see the evidence for "resilience" in Joseph's development. While his father, Jacob, shows some resilience—surviving in exile from cheating his brother, expertise in animal husbandry and breeding, having two wives, two concubines and thirteen children, returning home and making some kind of peace with his brother, Esau—we see psychologically, a man with fractious, deceitful sons and a man who lives his last years in despair.

His son Joseph goes beyond Jacob without having to contend with him. This is evidence of resolution of love of his father and his actions show evidence of Ego ideal. With Joseph, we have resilience not only outward—thriving, driving—but also in his character—measured, thoughtful, not impulsive and planning for a future dream, his father's, of a people as plentiful as the sands of the sea, the stars in the sky.

This is the kind of resilience, I suggest, we see in our thirty year subjects who defy early maternal vicissitudes, of our Israeli elite combat soldiers, who overcome crises, traumata, the need to kill, yet be measured, and the liveliness of our six-year-old Ethiopian children, who thrive despite a desperate background of their parents, who thrive because of the fruitful soil into which they have been transplanted.

To close, I also close a conceptual circle connecting the Ego Ideal with Secure Attachment. My developmental research is grounded in Bowlby and colleagues work on attachment, that parent-specific mental construct in which a child facing anxiety or fear can find safety and comfort, a secure base. From this secure base, healthy exploration evolves. I ask you to consider that the Ego Ideal is a psychic construct that is built upon, even contains the mental representation of a secure base, secure attachment. Returning to Peter Blos Sr.'s last book, the adolescent's coming to terms with loving feelings towards the parent of the same gender results in establishing an Ego Ideal. I suggest that this adolescent is building upon what he or she achieved in early childhood with that parent: secure attachment, a secure base, a sense of finding safety and comfort with the parent of the same gender. This reconciles the more classically psychoanalytic with Bowlby's attachment construct.

Let us then consider resilience a manifestation of secure attachment and the Ego Ideal psychic structure: these specific intrapsychic factors we hope to construct with our patients, and more so, for our children and children's children.

## References

1. Auchincloss, E. and Samberg, E. 2012 *Psychoanalytic Terms and Concepts*. Yale.
2. Blos, P. (1985) *Son and Father: Before and Beyond the Oedipus*

- Complex Basic.
3. Bowlby, J. (1969) Attachment Basic.
  4. Chasseguet-Smirgel, J. 1973. The Ego Ideal. London: Free Association Books.
  5. (Laplanche and Pontalis The Language of Psychoanalysis.
  6. Giovacchini, P. 2000. The Impact of Narcissism. NY: Aronson.
  7. Massie, H. and Szajnberg, N.M. (2008): Lives Across Time/ Growing Up: a Thirty Year Prospective Study. Karnac.
  8. Szajnberg, N. (1986). Ubertragung, Metaphor and Transference in Psychoanalytic Psychotherapy. Int. J. of Psychoanalytic Psychotherapy, 11:53-69.
  9. Szajnberg, N. Reluctant Warriors: Israelis Suspended between Rome and Jerusalem. IPBooks.
  10. Szajnberg, N. Sheba and Solomon's Return: Ethiopian Children in Israel. Createspace.
  11. Szajnberg, N. 2018 Jacob and Joseph, Judaism's Architects and Birth of the Ego ideal. Cambridge Scholars Press.

## **Resilience in Psychodynamic Psychiatry: Commentary and Conclusions**

By Ahron L. Friedberg, MD

In their important book *Resilience: The Science of Mastering Life's Greatest Challenges*, Southwick and Charney identify ten resilience factors. These include having an optimistic but realistic outlook, seeking and accepting social support, having good role models as well as an inner moral compass, religious or spiritual practices, and acceptance of what could not be changed. In addition, other features are attending to health and wellbeing such as with physical fitness and mental acuity, actively solving problems and finding meaning and opportunity in situations, and also humor. Finally taking responsibility for your emotional well-being and using difficult or traumatic experience as part of personal growth. The American Psychological Association has adopted a similar set of criteria.

Usually, coping and treatment are discussed as the solution to dealing with excessive stress and trauma. Obviously, it's better to prevent symptoms from developing in the first place. A useful approach includes considering primary, secondary and tertiary prevention. Primary prevention is with screening and training programs prior to any incidents (e.g., training for first responders and military). Secondary prevention is debriefing and educational approaches prior to symptoms developing (e.g., falling off a bicycle and getting right back on). Tertiary prevention includes treatment immediately after symptoms appear (e.g., CBT, propranolol, etc.). The idea is to intervene early on to prevent symptoms from developing or minimize them after their onset.

The key is to find a personalized approach that works best for the individual. It, of course, helps to nurture children and raise children with loving care, so they can be more resilient from the start.

Dr. Nathan Szajnberg gave a terrific presentation on resilience and the ego ideal. He considers three groups to study based on his landmark research contributions: children studied from infancy over 30 years, Israeli soldiers, Ethiopian children, and Jacob's biblical family. His important psychoanalytic contribution to resilience is linking it to the ego ideal, an original contribution.

With each group, we see factors that have helped them be resilient. With the longitudinal child study good or at least good enough mothering played a role in the emotional health of the children in adulthood. Some children benefited from

older siblings and other family members. This helped them weather traumatic experiences.

In the group of Israeli combat soldiers, not only their childhood experience, also their training experiences helped to inoculate them from the horrors of war. Also, the support of the community like in a kibbutz helped to give loving care and support. One boy developed an expertise with irrigation issues. This helped him be stronger through a sense of purpose in fostering the well-being and safety of his peers.

With Dr. Szajnberg's group of Ethiopian children, the quality of their attachment inevitably made a difference regarding their resilience later in life. Family and community support including friends and peers was vital. Good teaching and education helped too. Such factors mitigate their loss and suffering—and made them stronger.

Finally, Dr. Szajnberg, in his study of the Jacob and Joseph story makes a contribution to the field of resilience linking it with development of the Ego Ideal during adolescence. This psychoanalytic observation helps us see how resilience can develop throughout childhood and into adulthood. Here the contributions of Erik Erikson as well as Peter Blos are also relevant. It underscores another aspect of resilience, namely having a good moral compass and belief system. These values in psychoanalytic thinking are represented by the ego ideal. They help foster perseverance, creative solutions, and hope. Furthermore, having a mentor or guide is useful. No doubt, Joseph's quiet self-assuredness—measured, thoughtful and creative—is a reflection of his resilience and inner strength.

Dr. Novakovic presents an interesting case study in resilience. It not only underscores the relevance of resilience in treatment but also highlights his clinical acumen and excellent technique in the integrative care of this patient.

The patient, a gay physician in the later stage of his career, has an uncommon neuropsychiatric disorder, autoimmune encephalitis. But this does not make any of the psychodynamic approaches to treatment less relevant. For example, at least a third of cases of patients with major depression have an autoimmune component and novel treatments for depression are focusing more on this aspect of the disease.

Dr. Novakovic's exceptional work includes rebuilding the patient's capacity to rebound, cognitive-remediation and other exercises, role modeling, and insight and understanding, enhancing family and social relationships, and bolstering other resilience factors. He forms an empathic connection with the patient and builds trust. He gives him hope and a positive sense of the future. Always working in a psychoanalytically informed way, he interprets dreams and utilizes transference to best serve the patient.

One aspect of treatment is Dr. Novakovic teaches the patient to utilize his capacities as a physician in better caring for himself. The patient himself has shown character strength and perseverance throughout his life. He had shown a great deal of personal courage growing up as a gay man in an Orthodox Jewish community. He was committed to becoming more himself and found a higher purpose and way out through studying and practicing medicine.

Dr. Novakovic helped the patient find meaning and independence through rejoining the medical community and volunteering. The patient also connected further with sister. He developed greater openness to new ideas and flexibilities. So overcoming a medical issue and its sequelae led to

the patient's continued personal growth and betterment. Through utilizing the patient's capacity for resilience and incorporating techniques to bolster resilience in his own work, Dr. Novakovic advances the role of resilience in psychodynamic treatment.

For psychiatrists and psychoanalysts, psychodynamic approaches rely on improving mature defenses and responses to trauma through better insight and understanding. In psychodynamic terms, one approach is to bolster ego-resiliency to better adapt and deal with challenges.

Interestingly, attachment styles influence how people cope with secure attachment protecting against traumatic stress. Underlying feelings of guilt, shame and other complex emotions relating to the traumatic experience may also need to be analyzed. A Socratic method of learning through dialogue and reasoning may also be helpful in better appraising and dealing with situations.

Regarding other treatment options, helpful approaches included cognitive behavioral therapy (CBT) in which individuals are taught various coping techniques, meditation, mindfulness and relaxation approaches, eye movement desensitization and reprocessing (EMDR) while recalling the difficulty or trauma. Victor Frankl's logotherapy, which involves healing through finding meaning and a sense of purpose through one's experience, has been useful to some patients. Several researchers such as Christina Alberini and Rachael Yehuda are exploring memory reconsolidation, either in the post-retrieval or post-reactivation phase as a place to intervene. Beta-blockers are a promising therapy during this window. Serotonin reuptake inhibitors (SSRIs) have also been shown to be effective for symptom relief.

The idea is to become more oriented to preventing conditions rather than treating symptoms. Bolstering resilience is a part of that approach. It involves developing and enhancing resilience factors including positive outlook, social supports, insight and understanding as well as healthy living. We can now aid psychodynamic treatments informed by the clinical science of resilience in more individualized ways.

that can only be "told" not "mathematically measured." She outlines how neurosciences, the "hard science" of the brain is always seeking to measure experience.

### Prove/disprove

Leuzinger-Bohleber considers the idea of the equation feedback of prove/disprove and through Freud's tenants of psychoanalysis explores the mind-body experience beyond "proof." She enlightens the reader by outlining that experience "is." The effect of experience is essentially the "proof" of occurrence.

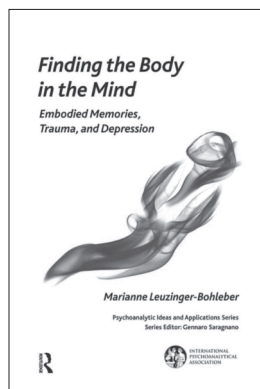
Leuzinger-Bohleber takes us through Mark Solms's twelve central psychoanalytic concepts of Freud, which sets the stage for the rest of the case explorations and articulately describes why the brain is not "just an organ" to be observed. Solms's arguments include pointing out how cognitive neurosciences in their "hard sciences" view see that brain as an organ much like a liver, or a kidney and so on. Neurosciences to date have treated the mind as an object and ignore its subjectivity, or dynamic, therefore the brain from a neuroscientific view is an object from which information is processed. It does not recognize the subjectivity of the mind's "experience." Oliver Sacks (1985) opines that a human being is a subject, not an object...it is the subject, the "I," which is excluded from neuropsychology. Leuzinger-Bohleber conceptualizes that the brain is unique in its capacity for subjectivity, feelings and agency. No other organ or mechanical device possess these qualities. For example, the brain has free will. Therefore, one can deduce that the brain is subjective, and a machine is objective. A machine or non-brain organ cannot feel or experience, whereas a brain can.

The text proposes a comprehensive and interesting framework from which to consider the neuropsychanalytic movement and its aim to break down barriers between neuroscience and psychoanalysis. Guterl, 2002, p.63 purports that the neuroscientific and psychoanalytic fields still need to prove or disprove Freud, that we have not finished Freud's job. Kandel (1988) states that Freud's remains the most satisfying view of the mind.

In her book, Leuzinger-Bohleber takes on the monumental task of trying to integrate an understanding of the mind-body through the disparate lenses of psychoanalytic theory/experience and the "hard science" of neuropsychology. In this vein, the book is intelligent, thorough and thought provoking. It may provide theorists and clinicians a pathway from which to consider the intersection between the objective/subjective experiences of the mind-body. A deep and considered text; highly recommend it for students, clinicians, researchers, and theorists of psychoanalysis and neurocognitive sciences alike.

---

## BOOK REVIEWS



*Finding the Body in the Mind: Embodied Memories, Trauma, and Depression.* Marianne Leuzinger-Bohleber; Karnac, 2015, London; 278 pp. 40.

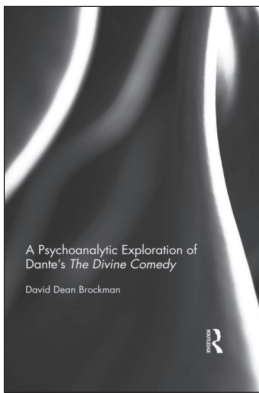
Reviewed by Jo-Ann Elizabeth Leavey, NP, EdD, C. Psych.

Marianne Leuzinger-Bohleber, in *Finding the Body in the Mind*, provides us with a generous

retrospective on a collection of clinical case studies that offer how psychoanalysis reveals the "neuro-cognitive-brain" experience in the body.

The author begins by reflecting on the value of psychoanalytic narrative and the complex meaning structures





*A Psychoanalytic Exploration of Dante's The Divine Comedy*. David Dean Brockman, MD, Routledge/Taylor and Francis, 2019, 199 pp.

Reviewed by David V. Forrest, MD

Seven hundred years before Freud, in 1302, Dante Alighieri, the immortal poet and skilled but losing politician, had not only failed to win the laurel wreath, but

was exiled from his beloved Florence and separated from his wife, 3 sons and daughter, who became a nun and changed her name to Beatrice.

His unlikely solution, to his eternal credit and our enduring gratitude, was in fantasy. His revenge and retribution against his compatriots of that moment in time was forever.

Dante takes us with him on a short vacation of only a week, in which our Travelocity reviews would range from hellish to empyrean. We descend to Inferno to experience sophomoric Schadenfreude at the torments devised for the corrupt popes and priests of the Roman Church who sell indulgences, only to ascend via the moral self-examination and sin-purging of Purgatorio to the brilliant celestial rewards of Paradiso, preceded by a procession Brockman compares to Cecil B. DeMille's. Dante also gets back at his boyhood tutor Latini, placing him in the 7th circle of hell with the large group of Sodomites who must run forever naked across the flaming desert beside the Phlegethon River, and suggesting Dante was abused by him. The Seven Deadly Sins carved into Dante's forehead are erased by contrition and absolution in Purgatorio. While Inferno's tortures are eternal, the sinners in Purgatorio, the middle canticle, each decide how much and how long their punishments last, akin to the purging trials of analysis, Brockman analogizes. If Inferno is literal, and Purgatory moral, Paradise is allegorical. Not all of us are invited into its lumen-drenched joys—unless we have the ticket of a Christian baptism.

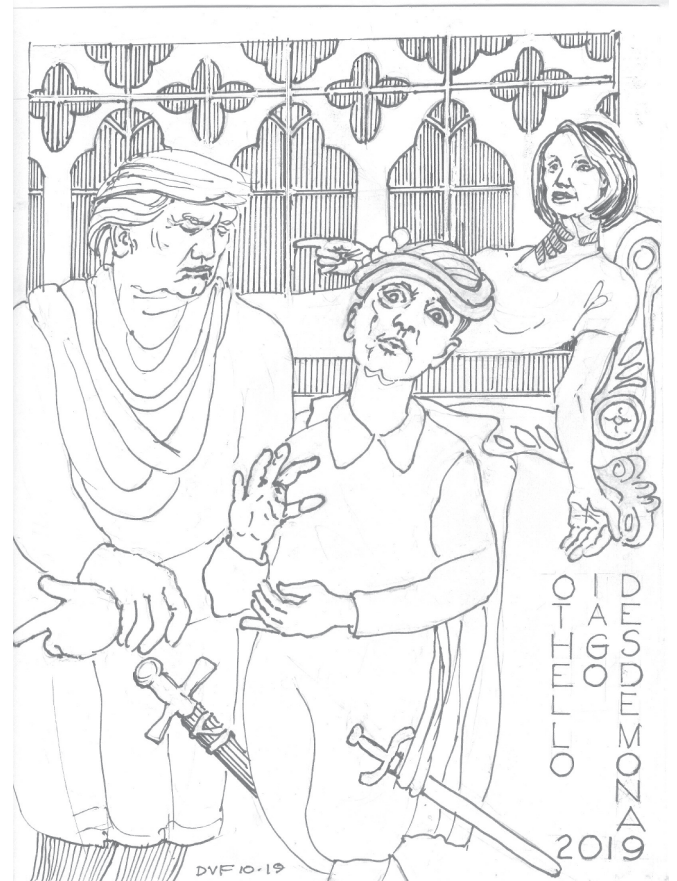
Poor Virgil, Dante's hoarse-voiced guide through hell, becomes distant in Purgatory—like the silence of the psychoanalyst, Brockman analogizes—and he cannot pass on through the Gates of Paradise because, as an ancient, he could not know Christ who came later. Instead the figure of Beatrice, a.k.a. the Virgin Mary, beckons and guides the now repentant Dante to his reward. Dante met the real Beatrice Portinari when they were children; he saw her again at 18. She then became his muse and ideal woman, although she spurned him and died when she was 24 and he 25, leading to mourning and melancholia on his part. He eventually had earthly affairs, married and had 4 children. He had some ambivalence toward women, blaming Eve a bit and working in Aurora to the effect that women cannot be trusted, can turn upon you, and sting you like a scorpion.

In Purgatorio, Dante has 3 dreams which symbolically pertain to Beatrice/the Holy Mother, and which incorporate the day residue, an ingredient of dreams to which Freud

helped himself, Brockman argues convincingly, not to mention the all-important analyst and-analyst therapeutic relationships with his many guides along the journey with whom transferences and countertransferences occur.

The Commedia is so iconic it can stand for any difficult journey toward enlightenment. Brockman discusses religious conversion at length and compares it to being analyzed. Dante invented the term transhumanization to convey the enlargement of human experience that can occur via religious conversion. (Sexual orientation conversion therapy in any direction is not discussed.) Dr. Brockman's contribution is scholarly, psychoanalytic and an excellent and engaging read.

On a related note, I depicted the Commedia in the accompanying cartoon as an allegory for psychoanalytic training, which requires endurance of the sensory deprivation of the couch, self-examination and coming to terms with one's weaknesses, relatedness to the analyst, and finally arrival at being able to think psychoanalytically, a capacity which can be applied broadly to therapy, literature, art, anthropology and even advertising, and which no one in my ken who achieved it has regretted possessing. The cartoon was drawn on the occasion of the retirement of our beloved and usually beaming administrator at Columbia, Joan Jackson, whose helpful presence taught the essential goodness of empathy, and whom I have depicted representing Beatrice.





## IN MEMORIAM AND NEW MEMBERS

### IN MEMORIAM – DAVID DEAN BROCKMAN, MD



David Dean Brockman was a significant contributor to psychiatry and psychoanalysis and a personal inspiration to many colleagues and students with his irrepressible determination to learn and his consistent generosity in assisting others.

Dean was born on August 4, 1922, in the small town of Greer, South Carolina. His father was a highly respected GP and Dean often accompanied him on house calls. Dean's father saw people regardless of their ability to pay. Dean decided, as a boy, to become a physician like his father.

Dean graduated from high school in 1939 and won the senior tenor solo prize at the State of South Carolina High School Music Festival. He attended Furman University, entered medical school in 1943 in South Carolina, where he was elected to AOA, and then went to Duke, initially studying pathology but then becoming intrigued by dynamic psychiatry and psychoanalysis and switching to psychiatry. He then had a stint in the Military, at Tripler General in Hawaii and at Osaka General in Japan, where he was Chief of Psychiatry. After working in a private psychiatric hospital in Winnetka, IL, for two years, he joined the faculty of the University of Chicago in 1952, where he initiated the use of anesthesia during ECT and directed the Division of Psychiatry.

Dean matriculated at the Chicago Institute in 1955 and graduated in just six years. He then joined the Parent Loss Research Project led by Joan Fleming. A book came out of this research project: *Childhood Bereavement and Its Aftermath* (1987), for which Dean wrote a chapter on the arrested development of an 11-year-old boy who had lost his father. Dean joined the faculty of the Chicago Institute in 1971, teaching the dream course from 1985 until 1992. He was appointed a training and supervising analyst in 1973 and was a sought-after supervisor who guided many candidates through their training. Dean served on the Chicago Psychoanalytic Educational Council from 1978 to 1990 as well as on many Institute committees. He was particularly pleased to be on the Chicago Institute's Public Relations Committee and served on Public Relations Committees with the Chicago Psychoanalytic Society and with the American

Psychoanalytic Association. He advocated a focus on popular works, like Janet Malcolm's books, to help inform the public about psychoanalysis.

Dean helped develop psychoanalytic training programs in Wisconsin and Minnesota when he served as the Chair of the Chicago Institute's Geographic Committee. In 1990, Dean became the editor of *The Bulletin of The Chicago Institute for Psychoanalysis* and turned it into a scholarly publication. Dean also held several offices with the Chicago Psychoanalytic Society and became a faculty member at the University of Illinois, supervising residents and teaching the continuous case conference and a course on how to start a practice. In addition to supervising at the University of Illinois, Dean also taught a clinical case conference as a Clinical Professor of Psychiatry with the University of Chicago.

Dean joined the American College of Psychoanalysts in 1978 and was program chair from 1987 through 1994, when he served as President. He edited the College Newsletter from 1990 through the merger with the Academy. He served on the College Board from 1987 on and was a continual source of inspiration for the College.

Dean's early psychoanalytic scientific interests were in parent loss and adolescent and young adult development. He published two books, *"Late Adolescence: Psychoanalytic Studies"* (1984) and *"Late Adolescence to Young Adulthood"* (2003). In his 90s he began researching Dante and published *"A Psychoanalytic Exploration of Dante's The Divine Comedy"* in 2017.

Dean had a rich family and personal life. He met his first wife, Martha Ann, when she was an Occupational Therapist at Tripler, and they married in 1950. They had three children. "Marty" died unexpectedly in 1996, and Dean remarried a few years later to Johanna. Both marriages were quite happy. Dean was an avid sailor, often sailing with other Chicago analysts. Dean also pursued a strong interest in artistic works, particularly by Gustav Klimt. In his later years, Dean took a strong interest in religious faith, exploring how religious faith interacts with psychoanalytic thinking.

Dean died on August 13, 2019, at 97. At that time, he was actively writing a fourth book, on maternal origins of the superego. He was, in his usual manner, courageously jumping into a new area. Throughout his life Dean was a scholar with a broad range of interests who generously shared his ideas and mentored many younger psychiatrists and psychoanalysts. His breadth of interests and his lifelong energetic pursuit of knowledge was unique. A few days before his death, Dean developed an unexpected heart rhythm problem leading to acute heart failure. When the ICU doctors said they could do no more, he thanked them for applying so much medical expertise for him – a gentleman to the end.

Respectfully submitted,  
David R. Edelstein, MD

**Psychoanalytic Fellow**

*Sponsor: Dr. Ahron Friedberg*

*Sponsor: Dr. Kimberly Best*

*Sponsor: Dr. Kimberly Best*

*Sponsor: Dr. Kimberly Best*

*Sponsor: Dr. Kimberly Best*

*Sponsor: Dr. Kimberly Best*

*Sponsor: Dr. Scott Schwartz*

*Sponsor: Dr. Kimberly Best*

**Inside Back Cover**

**The American Academy of Psychodynamic Psychiatry and Psychoanalysis**  
**One Regency Drive, P.O. Box 30**  
**Bloomfield, CT 06002**

**Outside Back Cover**