

ACADEMY FORUM

Vol. 65, No. 2 - Fall 2020



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Cover Photo

This photograph is titled "Walking in the Mist of Uncertainty." 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. 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 1,500 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 Do NOT use old, outdated programs as we may not be able to open the files.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

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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.

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MESSAGE FROM THE EDITOR

Ahron Friedberg, MD



Firstly, I'd like to thank Dr. Gerald Perman for his leadership of our Academy. During his tenure, he led several notable achievements for our Academy including integrating the American College of Psychoanalysis into our Academy, and with Drs. Douglas Ingram and Kimberly Best established

the Physician WellBeing and Support Project.

Dr. Joanna Chambers now takes the mantle as President of the Academy. As described in her message to us, her agenda for our organization includes furthering our involvement with the APA and other groups, commitment to the Journal and the Forum, the Physician WellBeing Project and other initiatives as well as our Academy's response to the COVID crisis. She rightly notes the emerging importance of video technologies in how we meet and communicate among our membership and broader community.

In her letter to us, Susan Matorin speaks of the passing of her beloved husband Dr. Richard Friedman, legendary Editor of *Psychodynamic Psychiatry* and a founding father of our field—and mentor to many of us. He'll be dearly missed not only as a colleague at the Academy but also a good friend.

Dr. Perman's letter highlights some of his own considerable contributions as Past President, and Dr. Alfonso and Dr. Cohen announce the 2022 Academy meeting on "How to Replenish a Passion for Medicine", which will follow the Academy meeting this Spring.

Dr. David Forrest's astute commentary offers us a way to assess public figures whose personalities (like those of our patients) often don't fit neatly into DSM categories, and his remarkable cartoon caricatures the polarized drama (indeed, Shakespearean) of our times. Dr. Ingram's sharp response to Dr. Forrest's contribution raises questions about the Goldwater Rule and politicized psychiatry. (It may also call into question Doug's sense of humor as well!)

Our Academy Forum has the privilege to print Dr. Friedman's Plenary Address to Symposium 2017: Women Now. It is a *tour de force* that highlights several of his contributions to the psychobiology of human sexuality. The originality and clarity of his thinking about differences in gender and sexual-orientation caused a sea change in the psychoanalytic community that has yet to be fully incorporated in our psychodynamic approaches.

My essay on the first phase of the pandemic portrays our experience as clinicians in trying to help patients through video- and tele-therapy deal with their lives disrupted by

COVID and its often severe and even tragic consequences. We do our best to be there and to help through screens and other technologies.

The piece by Dr. Aborabeh and Dr. Perman focuses on how telepsychiatry has become integral to our work and considers its pros and cons as we necessarily adapt to these changing times.

In his eloquent essay, Dr. John Tamerin considers the importance of music as an adjunct in psychotherapy and wellness more broadly. He draws from a professional lifetime of experience. Dr. Perman's discussion is a nice counterpoint, which while underscoring the value of Dr. Tamerin's work, also considers contributions about the language of psychoanalysis by Lacan and others.

In his piece about the capacity to be alone, Dr. Eugenio Rothe analyzes how working through painful memories that the coronavirus pandemic brings up may help a patient deal better with feelings of isolation and loneliness and gain more independence.

Dr. Peter Olsson's critique of Dr. Justin Frank's *Trump on the Couch: Inside the Mind of the President* urges us to be restrained in our armchair psychological analysis of world leaders. Dr. Bala's review captures Dr. Kuchuck's views on how psychoanalysts' personal lives and experiences, past and present, are integral to our daily work. Dr. Nicole Rouse's review of Dr. Linda Sherby's *Love and Loss in Life and Treatment* elucidates how the author's personal disclosures about loss helped patients in their own therapeutic experience.

Finally, I want to again acknowledge to loss of Dr. Richard Friedman. Dr. Friedman was a world leader in psychodynamic psychiatry and tremendous contributor to our Academy. As Editor of *Psychodynamic Psychiatry* for a decade and leader at the Academy, he helped establish us as a presence in academic psychiatry and psychoanalysis. In Memoriam touches on his extensive accomplishments.

Ahron Friedberg, MD

MESSAGE FROM THE PRESIDENT

Joanna E. Chambers, MD



Dear Fellow Academy Members,

As I sit down to write this article, preparing to list the incredible hard work and accomplishments of our members, I am struck with awe. The challenges that we have faced since March 2020, only six months ago, are unprecedented and life-changing

for all. The medical, psychological, and social effects of the pandemic have been enormous. The children who are experiencing the pandemic will be known as the “COVID generation”, and there will undoubtedly be long-term consequences from isolating an entire generation from their peers and common activities for such a significant time period. Furthermore, unlike the other nations of the world, the pandemic in the US served as a tipping point for an overt outcry against the longstanding issues of racism, chronic maltreatment of black Americans, and gross social inequalities that plague our nation. While racism and social unrest are certainly not new to us, the backdrop of the pandemic has perhaps provided an unprecedented and unique awareness and impetus for change.

We are all facing the profound effects that this uncertain era has on our lives, our work, our relationships, our patients—and we seek solace in knowing we are not alone. This is, of course, particularly challenging in the face of social distancing. We can no longer touch our friends, our patients, our loved ones who do not reside with us. We can barely see their faces behind their masks, worn to protect us and themselves from the threat of an invisible enemy. Reading each other’s affect has become a conscious effort. We spend hours on Zoom or some similar platform to connect with each other. Yet by the end of the day, we complain that we are “zoomed out”, fatigued by the screen and the lack of satisfaction that we had hoped to feel in our interactions.

As we progress in our journey into this new era, we, the Academy, remain committed to meet the needs of our members. However, we are aware that the needs are changing for a variety of reasons. It is my hope that we will have an ongoing conversation in the Academy for years to come, where we evolve together to ensure that all members feel welcome, supported, needed, and valued. In this regard, I want to share with you a few important updates of the Academy.

As many of you know, Dr. Richard Friedman, a long-standing academy member and the Editor-in-Chief of Psychodynamic Psychiatry, the official Journal of the Academy, passed away on March 31, 2020. A search committee led by past president, Dr. David Lopez, was tasked with inviting and reviewing applications and

selecting a new Editor-in-Chief. Meanwhile, we were fortunate that Dr. Jennifer Downey and Dr. César Alfonso agreed to serve as Interim Editors-in-Chief. To our great pleasure, Drs. Downey and Alfonso expressed an interest in continuing their leadership as Co-Editors-in-Chief, and the Search Committee unanimously selected them from the pool of applicants to serve as the incoming Co-Editors-in-Chief. Pending approval of the Executive Council at the end of October, we are extremely fortunate that our journal will continue under their expert leadership. The critical role of the Journal for our members as well as others practicing in our field cannot be overstated.

As I am sure you are all aware by now, the 64th Annual Meeting was cancelled due to the pandemic. The theme, “Psychodynamic Psychiatry and Relationships”, will hopefully be carried out as we plan for a possible Annual Meeting in 2021. The format of the meeting in the spring is unclear to date. With great appreciation for the work and leadership of Dr. Joe Silvio, our Chair of Scientific Programs, and the committee, we are working to develop a format for online programs to provide the opportunities for learning, teaching, collaborating, and sharing knowledge in the event that an in-person Annual Meeting is not held in the Spring. Furthermore, efforts are in place to ensure that these opportunities provide CME credit as we are aware that many rely on the annual meetings for their CME. We are also particularly grateful to Dr. Sarah Noble, Dr. Kim Best, and Dr. Jessica Eisenberg, Co-Chairs of the 2021 meeting in Los Angeles, who have ensured that our theme of relationships will be revisited. While uncertain what the world will look like in the spring, it is certain that our relationships will remain a central topic in the coming months. In addition, our gratitude extends to Dr. Mary Ann Cohen and Dr. César Alfonso for their willingness to Co-Chair the 2022 65th Annual Meeting, now scheduled in New Orleans. Their theme is also timely, given the increased demand for integration: “How to Replenish a Passion for Medicine: Psychodynamic Psychiatry and Consultation-Liaison Psychiatry”.

As we navigate the many changes and uncertainty facing us, I am extremely grateful to Dr. Kim Best and Dr. Jeff Katzman for their leadership of the Strategic Planning Task Force. The goals of this task force are to evaluate the future of the organization from a membership-needs perspective. Specifically, current and future membership needs, recruitment of new members, diversity of our members, strengthened relations with other organizations, development of regular zoom meetings, and increased visibility of the Academy are all areas of initial focus. Addressing issues of racism and diversity will be a common thread through each of these initiatives. While the overall mission of the Academy will not change, we are hopeful that we may find additional ways to meet the evolving needs of our members. As you may be aware,

the Task Force began by asking our members to share their thoughts via a survey providing a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats). If you have not yet filled this out, please take a few moments to do so at your earliest convenience. It is imperative that we hear from you, our members.

Our new and improved expertise with Zoom and other virtual platforms has perhaps been a silver lining. Dr. Kim Best and Dr. Doug Ingram courageously provided the first experience in this medium, giving us a taste of what is possible. Currently, through the Strategic Planning Task Force and the Committee of Scientific Programs, we are actively looking to initiate several zoom proposals over the next few months. Please be on the lookout for invitations and announcements about these events. We hope that you will all find at least one activity that feels pertinent to you. Your feedback on these events will be actively sought and appreciated.

Our work in the Academy requires significant integration with other organizations. We are very fortunate that Dr. Jeffery Smith is leading the Psychotherapy Caucus of the APA. His leadership, as well as that of his predecessor, Dr. David Mintz, have provided us with a wonderful opportunity to integrate and align ourselves with the interests of the APA.

Our involvement in education continues as the Teichner Award, led by Dr. Sherry Katz-Bearnot, continues to

provide support for underserved programs across the US. In addition to the vital contributions of the Teichner Award, the Long-Distance Learning Project, with additional support from the Laughlin Fund, is embarking on a new trajectory as Dr. Allan Tasman has kindly agreed to pave the way as the first long-distance continued education with last year's Teichner Award winner. This is imperative as we are all aware that psychodynamic education is not a "one time" event, rather it requires ongoing discussions, supervision, and experiential learning.

In addition, I have recently been invited to join the Psychotherapy Committee of AADPRT (American Academy of the Directors of Psychiatry Residency Training) to provide resources for Residency Training Directors to improve psychodynamic psychotherapy education across the country. As this is not something I could do alone, I will be looking to you for participation in some of the endeavors that we initiate to support the educators in psychodynamic education.

As always, I look to you, our members, for your collective wisdom and support of one another as we proceed through uncertain times of change and evolution. I sincerely invite each and every one of you to contact me at any time with suggestions, questions, answers and your thoughts and sentiments.

Warmly,
Joanna

REPORTS, LETTERS AND UPDATES

Letter from Susan Matorin, LCSW



Dear Academy Members,

Our family is so appreciative of the Academy's celebration of Richard's work and contributions to the field to which he devoted his career. Richard faced many health challenges since his bypass surgery at the age of 47. He dealt with them privately with grace, courage, and dignity.

After a very brief hospitalization in early March, he was fully prepared to return to work. Thus, his death was unexpected. The outpouring of support from Drs. Downey and Alfonso, and scores of colleagues and former students has been especially meaningful as we are unable to gather right now for a memorial.

Richard had planned for me to inform his patients "in the event". My calls were profoundly moving. Patient after patient described the impact of his transformative therapy on lives damaged by tragedies, painful divorces, career upheavals, and life threatening illnesses. He was described as "more than my doctor", "my friend", "part of my family". The writer Andrew Solomon wrote a riveting piece about their 25 year therapy in an on-line obituary for

The New Yorker. His window into the depth and breadth of a psychodynamic treatment was an eloquent education to the public about our mission, and a beyond splendid portrayal of the Richard we all admired and valued. Richard was a highly disciplined psychiatrist but well knew when to bend a "rule".

Richard loved taking care of patients but his true identity was as a scholar. Dr. Downey has exquisitely prepared material that describes the arc of his career from his groundbreaking sleep deprivation paper, to books and numerous publications in the area of sex and gender. His maverick challenges to the orthodox views about homosexuality have enabled scores of gay people to live their lives openly liberated from stigma, but stigma still persists in some quarters. The Academy and his editorship of the journal Psychodynamic Psychiatry provided him a platform to champion the value of the biopsychosocial frame for treatment and to be a bridge builder between neurobiological science and analytic concepts for the next generation. He was a tough demanding critique of manuscript submissions, but the goal was always to bring the finest quality to print.

On a personal level, Richard was an opera and Shakespeare buff, a fine pianist, earned money as a medical student playing the accordion at weddings, carried

a pocket version of the Constitution on him, railed at the flailing Knicks, and yes, detested vegetables.

Richard presented as formal, which could be misperceived as aloof, and his intellect and critical feedback could be intimidating. But we all knew his enormous loyalty, his generosity professionally and personally, and his underlying warmth. The key to Richard's heart was his emotional life with his family: a deep tie to our son Jeremiah, whose screenwriting career in Los Angeles earned his highest respect, his wonderful daughter-in-law, Rebecca, a clinical social worker, and their 2 beautiful children — Tess, age 4.5 with whom he developed a delightful relationship, and Theo, age 10 months, who unfortunately he only met in infancy, but he would be thrilled with this noisy high energy little boy.

The oldest of 3 boys, he spoke daily with his brother Daniel, a political scientist/social worker, currently in Hawaii. Dan, Richard, and Jeremiah share a terrific sense of humor.

Richard and I met in training at the Psychiatric Institute and reconnected somewhat later. I knew immediately his character and brilliance but could not have predicted I would be privileged to share his journey. My attachment to him is indescribable, and your friendship and kindness so appreciated.

Sue Matorin MS ACSW
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Letter from the Past President to the Academy Members

Gerald P. Perman, MD



Dear Members of the Academy,

It has been my great honor to have served as your 57th President of the American Academy of Psychodynamic Psychiatry and Psychoanalysis from May 2018 through May 2020.

Whereas it was a positive two years for the Academy, it has been a dreadful past six

months for many of our fellow citizens and those in other countries around the world. Since the beginning of this year, more than 13 million people have been infected by the novel coronavirus and over ½ a million people have died. Countries that were able to self-quarantine and socially-distance early and effectively have done better than other countries, including the US.

The pandemic resulted in the need for the Academy to cancel its 2020 Annual Meeting in Philadelphia. Our new President, Dr. Joanna Chambers, has communicated to our membership how the Academy dealt with the cancellation of the 2020 Annual Meeting, and many of our members have effectively stepped into the breach to maintain continuity in the Academy going forward.

During my tenure as President, we experienced the loss of two Academy members who served the Academy with distinction for many years and on whom I want to briefly reflect. First was the loss of Mariam ("Mims") Cohen who died in late 2018. Mims had been an Academy Trustee, an Editor of the Academy Forum, and she co-chaired an Academy winter meeting in Tempe, Arizona when the Academy was still having two meetings a year. Mims converted to Judaism in her early adult life, and she received a Ph.D. in religious studies. She became a psychoanalyst and combined her love of learning and Talmud with her love for psychoanalysis and psychodynamic psychiatry. Mims was always working

on her needlework at Academy meetings. She continued to contribute to the Academy right up until the end of her life and provided a moving written testimony of her struggle with neuroblastoma read by Dr. Douglas Ingram at the Opening Night of the 2019 Annual Meeting in San Francisco.

The other significant loss to the Academy occurred at the end of this past March. Richard C. Friedman, MD had been Editor of our journal, Psychodynamic Psychiatry, for nine years when he suddenly died after having battled a chronic illness. Richard was about to begin the last year of his second five-year term as Editor. He was perhaps the strongest proponent in the country of what he referred to as "the emerging new discipline of psychodynamic psychiatry." I believe that Richard was the most articulate speaker for what the Academy now stands for. He had a dry sense of humor, he was compassionate, and he was a consummate researcher and clinician, the latter quality expressed in abundance in the case history he presented during the previous year's Address.

Mims and Richard, I miss you both!

At the beginning of my presidency, the Academy was completing its merger with the American College of Psychoanalysts. This merger was facilitated by a number of psychiatrists who were members of both organizations. The former college is now represented within the Academy by the Committee for the Advancement of Psychoanalysis (CAP). CAP now organizes a psychoanalytic panel that presents at our annual meetings and arranges to have a number of designated psychiatric and psychoanalytic Laughlin Fellows attend the meeting. Dr. Henry Laughlin founded the College and also founded the American Society of Psychoanalytic Physicians (ASPP). I learned about the Academy when I was a member of the DC Chapter of the ASPP in Washington, D.C. when I took over as Editor of the ASPP Bulletin from Academy Member Emeritus and friend, Dr. Richard Chessick.

There were two personnel challenges that I faced during my presidency. The first occurred when I stepped down as Editor of the Academy Forum after 10 years. I view the Forum as a friendly and welcoming face of the Academy in which our leadership lets the members know about activities taking place within the Academy, and it provides a venue for members to contribute articles, and book and film reviews, in a relaxed and relatively informal manner. I met and got to know Dr. Ahron Friedberg, who was already the seasoned Book Review Editor of Psychodynamic Psychiatry, and asked Ahron if he would consider taking over as Forum Editor. He has already done an admirable job as our new Forum Editor. Sarah Noble continues her excellent work as Book and Film Review Editor of the Forum about which I am enormously grateful.

The second personnel challenge that occurred was the need to fill the position of Academy Representative to the American Psychiatric Association vacated by Dr. Eric Plakun when he was promoted to the position of APA Trustee. I am grateful to Eric for the years he spent as our voice in the APA, and I am appreciative for the new role he is playing as APA Trustee. I offered the position of APA Representative to Dr. Barry Fisher, a colleague of mine in Washington, D.C. Barry immediately and enthusiastically accepted, and he is doing a fine job!

When I think of Dr. Plakun, I also think of Dr. David Mintz, since they are long-time colleagues at Austen Riggs and have both participated, sometimes together, at many Academy Annual Meetings. David recently stepped down after two years as leader of the APA Psychotherapy Caucus, that has grown from 20 to over 700 members during his tenure. This is remarkable and a hopeful sign for the future of psychodynamic psychiatry. Academy Trustee Jeffery Smith is the new leader of the Caucus.

During my tenure as President, Dr. Douglas Ingram spent countless hours developing the Psychiatrist WellBeing and Support Project that is now represented by a page on the Academy website. This has given many Academy members an opportunity to write about their achievements and struggles in a number of clinical, health, forensic, administrative and training areas. Thank you, Doug, for this exquisite piece of work.

I am also grateful to Dr. Sherry Katz-Bearnot for having continued to manage the Teichner Project, to Dr. Jeffrey Katzman, Academy Treasurer and the Chair of the Academy's long-distance learning initiatives, to Dr. J.J. Rasimas for creating the Academy's closed Facebook page, to Dr. Alicia McGill for editing the Academy's e-Newsletter, to Dr. Joan Tolchin for coordinating the Academy's Italian meetings with OPIFER, to Dr. Joe Silvio who has served admirably as Chair of Scientific Programs and is President-Elect after Dr. Chambers term in office, to Academy Secretary Dr. Kim Best, to our Academy Trustees, and to all those who have served on our Academy committees that allow the Academy to function well as the fine organization that it is.

I am appreciative to Dr. Scott Schwartz for hosting our EC meetings in his lovely home that is actually a front for an art museum. We are also grateful to César Alfonso for chairing the Psychotherapy Section of the World Psychiatric Association where Drs. Allan Tasman, Joe Silvio and Tim Sullivan among others presented at the First International Meeting in Kuala Lumpur, Malaysia in July 2019.

It has been a great pleasure to work with Academy staff Executive Director, Jackie Coleman, and Jackie's Executive Assistant, Marie Westlake, who have both been as competent, friendly, efficient, and considerate staff members as I could have wished for. Finally, I am grateful to my wonderful wife, Martha, for her tremendous support during the time I devoted to my duties as Academy president.

So, Dr. Chambers, you will be taking over as the President of a terrific and well-run organization. Enjoy your new role—and thrive in it!

Respectfully submitted,
Gerald P. Perman, MD

**65th Annual Meeting
May, 2022
New Orleans, Louisiana**

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 New Orleans in May, 2022. We 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.



Central Casting to the Rescue?

David V. Forrest, MD



A mainstay of our principle of analytic neutrality is avoiding tendentious and partisan political expression. Like the ideal of celibacy of priests, this standard has been breached, as we, like them, are imperfect beings with human weaknesses. The Academy with its laudable considerations of culture, a legacy from Horney, Kardiner

and others, has been prone to partisanship over the decades. Lately psychoanalysts have been embarrassing in their pathologizing our President, violating the Goldwater rule.

Like political art, politicized psychiatry is a misbegotten botch.

We all have ways of looking outside of our psychoanalytic training and role. Many of us are former English or literature majors or are steeped in literary or theatrical designations of character that are not psychiatric descriptions. In *Beyond Eden*, my book about the lives of fine arts models when they are not posing on the podium, they were of course not my patients, and I could describe them and have them describe themselves, scrupulously avoiding psychiatric and psychoanalytic terms and formulations, and relying instead on literary descriptions, as for a *Dramatis Personae*. Would this be a model for us in our approach to public figures?

I drew the cartoon upon hearing of an aspiring female actor who took on the challenge of playing Iago, and being fascinated by the Othello-like television personalities of Adam Schiff, Chair of the House Intelligence Committee, Nancy Pelosi, Speaker of the House, and President Donald Trump. The two ideas merged in my mind, much as Mr. Trump and Disneyworld had melded in a previous cartoon of *Trumpworld* that was published in *Columbia's Bulletin*. I consider both tropes or, in today's language of young people, memes. Mr. Schiff has a mysterious presence, with dramatic hand gestures and eye movements (to which I am drawn as a consultant to *Columbia's Movement Disorder Group*). He appears to exhibit *Dalrymple's sign* from time to time, and not always

bilaterally to the same degree. This mimics thyrotoxicosis, sympathomimetic expression, and the eye roll test for hypnotizability, and conveys awe. Together with his hand movements, his stage (tv) presence is reminiscent of "Mandrake gestures hypnotically." He has a soft voice and a surreptitious, unctuous manner, as he seeks to subvert and convict the President, who has been literally fingered by Nancy Pelosi. Mr. Trump in his manner resembles the "overweening pride" and jealousy of Othello, and is one "that loves (himself) not wisely but too well." I pressed Nancy Pelosi into service as Desdemona for her (now impermissible) feminine masochism, with a touch of *stabat mater dolorosa*. These descriptions of the trio are not psychiatric; they are literary accounts of manner and stage presence. Pelosi was a model, Trump a "reality" tv star, and Schiff aspired to the theatre before he went into politics; together on stage they are riveting show business..

My cartoon attempted to avoid the political and instead position these real life characters as having emerged from Central Casting. I propose this is a way to observe and describe public figures without betraying psychoanalysis with partisan politics.



Response to David Forrest's "Central Casting to the Rescue?"

Douglas H. Ingram, MD



For several years I have been following David Forrest's work. What he offers is generally startling and insightful, generous and humane. I come away from his writings with new understanding. His current piece, "Central Casting to the Rescue," is a regrettable exception.

I do stand with Dr. Forrest in my endorsement of the Goldwater Rule. Our profession is better served if we restrain ourselves from expressing inferences about a public person's character. It is enough to evaluate individual actions by a public figure. But connecting the dots is fraught with the impossibility of knowing the extent to which public persona is congruent with private aspects of self. For that reason I stand back from pathologizing Donald Trump, though in no way does that prevent my criticizing what he says or does, nor my attacking the dreadful impact he is having on liberal democracy and the institutions of our society.

Though we agree on the utility of the Goldwater Rule, we differ in our views of 'politicized psychiatry,' as Dr. Forrest calls it. In my clinical work, it sometimes seems

to me legitimate, even helpful, to share political views. The doctrine of analytic neutrality can seem to me harshly inflexible and indifferent to the idioms of particular therapeutic alliances.

Now, to the cartoon and its accompanying discussion. Anyone familiar with Dr. Forrest's drawings, especially those of the models in *Beyond Eden*, would be baffled by these strained, wooden representations. Also, how is the Adam Schiff figure like Iago, or Donald Trump like Othello, or Nancy Pelosi like Desdemona? It beggars imagination to locate the storyline of Schiff, Trump, and Pelosi as anything like the storyline of Othello.

And, finally, Dr. Forrest's use of characters in literature to bypass the Goldwater Rule fails the smell test. As a psychiatrist who chooses to regard Nancy Pelosi as like Desdemona because she was a model in her youth (she wasn't) and rendering her supine on a couch to capture his sense of her as suffering from feminine masochism in no way diminishes this simple fact: Dr. Forrest is speaking from the presumed authority of psychiatric expertise. My assessments of Schiff, Pelosi and Trump are strikingly different from those of Dr. Forrest. Yet that's besides the point.

The point is, replacing psychiatric terminology with characters from literature does not get us off the hook.

ORIGINAL ARTICLES

Plenary Address at Symposium 2017: Women Now

Richard Friedman, MD



Thanks so much for your generous introduction and thanks to the panelists and previous speakers. It is always a pleasure to speak at a symposium like this because I learn so much.

The challenge of understanding sex has intrigued and baffled psychoanalysts from the beginning of our field. Today, when sexual science is discussed,

it can sound like this: "Sexual arousal is best construed as an integral multi-modality processing system, consisting of subjective, physiological and behavioral components. These components may at least be partially independent. We assume that this information processing system includes parallel cognitive processing of both situational dimensions and behavioral changes." Writing like this might evoke suicidal fantasies in you. Shoot me now!

This scientific prose contrasts with a moving description of sexual receptivity and arousal voiced by my favorite hero, Juliet. "Come gentle night, come loving black proud night, give me my Romeo, and when I shall die, take him out,

and cut him out in little stars, and he will make the face of heaven so fine that all the world will be in love with night." Juliet's expression of her experience, however, the meaning of sexuality to Juliet, cannot lead to a general conceptual model of human sexuality. Even though today's discussion is of scientific and clinical issues, the personal, meaningful aspects of sexuality must always be with us. And as I talk a little bit about the brain and sexuality, please keep in mind that Shakespeare is always with me personally as well.

As I wrote today's talk I was also reminded of an essay by C.P. Snow. In 1959 Snow delivered a lecture at Cambridge University entitled: "The Two Cultures and the Scientific Revolution." Speaking as a scientist, Snow held the feet of whom he called literary intellectuals to the fire, and he accused them of being unsympathetic to—uncurious and unknowledgeable about—scientific discoveries. I allude to this because some psychotherapists may have an aversion to science pretty much for the same reasons as the literary intellectuals that C.P. Snow took to task. At this point in its history, psychoanalytic psychology needs to make a much more effective working alliance with science and with scientists than it presently has. Even though we do have a Society of Neuro-Psychoanalysis, the knowledge involved in

interdisciplinary work can't be siloed to a particular scientific society but has to percolate down to all aspects, everyone in the field, and people have to really get excited about the interface between biology, culture, and learning.

Now let me talk to discuss sexual science and sexual orientation a bit. What I will be talking about today is mostly selected areas of sex differences and behavior involving sexual orientation, homosexuality, and bisexuality. And then I will talk a little bit about male aggression too, which is relevant to the whole discussion. The discussion begins with sexual differentiation of the brain and behavior. Modern conceptual models of sex and aggression in women and men pretty much mandate a paradigm that integrates psychodynamically-informed concepts with an understanding of sexual differentiation of the brain and behavior.

A central point of today's talk is that it is important to understand the behavior of both sexes in order to understand either. And as I talk about both sexes, I am well aware of the dreaded concept of the binary in the behavioral sciences. There is no question that we have to make space for the fact that some people in the diverse population that we call human behavior, some people don't fall into either sex. But most people do, actually, and it is them that I have in mind as I go on with this, although the intersex group will come up as well.

Now, in 1959 a whole new area of psychology was discovered that illuminated our understanding of sexuality. The sexual development of boys and girls, men and women, is asymmetrical, beginning in prenatal life. In male embryos, fetal testosterone is secreted and synthesized by the fetal testes during the first part pregnancy, beginning at about seven weeks of gestation, under the direction of a gene on the Y chromosome until about week twenty. This corresponds to circulating levels of testosterone in the human fetus and neonate. Males prenatally have very high levels of testosterone and females do not have any. Males get also a testosterone surge during the first year of life and no one exactly knows what that does. But the data about prenatal testosterone are quite overwhelming, and we do know a lot about what that does. If no testosterone is secreted, the embryo differentiates as female.

Prenatal testosterone and partner preference is the next topic. Prenatal testosterone organizes the brain such that certain behaviors are expressed during adulthood under the then activating influence of sex steroids or hormone. So the model is prenatal, prepubertal, pubertal are three waves. The next point is important because it presents a developmental model that is entirely different the one that is familiar to most psychotherapists. There is a critical phase of sensitivity of brain development immediately following birth. In rodents immediately following birth, and in humans prenatally, when sex steroid hormones produce irreversible effects on the sexual behavior of the animal. That is, sexual hormones experienced embryonically in humans can produce irreversible effects on adult sexual behavior.

What are those effects? Originally, starting in rodent work what we studied was lordosis, the usual response of females, which is arching the back and being receptive to penetration and mounting behavior. And also the preferred sex of the sexual partner, male versus female. These behavioral characteristics cannot be modified by hormones in adulthood. They are irreversible. Understanding this has relevance for understanding behaviors in human beings, that also cannot be modified in adulthood. I think you see where this line of reasoning is going. A central concept here is that of a critical period of sensitivity. This prenatal critical period of sensitivity leads to irreversible changes in brain and behavior during adulthood. I emphasize this because one of the central issues that clinicians struggle with is flexibility versus rigidity of specific behaviors. Which behaviors can actually be changes by psychotherapy? The fact that a behavior is persistent, for example, does not provide the answer. Conversion symptoms may be chronic but treatable with psychotherapy.

Some behaviors are motivated by unconscious conflicts and can be altered by psychotherapy. They seem rigid but they are actually fluid. Other behaviors, however, are rigid and unchangeable, and are not responsive to examining unconscious conflict. Confusion about this bedeviled the way psychoanalysts used to think about sexual orientation. One of Freud's central points, after all, is that infantile experiences can be processed, internalized, and become part of the dynamic unconscious. What I am talking about here, however, does not occur because of infantile experience, or because of anything Freud studied or wrote about, or post-Freudian psychoanalysts studied or wrote about. It is likely that sexual orientation is influenced by prenatal hormones and that this can lead to irreversible effects.

Let me return here to consider our non-human mammalian relatives again. The part of the brain where these organizing effects occur is in an area of the hypothalamus, the medial pre-optic area. A certain nucleus is found in the area whose volume is smaller in females than in males. Once acquired under the influence of prenatal androgens, the volume of this brain nucleus can no longer altered by hormones. For example, male rats can pharmacologically be made to have a small nucleus, a sexual dimorphic nucleus, characteristic of females. These rats will then prefer males sexually and prefer being mounted by males to mating with sexually receptive females.

So, let's reflect on this line of research from the perspective of a practicing psychotherapist- psychoanalyst. For one thing, it is not about human beings. When I talk about rats to psychotherapists their eyes roll. The notion that human sexuality is determined or influenced by the same biological factors as rodents is inherently unsatisfying to some people, and it offends our narcissistic self-evaluation to fully accept that we are not sexually unique. After all, there are no gay rats. As far as we know, self-identity at least as gay or straight is a uniquely human phenomenon. Darwin's theories about it were originally found unpalatable because of reasoning like this. Also, the type of person who works

with hormones on rodent brains is not exactly like the type of person who becomes a psychotherapist. Go try to get these two types of people talking to each other. It is worse than doing couple's therapy. Also, the irreversible coding of sex-of-mate preference by events that occur at critical period of prenatal life is not intuitively particularly reasonable. To paraphrase one of our well-known political celebrities, who knew things were so complicated?

When I began working in the field I tried to get some psychoanalysts interested in this animal work, but it was mostly shrugged off. The lack of attention wasn't entirely due to avoidance of science. Clinicians often pointed out that rodent sexual behavior was not analogous to that of humans, because there seemed to be not naturalistically and spontaneously occurring example of preferential homosexuality that existed in non-human mammals. Human sexual behavior for a time did seem to be more or less unique until the story about the sexual behavior of sheep emerged. It was subsequently discovered that there is in fact a population of male sheep living in the far west, eight percent of whom choose to mate with male partners, prefer to do so over sexually receptive females. In fact, these are homosexual sheep. They are naturalistically occurring; they are not laboratory created. This discovery was quite interesting because the percent of those in the total population that expressed homosexual behavior is more or less similar to the percent of homosexuality among humans—not exactly identical but close enough. Studies of these sheep reveal that the same brain nucleus is smaller in them in females than males, and it is also smaller in males that are sexually drawn to other males and is set embryonically. It cannot be modified during adulthood.

Although this type of relationship between the brain and sexual orientation has yet to be absolutely and definitively proven, the relationship actually holds true for many people, using circumstantial evidence and is just common sense. There is evidence from the human sector indicating that this is so, and I refer to the prenatal androgenization studies of females in which the incidence of homosexuality is increased and to Levay's famous study which showed that the same hypothalamic nucleus in gay men was similar to that women and smaller than in heterosexual men in the sample he studied. So there are converging lines of evidence indicating that among gay men, a subgroup are gay, by reason of nature rather nurture, and we also have to keep in mind that human homosexuality is inheritable to some degree.

Let me turn now to human beings for a minute or two. Sexology in this country was pioneered by Alfred Kinsey in the 30s and early 40s. As we all know, Kinsey, who was a biologist, an entomologist actually, was recruited to put together a course on human sexuality at the University of Indiana. As many scholars do, he headed directly to the library to learn about sex—other than his personal experience, he didn't know anything about it—and to his amazement, knowledge turned out to be minimal to absent. No one knew what people were actually thinking and doing sexually. And he decided to take sexual histories from his

students. He worked out a format and notational system that was admirable. Psychoanalysts were at that time very much rooted in Freudianism and especially in Freud's ideas about sex and psychosexual development.

Kinsey's group and the analysts didn't like each other much. The analysts felt that Kinsey's methods were superficial since they did not take unconscious motivation into account. The sexologists felt that the analysts were imprecise, not empirical enough, and rejecting of scientific open-mindedness. The course that he designed at the University of Indiana, the local clergy objected to it and they closed it down after two years. Fundamentalism is still a major problem as a public health problem throughout America. And at least 20 percent of Americans are fundamentalists. They don't believe in anything like normal homosexuality, and they represent a major clinical problem today. Having been out in Dallas recently, I can assure you that this problem affects millions and millions of families.

Kinsey's devotion to descriptive history documentation can only be admired, and as psychotherapists we would do well to follow his example when assessing patients. However, sexual histories are generally not to be found in the analytic literature, and over the years I have rarely heard solid sexual histories presented at clinical conferences even when sexual issues are focused on, such as the erotic transference. I have been in many conferences involving the erotic transference where the presenters didn't exactly know what the patient were doing with partners sexually. And this occurs despite the very high incidence of childhood sexual abuse, and the often clear clinical relationship between depression, anxiety, and other psychological symptoms associated with childhood sexual experience.

Now in my own work, I recruited a sample of socially functioning, non-patient homosexual men and compared them with the heterosexual men. The reason I am bringing this to your attention is today has to do with concepts that are very in psychotherapy conferences today, categorical versus dimensional ideas about sex and gender. The men in my study considered themselves categorically homosexual. This is an important point because there is so much fuzzy thinking today about categorical and dimensional behavior. The notion of behavioral category has gotten a bad reputation without cause, especially as applied to gender identity. But I have met many gay and heterosexual men who don't view themselves dimensionally with respect to sexual orientation. They are categorically gay or straight. While this is not the case for all men, it is for some and for many. The categorical nature of homosexual orientation explains why attempts at sexual reorientation and conversion therapy failed decades ago, and why the gay community was traumatized by such efforts. As you all remember, it was just a short while ago that people felt that only heterosexuality reflected resolution of the Oedipal conflicts. The entire psychoanalytic community, in my lifetime, believe that homosexual activity was motivated by Oedipal and pre-Oedipal conflicts. And this assumption led to much misery in the patient population, but what is important is that the entire community believed

in this and didn't really pay that much attention to the concept of validity, which wasn't possible for Freud to do when he did his work.

Now, most men in contrast to most women are sexually programmed early in life. This program determines their erotic fantasies including masturbation fantasies, their interest in pornography, and this programming is inclusionary and exclusionary. Stimuli outside the frame are of no sexual interest. This phenomenon of rigid and exclusionary programming does occur in women, but it is much less common than fluidity. Context, emotional intimacy, and deeply meaningful relationships enable the kindling of sexuality in women more than men. Much has been written about it, but I would cite Lisa Diamond's work on female sexuality and Bassin's conceptual framework for female sexuality generally. The first psychoanalyst to discuss political homosexuality, that is LUG, Lesbian Until Graduation, which many therapists who work on college campuses are familiar with, was Zara Defrise, a relational psychoanalyst. Many of those kids who are lesbian until graduation stay lesbian as well. but many don't.

The inclusion-exclusion mechanism that characterizes male homosexuality is not the rule for women. What that means is that affectionate and intimate bonding, for example, can and does stimulate sexual desire in women-to-women relationships. This emergence of sexual desire can take women by surprise particularly if it occurs later in life. Many clinicians have experience of this type of situation in which a middle-aged woman who has long been married to a man who is into sports, the stock market, the Wall Street Journal, and his work. She longs for day-to-day communication and real mutuality. He authentically and honestly does not. They are stably married and have sexual intercourse on a regular basis. He rates their marriage highly, but she feels that something is missing. There is a cartoon that says spring is sprung and a bird is on the wing. But that is absurd, the wing is on the bird. But look, I might be wrong about that. I am no ornithologist. I am no botanist either. And the husband, however, does not seem to be empathically relating to his wife.

The idea that this lack of relating on the part of the husband could have anything to do with prenatal testosterone is what I would call a cutting edge idea. Our hypothetical woman in this situation starts taking tennis lessons from a woman pro. The two women become friends, fall in love, begin a sexual relationship. Each may find it unsettling and confusing but deeply gratifying. Sometimes folks like this seek the help of clinicians, not necessarily because they feel threatened in their sexual identities, but more often I think, at least in my experience, because they feel guilty about having an affair. With respect to sex, sexual orientation provides an extreme example for stereotypical male behavior and female behavior. On the male side, prior to the HIV epidemic, it was not unusual to find reports of gay men who had many hundreds of sexual partners. Anecdotal data suggest that many straight men envied them their sexual freedom. From their perspective, women tend to slow thing down a bit.

Another point is that throughout life, men are more sexual than women by all measures to access sexuality, probably because of the influence of postnatal testosterone.

This general group guideline, however, must not be taken as a guideline for the behaviors of individuals. Many men vow sexual fidelity and keep their vows. Many women are as sexually intense and adventurous as any man. The term "prototypical" really refers to group behavior. The absence of sexual desire, turning again to women, or "lesbian deathbed", is a well-known problem in the lesbian community. Why do people who love each other lose the lustful part of the motivational component of making love? This happens to people over a long period of time in a sexual relationship regardless of sexual orientation but does seem to be more common in the lesbian community. There are many theoretical reasons for this, but the psychobiology hasn't been worked out yet.

Women may experience sexual desire for other women as a result of many different psychological determinants probably involving intense emotions including affects such as anxiety and anger and depression, but also affection, companionship, and an emotionally felt need for love and communication. This is not a pathological view, but it is a psychodynamic one. There are probably more contextual situations that activate homosexual desire in women than men. Bisexual activity in women is also less likely to threaten the sense of identity than in men.

In thinking about bisexuality and fluidity, we have to go back to the example of men again for a moment, because the topic of sexual orientation change is such a hot topic in the therapeutic and ethical community. Most psychotherapeutic situations involve individuals, not groups. Even though groups of men, compared to groups of women, tend to be rigid in their sexual programming, individual men might in fact be plastic. Their sexual activities and fantasies might change for many reasons. Because of inherent plasticity that occurs for reasons that have not yet adequately been researched, some men might experience their sexual orientation as fluctuating over time. The empirical fact that might astonish some is that the homosexual may shift towards either pole, more homosexual or more heterosexual, depending on person and context. So people whose homosexual or heterosexual balance shifts usually have psychodynamically relevant reasons having it shift, but haven't been systematically studied by researchers. There are no bisexual men that are distinctive in some way. However, it is important to identify men who are inherently sexually plastic, a characteristic that is probably distributed across diverse psychopathology and normalcy. The fact that most men are rigid explains the fact that sexual conversion is a bad idea generally, and why paraphiliacs are so difficult to treat. But an individual patient in a therapist's office might not be like most men. The notion of clinical judgement must continue to be privileged in our work. It is important to stress this because of pressure to adjust our therapeutic approach to conform to rules or to ideologically driven norms of one type or another.

Let me make a final point about sexual orientation in women and men. For many years the entire field of sexuality, sex research and sexual science, was dominated by a sexist perspective. Male homosexuality and bisexuality were taken as universal models, I would attend conferences about homosexuality, and what I heard was mostly men talking about men and assuming that women somehow fit in. Thankfully, this has changed, however. In my view the point about developmental asymmetry is still underemphasized.

I want to change topics entirely now and talk about a different psycho-biologically relevant topic, rough-and-tumble play. Another area that is influenced by psycho-biological research concerns rough-and-tumble play, a type of behavior that occurs much more frequently in boys than in girls. In every society studied, and in all reports between age six and twelve, boys engage in rough-and-tumble play much more frequently than girls do. And this is one of a number of arguments that rough-and-tumble play is under the influence of prenatal androgens. The question arises whether rough-and-tumble play couldn't be the results of cultural influences alone. And cultural influences are important but, the fact that rough-and-tumble play occurs in animals, in nonhuman animals, at the same time in development that it occurs in human children, middle school years, and during an age interval when there are no blood differences between boys and girls, suggests that it involves differences in brain programming. The fact that it is sensitive to androgen has been validated by the fact that it goes up when girls are exposed to too much androgen prenatally. It goes up in the offspring regardless of the cause of the increased androgen.

Rough-and-tumble play is part of a pattern of other behaviors, including sex differences in boy preferences in early childhood, which are also under the influence of prenatal androgen. Considered as a group, boys innately prefer weapons, trucks, cars, and hard objects that they can throw in contrast to girls. Now what about tomboys? Well, girls who engage in rough-and-tumble play may be called tomboys but usually not derisively. The term has no negative connotation in our culture. But boys who avoid rough-and-tumble play may be negatively stereotyped for reasons of psychology that have to do with what boys are like, during the ages of six to eleven. Although rough-and-tumble play is one of the most robust sex differences in behavior, an area of behavior that is even more robust, I think has to do with male violence. The two could be conceptually related to each other but presently are not. So this is a cutting-edge area. Rough-and-tumble play itself is generally considered a form of non-harmful play. The lens through which this is viewed is that of play behavior.

Human children studied in research on play behavior tend to be psychologically healthy normal kids, and rough-and-tumble play is labeled a form of play, not violence, and in itself it is not a form of violence. However, developmental psychologists and therapists have the following problem: gender is probably the most important predictor of seriously violent human behavior there is and rough-and-tumble

play raises some interesting questions about studying gender. One of the questions that it raises is when you are a practicing therapist or psychoanalyst, do you really bother reading research studies on rough-and-tumble play and seeing how many people in the samples come from normal families? How many people in the samples come from pathological families? Actually, the entire literature database is pretty much composed of kids that come from non-pathological families.

Let me turn to violence again and make another point or two about it. From my perspective, arguably, the most important psychological factor adversely influencing women's health, and mental health around the world is gender abuse and violence. The data about gender differences in perpetrators of violence is so overwhelming that specifics are hardly needed, but I will provide one arbitrarily chosen. U.S. government agencies define the category "active shooter" as an individual actively in killing or attempting to kill people in a confined and populated area. The F.B.I identified 160 active shooter incidents that occurred in the United States between 2000 and 2013. 160 active shooter incidents. Of these only six shooters were women. All the rest were men. Data like this are pretty much par for the course of violent crime throughout the world. Throughout the world serious violence is predominantly inflicted on others by males. So the human male is dangerous, and frequent victims of male violence are girls and women. Other men, and transgender and gay individuals, are also victims as well. I will say a bit more about this before I stop.

The biology of rough-and-tumble play has not yet been related to the biology of male violence. This is an area for important research. Perhaps the major difference between violent males and other males, that is those that are prone to childhood rough-and-tumble play but not violent, is in psychosocial development. That is the influence of environments of abuse, neglect, and violence on the brain and behavior of individuals who belong to a gender predisposed to rough-and-tumble play. Let me put this differently. Males have the central nervous system equipment in place, in the form of hormonal androgen receptors in normal environments. What happens to them when the environment is not normal? The answer is not presently known. But we do realize that males in abnormal environments are at increased risk to become violent.

The supporting data that violent males and the power differentiation between males and females is perhaps the most important public health problem affecting female sexual health today. A lot of it comes from studies of intimate partner violence. Intimate partner violence has an impact on the health status and the mental health status of women throughout the world. In 2013 *Psychodynamic Psychiatry*, the journal I edit, devoted a special issue to intimate partner violence coedited by Levendosky. As many of one quarter of women in the world have been involved in romantic relationships in which they have been choked, beaten or burned by a male partner. There are many data

about the frequency of intimate partner violence and about the seriousness of intimate partner violence that we don't really have time to go into today, except I will point out that children below the age of twelve are present in the household of about half of all female victims of intimate partner violence.

Because of practical limitations I am going to stop in a minute or two. I have outlined some issues pertaining to sex differences and sexual behavior, both illustrated by homosexuality, bisexuality, male rigidity of sexual programming versus female fluidity, with a lot of individual exceptions on both sides. I have spoken about rough-and-tumble play, which is biologically programmed under the influence of androgens on a different part of the brain than affects sexual behavior. Sexual behavior is medial pre-optic nucleus and hypothalamus. I have arbitrarily picked two types of behavior to illustrate the profound problem of sex differences in behavior in creating a psychodynamic, psychoanalytically sophisticated model of the mind. None of this was known to Freud, and hardly any of it, as far as sexual differentiation of the brain and behavior, was known to Karen Horney, and none of it was known to Melanie Klein. So that when psychoanalysts think of making a universal model that explains universal human behaviors, such as for example feelings about parenting, or feelings about love, or feelings about hatred, what the field needs is a much more specific effort to build models that are based on knowledge that comes from outside of psychoanalysis. But that presently is not being tapped by adequate working groups across disciplines. I will arbitrarily stop here.

Resilience in a Time of Pandemic

Ahron Friedberg, MD

It's not like when JFK was shot or 9/11 happened. Everyone who was over the age of, maybe 7, knows where they were when those tragedies occurred, and exactly what they were doing. They remember being stopped cold, stunned. But this tragedy is different. As a psychiatrist, people come to me all the time with fears and anxieties. Heightened fear is nothing new. But slowly, over several weeks, the nature of this fear began to change. It was morphing into a terror of harming people, even oneself. It was guilt-ridden. In the space of a few days, fear was laced with mistrust, anger and dread. That's when it hit me that, in its slow insidious way, COVID-19 was right up there with JFK and 9/11 in its impact on people's psyches. Only it took time for us to see it that way.

Even though I am an MD, and have over 25 years' experience, like many people I wasn't prepared for the bad news – probably because, like in the Phony War of 1939, nothing seemed to be happening. There were scattered reports. The first real sign of things for me was back in January when some Asians I commute with on the Long Island Railroad started wearing N95 masks. But my frame of reference was wrong. I knew about an outbreak in Wuhan

and saw this face-covering, naively, as a show of solidarity – like wearing white for the suffragettes – rather than a proactive measure against what could happen here.

It wasn't until it did happen, inescapably, that I realized that it had. Then suddenly I was scrambling. Whereas before I was practicing out of a Park Avenue office, talking to patients in an intimate but professional setting, I was now skyping in my attic, trying to maintain some professional distance when our screens were filled with each other's faces only inches apart. I struggled to mitigate the medium's intensity, afraid that my reactions might seem extreme when my patients expressed their own, overweening fear.

Psychiatrists are not trained to refract their therapeutic approach through social media. I was on my own. As I would discover as the pandemic progressed, there were no protocols for a situation so totally out of whack. Even in the aftermath of 9/11, which affected every person in the City, I was back in my office in a couple days. My patients came there to feel normal, if only briefly. But nothing I can do now simulates normality. The stress is everywhere. It's intensifying. Some of my colleagues cannot practice under these conditions; they are disoriented by the makeshift adaptations that seem foreign to their concept of how we treat patients.

I am pushing on, but this is new territory. Among my patients, I have never seen such a sudden access of single-minded fear. All their usual, kaleidoscopic concerns – office politics, children, extramarital affairs – have snapped into abeyance behind one overriding worry: everything feels out of control. What comes out when we talk is a kind of hyped-up banality, a sense that quotidian tasks are potential inflection points along the road to their only goal: not getting sick. They ask about where to walk the dog, when to buy groceries.

I try to offer realistic reassurance, but am afraid of lapsing back into that same blinkered frame of mind that I had in February. So, I say something about not panicking. But are people so panicked already that they're not listening to reassurance? I wonder if they can process advice, based on sound medical principle, that panic elevates stress levels even further. I wonder if they resent when I offer what they hear to be platitudes, stock responses, when what they really want – perversely – is someone to share their doom and gloom. We seem to be missing each other's cues.

I wish I could keep the chaos outside from enveloping the space that I share with my patients. But it's impossible. My simplest question is received as an existential challenge. I usually start a session with "How's it going?" or "How are things?" Now my patients ignore pleasantries. "I lost my job" is a common response. Or "My dad is in the hospital," or "My wife has COVID." If they've thought about their response in advance, they seem to have concluded that whatever they say will not match the anxiety that they feel, so they just confess, "I'm not sure."

My regular patients know that I may press them to be explicit, so they're surprised when I accept this response

and thank them for their candor. I tell them we have to acknowledge the uncertainty surrounding this pandemic. The scientists who issue daily updates on infection rates, mortality, and when this will end are conspicuously uncertain. To them, COVID-19 is a moving target. Their imprecision is a form of honesty, the unalloyed outcome of number-crunching disciplines that prohibit certainty where data fails to support it. Moreover, since we are the data, we should adopt the same epistemology to describe our own lives. If our lives do not compute right now, we should say so. That extends to our employment status, our wavering confidence in the government – to whatever seems uncertain, and not just whether we will escape this plague.

Of course, honesty about ourselves may be received as an intrusion on others' carefully constructed sense of well-being. But for the most part, it sets others at ease, letting them know that they're not alone in feeling unsettled. If it is a paradox that shared unease is reassuring, this only reflects our need to be understood. In the context of mutual understanding while under the threat of plague, the old cliché, "misery loves company," has been newly renovated: now it permits us to be honest with each other when we are walking examples of the Uncertainty Principle. "I'm not sure," as a response, is the quintessential form of honesty.

My epistemology has its source in literary history. A lot of comparisons have been made to the London Plague of 1665, and I suggest that for sheer psychological acuity – and the first real claim that uncertainty is the only honest response to pandemic – no one beats Daniel Defoe's fictionalized account in *A Journal of the Plague Year* (1722). Defoe's narrator, H.F., introduces his account by acknowledging that while the incidents he describes are "very near Truth," it is a fact that "no Man could at such a Time, learn all the Particulars." To be in the midst of the Plague was to see it incompletely. Later on, when looking into a pit of the piled-up dead, H.F. acknowledges the ineffability of plague phenomena and the inability of language to render them: "[I]t is impossible to say any Thing that is able to give a true Idea of it to those who did not see it, other than this, that it was indeed very, very, very dreadful, and such as no Tongue can express." In an eerie anticipation of our own plague, H.F. asserts that the Bills of Mortality "never gave a full Account, by many thousands; the Confusion being such, and the Carts working in the Dark, when they carried the Dead, that in some Places no account at all was kept, but they work'd on." In example after example, H.F. demonstrates that the only honest response when trying to describe plague is to say you don't know because can't know. In a time of plague, you accommodate to uncertainty. You must.

When I read this old book, the irresolution it depicts was clarifying. It felt like a diagnosis. We are experiencing the same inability to grasp the situation. We don't know who is still going to get this disease; how long it will persist; how it will permanently alter our lives. Right now, while we must live in uncertainty and accept it, our chronic inability to fathom it produces enormous stress.

As I talk with patients, and they worry about getting the disease, they worry as much about the effect of all this worry. Like H.F., they see an infinite regress into a morass of unanswerable questions. I can't tell them not to worry. I can't say to focus on the important things, when they can hardly focus at all. There has been a lot of discussion recently about how, during this pandemic, people's ability to focus has declined. One of my patients said "I try to work, but I keep interrupting myself, and then I interrupt the interruption with something else." I think that lack of sensory stimulation, the effect of sitting at home day after day, turns the mind into a closed box where whatever is there just keeps ramifying. It can be done. I have told some of my patients about H.F. and how he makes it through the Plague by means of luck and resilience. I can help my patients to elicit luck by developing skills that contribute to resilience.

My first clinical experience with COVID was with Sam, whom I had treated for Generalized Anxiety Disorder, currently the most commonly diagnosed psychiatric condition with symptoms that can include excessive anxiety, fatigue, difficulty concentrating and falling asleep, and occasional panic attacks. However, Sam responded well to a low dose of propranolol and to an additional exercise regimen. His problem arose when his boss, a prominent figure in New York City government, tested positive for COVID and Sam had been in private meetings with him. Sam and his colleagues had to be quarantined.

During his quarantine, Sam and I kept talking. But he had to keep a safe distance from his pregnant wife. Ultimately, he tested negative for the virus, and was happy to be close to his wife again, but felt guilty about putting her through what he called "vicarious stress." He thought he also might potentially have harmed the fetus. His concerns were not unusual. I have found that during this crisis, patients take on guilt for the knock-on effects of events they had no control over. Sam could not have prevented his boss from testing positive, but because this sent Sam into quarantine – and then caused his wife to withdraw to a spare room – Sam blamed himself. He was concerned that his panic attacks might return.

I could not tell Sam that he was being irrational (though he was). I could not tell him that his panic attacks would not return, since the stress that he was under could easily trigger them. But I could explain the origin of his guilt feelings which, I think, were a sort of displaced expression of love for his wife. Because Sam was the proximate cause of his wife's own stress during the quarantine, he felt as though he was not acting like a responsible husband. He was absent when he should have been present, almost as if he had been cheating. So, afterwards, he made up for his absence by feeling guilty.

When Sam and I discussed why he felt guilty, he understood. "Look, berating yourself when so much is out of your control is pointless. You love your wife, and would

never harm her.” That’s what he needed to hear so that he could clear his mind and, he assured me, get on with life post-quarantine. He felt that together, he and his wife could manage this crisis, sheltering in place, ordering in Chinese food (the new icon of survival in COVID-stricken New York). I felt comfortable at this point in bringing up some long-term strategies for saying resilient, i.e. for maintaining the best outlook for keeping on.

I recommended Grit. That’s not a scientific regimen, but there is scientific evidence to show that grit – the determination to overcome adversity – is an important factor in resilience. You have to believe in your own strength, and persevere even when others are giving up. I told Sam about strategies for coaxing your strength into overdrive like, for example, slowing down, making the right decisions as often as possible. “Right now, you could make 100 right decisions. But if you make one wrong one, you could be dead.” That’s sobering. Daniel Kahneman and Amos Tversky’s great *Thinking Fast and Slow*, identifies a thought process that is “slower, conscious, effortful, explicit and more logical” in contrast to one that is instinctual. In other words, self-aware. I would add that just as acting precipitously is dangerous, so is the inaction that comes of despair. To the extent possible, we need to be measured when under stress.

I’m often impressed by New Yorkers’ grit. I’m thinking of another patient, Sally, whom I started seeing several years ago for a Major Depression (Major Affective Disorder, Depressive Episode). She was referred by a colleague who specializes in the treatment of cancer. Her current stresses included financial difficulty with her interior design business and being a cancer survivor. She was status post a double mastectomy. At the time of presentation, in addition to a depressed mood, she had neurovegetative symptoms with difficulty falling and staying asleep, and decreased appetite with weight loss.

After discussing various treatment options, we decided on a combination of psychopharmacology for initial symptom relief and insight-oriented psychotherapy. Sally responded well. I also coached her on the business, and things plateaued for a while. I suggested perhaps even cutting back our sessions. But then came COVID, which hit her business like a sledgehammer. It had only limited reserves and had to close. But Sally did not give up. She was still able to maintain the payments on her house, so I encouraged her to reconnect with clients and old friends whom she had neglected during her cancer scare. One client offered her a substantial project. An old boyfriend showed renewed interest. She began to feel less dejected.

In Sally’s case, resilience required exposing herself to people who might have moved on with their lives, might not have cared, might have left her feeling even more vulnerable. Resilience requires taking chances on people. When we need people, we have to swallow our pride. “It’s a good thing pride isn’t fattening, since I’ve swallowed so much of it.” I wanted Sally to see that I had survived the same risks that I was asking of her. We can take chances when we can

plausibly imagine ourselves benefitting from them. I offered my experience as an example.

But still. That was long ago. When I try to situate taking even an ordinary risk now, in context with the existential risk posed by COVID-19, I have to ask: Is any risk worthwhile when we’re already stressed to the max? Yes, provided it helps move us out of a bad place to a better one. Risk can be an element of adaptation – the first principle of evolution. Throughout this crisis, we can’t suppose that “sheltering in place” means staying fixed in old assumptions, habits, ways of doing things that don’t work anymore. Resilience requires readiness to end up in a new place. We have to be willing to become different, to end up not even recognizing ourselves.

My patient Bobby needed to change his business model when COVID upended Wall Street. His team at a major hedge fund includes over 100 analysts, traders and support staff. It’s a collaborative, fast-paced operation, but when no one could any longer work at the office, he moved everyone onto Zoom. He wasn’t sure how this would work since much of the multi-directional spontaneity of the office would be lost. But Bobby saw no choice and, after a period of adjustment, things clicked. Bobby even found ways to hedge the risk with his fund that were profitable while markets were tumbling. He never considered giving up. He adapted.

Though Bobby was doing well, he was sufficiently self-aware to recognize a case of “survivor’s guilt” – he was barreling ahead while others were not so lucky. In response, I suggested that he consider donating some of his resources to charity, and he generously embraced the idea. This helped him feel better. But this was not because he could simply buy back his guilt, but because he could experience himself as part of the community, acting on its behalf as it struggles through crisis. In *The Altruistic Brain: Why we are Naturally Good*, Donald Pfaff explains the neuroscience of why humans are designed to be generous. Sheltering in place tends to isolate us from any inclinations that extend beyond our immediate circle but, when we follow them, we’re acting the way that we would in normal times. Resilience in a time of plague requires clearing out enough mental space so that we can replace non-productive inclinations with affirmative ones. We feel more like ourselves when we do.

Indeed, there is now an opportunity for people who have recovered from a COVID infection to donate plasma, which has antibodies to the virus for people in need of greater immunity. Adam Grant’s *Give and Take: A Revolutionary Approach to Success*, demonstrates that generosity is one of the best anti-anxiety medications in that it lowers the levels of stress hormones. Recent work by Emily Greenfield at Rutgers demonstrates that when we take responsibility for others, we feel better about ourselves. We believe in ourselves and, in effect, become more resilient.

Jennifer, a physician in her mid-thirties, is perhaps the heroine of this piece. She presented to me over a year ago with anxiety and depression, stressed over her work in an ER and uncertain about her boyfriend. Then COVID hit. She had been called in over a weekend to work a double shift.

Hospital beds were filled to capacity and medical supplies were dwindling. She had to use the same N95 mask for the entire day, which worried her, since a co-worker had contracted the virus and unexpectedly died. I empathized about how vulnerable that must have made her feel, and she became tearful over the loss. She recalled her brother who died of a drug overdose and wondered if she and her family might have done more to help him. I said that her present loss had brought up feelings from the past, and that we could talk more about that over time, but for the moment we had to help her deal with her current situation. I suggested that even though she was asymptomatic she best be tested for COVID.

About a week later, she developed symptoms and tested positive. She self-quarantined for two weeks and is now doing better. But doctors and health care workers are now under great pressure. Jennifer has asked to talk about what she feels so that she can process it before diving back in. People in other critical professions are equally under stress.

Some of the stresses are acute or situational, as when a patient or colleague suddenly dies. Acute stresses are experienced as immediate threats, either physical or psychological. In responding to acute stress, the body produces increased amounts of cortisol, adrenaline and other hormones. These leads to an increased response of the autonomic nervous system including increased heart rate, rapid breathing, and higher blood pressure. The reaction is known as a fight-or-flight response because it prepares an individual to respond effectively. Generally, it is possible to recover from acute stress. The body can rebound and return to a normal state. Deep breathing or some relaxation technique like meditation can help to calm the mind.

However, many stresses are chronic and, in the case of physicians, can lead to burnout. Chronic stress can weaken the immune system and contribute to major medical conditions such as heart disease, diabetes, obesity, gastrointestinal disorders as well as sexual dysfunction and mental health problems. With chronic stress, the body's ability to fight off antigens is reduced because corticosteroids, hormones related to stress, suppress the immune system. So, the body becomes more susceptible to infection such as viral illnesses like COVID, and recovery becomes harder and longer.

Another problem is that stress can augment pre-existing stress. In an piece in the New York Times regarding the effect of our current isolation, Andrew Solomon wrote that "many who were already suffering from major depressive disorder have had their condition exacerbated, developing what clinicians call 'double depression,' in which a persistent depressive disorder is overlaid with an episode of unbearable pain." Moreover, extreme stress can shake loose stressors that the individual had previously kept under control.

For Jennifer, resilience will entail dealing with acute and chronic stress, sometimes at once. We spoke about grabbing moments to relax, basically to allow herself to recover. The harder that relaxation seemed, I suggested, the more crucial it was. Of course, sitting in my attic, with none of my patients critically ill, I felt self-conscious talking about

relaxation. But I hoped that if I was honest and shared my feelings, Jennifer would take my advice. I think that one of the biggest challenges posed to psychiatrists and other mental health professionals by COVID is that it exacerbates a concern with emotional detachment that we frequently have anyway: how can we give advice when we are outside the situation, looking in from a position of relative comfort? My response is that both Jennifer and I need to take a step backwards, remove ourselves from our personal psychological environment, and objectively think about how she can adjust to this crisis.

The fact is that Jennifer is starting from an enviable position, however precarious she may feel. She has a terrific education and an has worked her way up to shoulder huge responsibilities. Often, it helps to recall the mountains we've climbed to bolster our resolve for the next attempt. One of my patients (who takes this M.O. literally) told me that every time she wants to give up, she pulls out her photos from the Himalayas. She trekked across the Thuring La (18,000 feet) and made a 300-mile circuit around the tallest peaks in the world. It was exhausting and at times terrifying, and she lost ten pounds. But she made it. Recalling past accomplishments can be a source of strength. It helps us maintain our self-esteem when guilt, exhaustion, or failure allow us to forget why we should be self-confident.

Dedicated self-care is no crime. In a time of plague, it may seem vain to focus on oneself any more than is necessary to stay alive. But evidence demonstrates that dressing well and staying groomed – even if no one is around to appreciate the effort – can reassure us that we are not giving in or giving up. In a recent "Here to Help" piece, the Times' fashion editor, Vanessa Friedman suggested that thinking about one's self-presentation at this awful moment can "be a sign of faith in the future, and the idea that one day we will again be in public, dressing for the occasion, not hiding away from each other." That's a powerful message. So much of getting through this will depend on the belief that we will make it through.

Of course, it is hard to believe in the future when we are isolated, and every day just reinscribes the previous one. Several of my patients almost missed their Skype appointment because the calendar became irrelevant ("I didn't realize it was Wednesday!"). One major resilience factor, therefore, is to maintain connections. Some friends have regular check-ins with each other. The point is to talk to people, make appointments, keep them. This may be hard when a job has disappeared, but then find other outlets. A book club, for example, allows people to talk online and in some cases on air or by Zoom. In New York City, the WNYC program "All of It" has a book club that anyone can join, thanks to the New York Public Library which will order thousands of copies of the books assigned. PBS has the phenomenal Readers' Club, and a related group discusses British TV mystery shows (available on PBS). The list goes on and on. Engagement with perhaps three or four such outlets can add lively connections to our lives. They can add structure to our days.

Prolonged periods of unstructured time can be disorienting. If we are accustomed to a routine that suddenly collapses, we have to find ways to reconnect one hour to the next. We have to experience personal progress where, at the end of the day, we can remember what we did, and when and why we did it. Sensing the need to feel accountable, if only to oneself, day-long projects like baking bread have become popular; they entail specific tasks at time-sensitive intervals, and watchful waiting between intervals. They produce a tangible – edible – result. Home schooling children makes comparable demands. Writing a novel, less so, unless one is disciplined. Discipline is key. Others can reinforce one's discipline, so that learning a language by speaking it two hours a day with a friend may be exponentially better than talking to yourself in the mirror.

One of the best ways to structure time during the endless days of lockdown is to form a self-help group. It can call on the same level of commitment as any job, giving us a reason to get up in the morning and stay focused. "Unemployment Nevada Information and Help" sprang up when one woman started a Facebook group to help the furloughed and the fired navigate the state's unemployment benefit system. She was inspired because of her own struggles with the state's unemployment website. Currently, the group has nearly 7000 members, and additional moderators have been recruited to help with the workload. A constant stream of emails needs responses, and research is required as the federal government augments the state's capabilities. This sounds like a job! Moreover, the initiative is impressive because it demonstrates how resilience derives from thinking creatively – that is, outside the box. Where we sense a need, we can try to fill it by devising a new solution; offering others the benefit of our own experience; even, as in this case, creating a community where none had existed.

As I continue talking with my patients, I realize that what may be the crucial factor in their recovery from this maelstrom is that they not equate recovery with a return to the Old Normal. We will all be fundamentally changed – more sober, more appreciative of the importance of intimate connection, more aware of the fragility of everything. We have to think about how we will adjust to our new reality, whatever it turns out to be. In *Resilience: The Science of Mastering Life's Greatest Challenges* (2012), Dennis Charney and Steven Southwick observed that to survive stress, cognitive and emotional flexibility are crucial because they enable you to tolerate a highly stressful situation and reassess it. As in your own body, flexibility enables you to move, and to change directions as you continue to evaluate your position. During stress, movement is more important than knowing where you will ultimately end up. They argue further that assigning meaning and purpose to life can strengthen one's resilience and may help prevent the symptoms of stress from becoming worse. Jennifer had her eye on returning to the ER even while she was in

quarantine, and this allowed her to get through it without falling into a cycle of guilt and regret. If you give yourself up to stress, like Sam might have done, you will Likely have a harder time becoming productive again. Finally, Charney and Southwick argue that persistence and commitment to building resilience is necessary to consistently maintain a positive outlook and manage adversity.

But why stop? Shouldn't we keep building resilience for the next challenge in our lives? It probably will not be another pandemic, but it could be a job loss or move to another city. One of the first principles of resilience is that we should cultivate it for the long haul, learning to be adaptable, to make connections, and to act decisively when the need arises. I suggest that we think of resilience as part of our personal reserve – like the strength in our muscles – rather than a quick-fix skill that we can learn on the fly. We can't just learn it when we need it; it comes with experience. If something positive emerges from our bout with COVID-19, it will be that we came through it, better equipped for the next time. We will have gained a greater appreciation for how quickly we need to draw on resilience when the need arises. Even if the level of stress is relatively minor, it is better to address it from a position of psychological agility.

We should also stop thinking about resilience merely in personal terms. Our own resilience frequently depends on that of society. We have now experienced the disastrous shortages of N95 masks and other Personal Protective Equipment (even as reports come in that Finland has been stockpiling such materials for years). Food banks are under stress as restaurants close. E.M.T. workers are falling sick, and back-up personnel are scarce. The unemployment system was woefully unprepared for the surge in applications. Thus, in designing our own program of resilience, we need to think socially. Self-help websites, such as "Unemployment Nevada," bridge the gap between personal response and social impact. Once this pandemic is under control, it would be wise to measure our own strength-building efforts in terms of how they strengthen society's responsiveness. If we truly believe that forming connections is the best way to resist the disorienting effects of isolation, then we need to project that belief outward and work at it.

Nonetheless, I am reminded of the standard airline instruction, "Put on your own mask first, before helping others" (oh, the irony!). During this period of mass social unease, we must first help ourselves, and find our own path towards resilience. Each of us has our own histories, which make us uniquely susceptible but also uniquely capable. We have to navigate towards whatever makes sense – as quickly as possible. In "10 Ways to Build Resilience," The American Psychological Association suggest 10 practices that, in some personal combination, can help: (1) Make connections with people and build strong relationships with family and friends. (2) Avoid seeing crises as insurmountable problems. (3) Accept that change is a part of living, and there are circumstances you cannot alter. (4) Move toward your goals but make them realistic. (5) Take decisive

actions, and act on adverse situations as much as you can rather than being passive. (6) Look for opportunities to discover more about yourself and gain an increased sense of self-worth. (7) Nurture a confident, positive view of yourself. (8) Keep events in perspective, and do not blow them out of proportion. (9) Maintain a hopeful outlook, and visualize what you want. (10) Take care of yourself by paying attention to your emotional and physical needs. In examining the lives of four of my patients, I have touched on most of these. You can start with one or two, as Sally did when she reached out to a business contact and an old boyfriend. You can then build out. The point is to remember that we are all in this, and that nobody will think you are acting out of turn by trying to survive with your sanity intact.

I practice what I preach. I have increased my own regimen of morning yoga and meditation, and my daily steps from 10,000 to 15,000. I participate in a physician wellbeing initiative sponsored by the American Academy of Psychodynamic Psychiatry and Psychoanalysis. I've also started writing more poetry. Poetry is not for everyone, but it works for me – and that's the point I'm making. We each need to find our specific way through. One of my acquaintances, a scholar of Renaissance poetry, is writing a crown of sonnets or sonnet "corona," an interlocking series of sonnets that elaborate on a single theme, in this case the eponymous virus. The form dates back to the 15th century, and there are many later examples. But where you might expect the usual sonnet conventions of love and loss, this current corona extends into scenes of reflection on the massive loss of life. It's cathartic.

Slowly, it is becoming apparent that we will each need to dedicate ourselves to resilience because the virus is resilient. It is opportunistic. It's always there. As H.F. observes when considering how the Plague is spread, "[D]eath now began not, as we may say, by hovering over everyone's Head only, but to look into their Houses, and Chambers, and stare into their Faces." If we manage to contain the virus, we still have to be ready for a second wave, which could burst out anytime until we achieve the so-called herd immunity which, in the absence of a vaccine, may require over half the population's becoming infected. We can't let go of resilience, or we may catch the virus on the rebound. This is yet another reason why, when I suggest that we build our resilience for the long haul. We really have no choice.

Of course, even though everyone chooses his or her own path to resilience, some choices make more sense than others. A woman I know has decided not to read the paper or watch the news, on the assumption that information will only depress her. She reads novels, takes care of her house, and blissfully exclaims, "Wake me when it's over." She bullies her friends into silence if they mention the stock market or how they are afraid to touch the packages that are also their lifeline. On the other hand, her best friend reads everything on the assumption that, if we are ever to recover, we'll have to know how we got to where we are when we begin. She grits her teeth, admits to existential terror, and follows the statistics. So, who has the better approach? I

prefer the woman who is actively engaged, preparing to take responsibility. There is a difference between solipsism – which may feel like self-protection – and the resilience that comes of being clear-eyed, open to the world, and ready for what's coming. It is tempting right now to circle our personal wagons. But that will only stunt our ability to meet this and future challenges. Of course, we must look inward now (as we always must), but not at the price of disavowing an interest in others. At this point in our personal and national history, it is crucial to remain part of the community. Suppose the tables were turned, and everyone ignored us?

As the doctor in the family, I have had to talk with my wife and children concerning the possibility that life will not return to normal for quite some time. We have developed family routines, which are helpful for establishing a type of normality within the abnormal. My children diligently pursue their studies remotely. We discuss what they are learning. I make a point of joining the family for dinner, even if I have to climb back upstairs for after-hours calls with patients. This new level of family intimacy – which has the potential to become claustrophobic – is still a great support to all of us. I feel guilty about enjoying any aspect of the pandemic, but this aspect is reinforcing our resilience. Routines that are sustaining and that reinforce connection are easier for families than for individuals on their own. But they still require commitment.

This is hard for me considering the continuing stress. As a mental health professional, I am not on the frontlines, but I feel the effects. One of my patients, a businessman in his 50's, got a call during our session that his best friend had just died of a COVID infection. Another patient, a former military man in his 40s, reported that one evening the previous week he went to bed with a low-grade fever and some aches; the next day, he woke up with the "worst headache of my life" and a fever of 104; he thought he was dying. He was admitted to a local hospital and by Monday was starting to recover. He was discharged by the time we spoke but still feeling weakened and malaise. He talked about his fear and distress that even he was vulnerable and how his life felt so fragile. The third patient, a hospitalist in his fifties—23 of his 25 patients had COVID—recently tested positive for COVID and is himself now quarantined. As a psychiatrist, I don't do triage. I treat every patient as an individual and each makes an impact. But precisely because I am "on" for all my patients, I need to remain resilient. When I am talking with a patient, I try to put all the grief from the others out of my mind so that I can stay focused and present with each of them.

Perhaps my most important recommendation is that we try to live in the present, and not allow this crisis to reopen old wounds. Some of us have been abused but have repressed it. Or we feel guilty and can't apologize because the person we hurt is dead. Or we never followed through on a promise, and now the opportunity is past. Normally, I would treat these issues, and try to bring someone to a place where they acknowledge and accept what occurred. That is the first step towards healing. But, as in Jennifer's case, now is not the

time to go back over issues whose resolution can take time and, while they are still festering, can leave us dispirited. “Tomorrow is another day” was never less the cliché. Above all, we have to believe that there will be a tomorrow.

Along the way, we cannot allow ourselves to decline. Accordingly, we have to counteract the deadening effects of loneliness, and of disconnection from our usual means of social support: workplace, the gym, religious community. Recent clinical work has demonstrated that loneliness has a physical impact on our capacity to resist disease, the very last thing that we should want to risk. By remaining connected, even if virtually, we literally support our ability to fight COVID-19 in the first instance.

So, I recur to H.F. Defoe’s brilliant characterization was built around someone who understood the limitations that his own precarious situation imposed. He wanted to be honest, but knew that everything he said was provisional. This is because everything was provisional. Part of H.F.’s resilience was that he did the most with what he had, and lived to write *A Journal of the Plague Year*. That’s a frame of mind that may prove useful during this crisis and beyond it. We will need to live fully in the present even as we work, look toward, and hope for the future.

Telepsychiatry During the Coronavirus Pandemic: Some Pros, Cons and the Future

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The coronavirus pandemic that began at the end of December 2019 in Wuhan, China has affected the lives of almost every human being on the planet and, for many, the occupations in which they are engaged. The necessity of social distancing and self-quarantines at home to avoid becoming infected with the virus, and infecting others, has resulted in dramatic and widespread changes to the practice of psychiatry as well.

With the exception of psychiatrists working in hospital emergency rooms, on inpatient psychiatric hospital units, in jails and prisons, and tending to the homeless population on the street, almost all psychiatrists are now meeting with their patients remotely over the internet using a variety of online platforms that include the recommendation that these are HIPAA (Health Insurance Portability and Accountability Act) compliant.

In this article we plan to address some of the clinical and administrative issues in providing online telepsychiatry treatment to patients including what we see are some of the benefits and the disadvantages of this medium of treatment, and how we anticipate the future of the practice of psychiatry will be affected when the pandemic is over.

Introduction

During the COVID-19 public health emergency, the new waiver of the Social Security Act (under this waiver, Medicare can pay for office, hospital, and other visits

furnished via telehealth across the country and including in the patient’s places of residence starting March 6th, 2020) authorizes use of telephones that have audio and video capabilities to provide Medicare telehealth services. (1)

Additionally, the HHS Office for Civil Rights waived penalties for HIPAA violations against healthcare providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype. (2) These changes along with social distancing measures led to massive and widespread use of teleconferencing to provide various psychiatric services throughout the U.S and the rest of the world.

The American Psychiatric Association (APA) defines telepsychiatry as a subset of telemedicine - the process of providing health care from a distance through technology, often using videoconferencing - that can involve providing a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education and medication management. (3) It can involve direct interaction between a psychiatrist and the patient. It also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise. Mental health care can be delivered in a live, interactive communication. It can also involve recording medical information (images, videos, etc.) and sending this to a distant site for later review.

It’s worth noting that the use of videoconferencing in psychiatry has been in place for several decades. It first began in the middle of the last century. Nebraska Psychiatric institute and Massachusetts general hospital were some of the first institutes to use videoconferencing to provide several services in 1959 and 1969 respectively. (4) By the end of last century, videoconferencing found its way to many countries across the world and obtained wide range of acceptance given the easiness it provides to access care. Studies have shown that videoconferencing is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, and patient satisfaction; it often saves time, money and other resources. (5,6)

Some considerations

In order to conduct telepsychiatry treatment over the internet, both psychiatrist and patient must have a secure internet connection, and both will ideally be located in a place of privacy and free of distraction. One author (GP) recently realized late into a psychotherapy session that his patient’s spouse was in the same room as the patient, out-of-sight but listening to both sides of the conversation.

Some patients will necessarily participate in the sessions in their car (hopefully, not while driving!) in an effort to achieve confidentiality. On the side of the psychiatrist, it is important to avoid having family members, pets, etc. running around in the background to provide for confidentiality and to avoid distractions. When distractions intrude, however, this can become grist for the therapeutic mill.

It can take several minutes for both parties to establish a secure internet connection and be ready to begin the

session. It helps sometimes to use one platform on a laptop, e.g. the video, that allows for a full-screen view, while using a cellphone for the audio that may provide a better audio connection. Investing in an adequate, if not high-end, headphone is recommended. One author (GP) lets patients know that he will extend the time by a few minutes at the end, if necessary, to make up for lost time at the beginning while establishing a connection. This becomes problematic, of course, if either party has a commitment immediately after the session ends.

It is important for the psychiatrist not to have the remote program running in the background after meeting with a previous patient, since the next patient can view and hear what is taking place if he or she goes online early for the session. If a session is going to be recorded for any reason, informed consent is necessary, not only for ethical reasons but also because stored videos of recorded sessions have been hacked. (7) Many remote programs have a free, basic level of their product that have fewer features and lower quality audio and visual transmission, whereas upgraded versions (at a cost) have improved audio and visual quality and may also be HIPPA compliant in contrast to the basic level programs.

Psychiatrists should check with their malpractice insurance carriers whether telepsychiatry services are covered or a purchase of further coverage is required. Additionally, reimbursement-related issues may need to be verified with the patient's health insurance carrier. States have different requirements in regard to telemedicine. In general, psychiatrists are required to hold state license in the jurisdiction where the patient resides.

Advantages of telepsychiatry

Some of the advantages of telepsychiatry, for both parties, are self-evident. No time is spent commuting to the psychiatrist's office for either patient or psychiatrist. Thus, time is "saved," money is not spent on gasoline, electricity (in the case of an electric vehicle) or on automotive wear-and-tear, or on the cost of a metro, bus, Uber, or Lyft, etc. The potential for having an accident, getting a speeding ticket, or not finding a parking space is completely avoided. Scheduling can be easier too, since it will be more convenient for a patient to take 15-45 minutes out of the middle of the day for a medication or psychotherapy appointment, rather than up to three hours, including travel time, to and from the psychiatrist's office.

Office expenses for the psychiatrist are virtually eliminated. Since psychiatrists will most likely bill the same amount, whether the sessions occur in-person or online, online appointments will result in a net financial gain because of this factor alone.

Patients may feel freer to be more forthcoming with their aggressive and sexual thoughts during psychotherapy sessions since there is no possibility of having them put into action during the telepsychiatry sessions. At the same time, patients need not worry, even unconsciously, about the possibility of the psychiatrist physically retaliating for what

they have said or engaging in sexual boundary violations while meeting over the internet. If either party has an offensive body or breath odor, this will not be perceived by the other. Some online programs can electronically remove facial wrinkles, providing a more youthful appearance to the viewer on the opposite screen.

Disadvantages of telepsychiatry

We believe that there is a generational divide between younger and older psychiatrists, and younger and older patients as well, regarding the willingness to engage in telepsychiatry. The coronavirus pandemic has had a devastating effect on the practices some older psychoanalysts who have found it impossible to make the leap from doing in-person psychoanalysis to conducting tele-psychoanalysis either by telephone, or using an audio-visual internet hookup, although the visual component is less necessary in classical psychoanalysis in which the analyst sits behind and out-of-sight of the patient.

Older psychiatrists have come up with a variety of reasons why face-to-face treatment is preferred, citing the need to be "in the same space" with the patient, proclaiming that the presence of another person in the same room creates a necessary "holding environment" ala Winnicott, that slight visual cues, such as small, non-verbal motor movements or the glint of a tear in a patient's eye, will be less visible online. One seasoned psychoanalyst (known to author GP) continues to meet with his analysands at his office in spite of state-ordered social distancing and self-quarantine recommendations, thus putting the lives of both patient and analysand in jeopardy.

On the other hand, the younger generation of psychiatrists and patients, having grown up on Facebook, Twitter, Instagram, text-messaging, and the plethora of dating, gaming, and other social engagement apps, have experienced years of "virtual" relationships, many of which have never become actualized in person. These younger psychiatrists would likely label the reservations of older psychiatrists a rationalization and a resistance to doing the work of online treatment.

The potential for both psychiatrist and patient to become distracted during the sessions are less likely with face-to-face, in-person sessions. Whereas it is now common for in-person psychotherapy sessions to be interrupted by cellphone calls and text messages, this has become even more common with on-line treatment. Both patient and psychiatrist can see emails streaming across their screens, often accompanied by beeps and rings, during the session, and even respond to them, deluding themselves into imagining that the other person is unaware of this activity. Additional effort is required on the part of the psychiatrist not to be distracted by such temptations on his or her side of the treatment.

Patients can more easily lose track of appointment times – both day of the week and time of the day - when online sessions have been scheduled. For this reason, one of the authors (GP) often sends a reminder to the patient the day before, or earlier the same day, that an online session is

scheduled. He rarely thought there was a need to send such reminders for in-person treatment in his office that was a more “real” and tangible experience for both patient and psychiatrist.

The future of telepsychiatry

Having practiced telepsychiatry for over 20 years, author GP has found that patients have made significant positive changes in their lives, have had reductions in their psychiatric symptoms of anxiety and depression, characterological problems have been resolved, medications have been well-managed, and patients appear to have done as well in online as in face-to-face treatment. This, of course, is an entirely subjective observation. High quality psychotherapy process research is notoriously difficult to conduct because of the challenges in matching patients, in matching treating clinicians, and in matching many of the other aspects of the treatment situation. Thus, performing placebo-controlled, double blind studies, the gold-standard in pharmaceutical research, is difficult if not impossible to do in the interpersonal cauldron that is psychotherapy although substantial efforts have taken place in this regard. (7,8)

There remain some knotty legal issues in need of clarification for the practice of telepsychiatry. A psychiatrist is only licensed to practice medicine in the state in which he or she is treating the patient. However, with the coronavirus pandemic, many patients who had been living in state in which psychiatrist was licensed to practice relocated back to their home of origin in another jurisdiction. Author GP attempted to learn if it was legal for him to continue to treat such patients. He consulted with the Board of Medicine in the state in which he holds his license and was told to consult with the state medical association in which the patient was now living. He contacted this state medical association and received the recommendation that he consult with his own the state medical society. GP’s state medical society referred him to the state in which his patient was living. Thus, a loop was established and the question was not been resolved. GP also called his malpractice insurer for advice and was referred to the medical associations of the patient and psychiatrist.

Conclusions

Given the current, almost ubiquitous, practice of telepsychiatry as a result of the coronavirus pandemic, and the significant advantages that it brings with it, in spite of the disadvantages cited above, the authors predict that there will be a robust shift toward the practice of online, remote, psychotherapy and psychopharmacotherapy when the novel coronavirus pandemic is over.

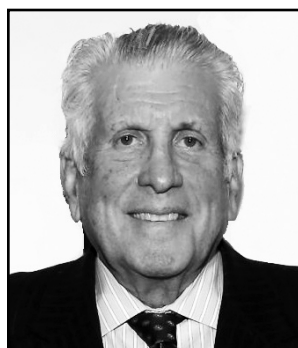
If the telepsychiatry appointments are conducted from the psychiatrist’s home, it may dawn on the psychiatrist that, after the pandemic ends, why have an office at all and continue to pay for rent, telephone, utilities, and other supplies, if a robust psychiatric practice that produces effective therapeutic results can be maintained over the internet?

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Music as a Source of Wellness and as a Useful Adjunct in Psychotherapy

John S. Tamerin, MD



In psychodynamic psychotherapy, treatment is conducted in a language common to the patient and the therapist. The essential ingredient is the spoken word. Ironically, the experience most frequently associated with a therapeutic breakthrough is not language, but rather a feeling or emotion. Franz Alexander

referred to this as the “corrective emotional experience,” not the corrective verbal or intellectual experience. Words can and do touch feelings and emotions but often less directly and less effectively than music.

Albert Einstein said, “If I were not a physicist, I would probably be a musician. I often think in music. I live my daydreams in music. I see my life in terms of music” and the great lyricist E.Y. “Yip” Harburg who wrote the words to “Over the Rainbow,” voted the greatest song of the 20th century in a joint survey by the National Endowment for the Arts and the Recording Industry Association of America, said, “Words make you think a thought. Music makes you feel a feeling. A song makes you feel a thought.”

Music is one of the most primal and fundamental aspects of human culture with many researchers even arguing that music (at least in a primitive form) pre-dates the emergence of language itself, a fact, ironically, not lost on some of the greatest writers in history. As Henry Wadsworth Longfellow once observed, “Music is the universal language of mankind.”

Finally, to quote Oliver Sacks author of *Musicophilia*, “We humans are a musical species no less than a linguistic one. We integrate music in our minds using many different parts of the brain. And to this largely unconscious structural

appreciation of music is added an often intense and profound emotional reaction...that air, which has almost no substance whatsoever, when moved and when made to hit the eardrum in tiny subtle ways can make people dance, cry, have sex, move across country, go to war and more.”

It's remarkable that something so subtle can illicit profound emotional reactions in people and, furthermore, hit an emotional target with more precision than could ever be possible with words alone.

Plato once said, “Music gives a soul to the universe, wings to the mind, flight to the imagination, and life to everything.” More recently, Friedrich Nietzsche stated, “Without music, life would be a mistake.” I totally agree with Plato, and although I never agreed with Nietzsche's politics, I do applaud his statement about music.

Most mornings, my life begins with a ritual. I turn on the music I love, often jazz or rhythm and blues, and symbolically march up Rampart Street in the usual pattern of the traditional New Orleans jazz funeral. The funeral starts with a sober note, but then quickly shifts upbeat into a spirit of hope, optimism and joy. And I march off to the kitchen to make myself a cup of coffee and start my day on a positive note.

Music is and has always been a huge part of my life. My father was a fine amateur violinist and frequently played quartets with professional musicians. I studied the cello. At age 12, I went off to the National Music Camp in Interlochen, Michigan where I was required to take up an additional instrument. I took up the Eb alto saxophone. My mother was an amateur jazz piano player who studied at Julliard. Music filled our home and visits to Carnegie Hall were a large part of my upbringing in New York.

My interest in music has always continued but took an interesting turn 20 years ago when I was divorced. Perhaps I might have gone back into psychoanalysis. Instead, I picked up the saxophone which I had not played in 40 years and began to take lessons and then went to the Banff Centre for the performing arts in Banff, Canada to play with other musicians. I have been playing, studying and taking saxophone lessons ever since and I take every opportunity I can to play my sax with other musicians and to listen to the music that I love.

Music has always served as a wonderful way of lifting my mood, inspiring and empowering me, or alternatively putting me in touch with my deepest emotions. Sometimes these emotions are painful or embarrassing, but as an ancient sage wisely commented, “Water which is too pure has no fish in it.” I believe that music has served these same functions throughout the centuries for millions of people all over the world.

That being the case, I have wondered why music is so rarely spoken about either in the scientific literature or even in clinical practice as a factor in lifting one's mood and/or connecting with one's deepest emotions as one attempts to cope with and recover from emotional illness in general and depression in particular.

One area where music has been extensively studied and utilized is in the treatment of dementia. Much has been written about this by Oliver Sacks and others who have brilliantly demonstrated that everything and everyone is forgotten with advanced dementia except the music which amazingly restores the memories. People with dementia visualize themselves as adolescents and get up in nursing homes and start to dance and sing. Many also remember an extraordinary amount of detail about precisely what was going on at that time in their lives, though prior to listening to the music they could barely talk, were virtually non-responsive and could barely state their names. The music impacts and restores not only their memory but their mood and vitality. In effect, they have briefly reacquired their identity through the power of music.

Most of us know intuitively the impact that music can have on our emotions, and neuroscience research is now validating the therapeutic properties of music. Indeed, the NIMH has committed a substantial amount of money to support current research in this area.

It is well known that music, if chosen correctly, can dramatically increase the pleasure states in our brains. Music can raise our serotonin levels and boost our norepinephrine and dopamine. Also, studies have proven that music can dramatically affect physiological indicators of emotional arousal such as heart rate, respiration, electrodermal activity and body temperature. I, and many others, believe that we can use individual pieces of great or personally relevant music to change our brain chemistries and physiological states often in a matter of minutes, sometimes in a matter of seconds. Like many, I believe music is a great medicine for the mind, the body and the soul.

Perhaps it should be added that attention, planning and memory have consistently showed activation when people listen to music. So, it might be reasonable to hypothesize that some of the symptoms of depression such as decreased movement, poor attention, poor planning and execution, loss of energy and poor memory might benefit from a “therapeutic regimen” of music. Indeed, I suggest that for optimal results, music might be utilized like medication – prescribed in a specified manner.

Although music is rarely utilized as part of the clinical treatment for the “pain” of mental illness, it has been shown to have a salutary effect on chronic pain. Music is often used with cancer patients in conjunction with chemotherapy. Indeed, the Mayo Clinic has employed harpists to help patients heal following cancer treatments. In a related area of trauma and pain, it has been reported that former Representative Gabrielle Giffords, who was badly injured in a Tucson, Arizona shooting a number of years ago, apparently recovered her speech with the help of music. One might reasonably ask, if she could recover her speech by this means, then why can't someone else recover their spirit?

Dr. Richard Kogan, who is Professor at the Weill Cornell Medical College, Director of their program on music and medicine and himself a concert pianist has said: “I think it's really important for healthcare professionals to not lose

sight of the fact that music has an unparalleled capacity to ease pain, to soothe anxiety, and to lift spirits. When all the scientific findings come in, I think there's potential for an explosion in the use of music in medical centers."

I have spoken at AAPDPP meetings in the past and written articles which have appeared both on our website and in the Academy Forum on the value of peer support in general and in particular about our Greenwich DBSA (Depression Bipolar Support Alliance), a support group which began 20 years ago. Initially, much of the discussion by the group members was about the disabling symptoms of the disease or problems associated with medications that were being prescribed.

Over the years the conversation has shifted dramatically from the disease and the pharmacology to the human experience of recovery. Most recently, our Greenwich DBSA group has begun to discuss the role of music in recovery and healing.

To be specific, we have helped members of our group to develop personal playlists that they can utilize whenever they want to lift their moods, inspire themselves, calm down, achieve a sense of balance, or feel more connected to people they love or have loved in the past. Through this process they have also become more aware and better able to deal with their underlying feelings previously numbed by their depression or by the medications they have taken to dull the pain of their illness.

People have put together highly personalized lists of songs from rock, blues, show tunes to opera, symphonies, choral music, gospel, meditative music used for yoga, etc. that have served a wide variety of psychic functions and with modern technology can be easily called up as needed with the touch of a finger. Members have discovered that incorporating this practice into their daily lives literally has become a mood-altering opportunity and experience.

Simply stated by one group member:

- "Music has no downside if you create your own playlists in advance and remember to press the button. It is an easy, effortless, risk-free, almost instant mood-altering 'medication' that can be life-enriching and life-expanding. I can repeat that every day as often as I wish."

Another group member added:

- "Music has become an essential part of my life no matter what place I am in. I reach out for it and use it as needed, even when I work, and it has saved me from many cocktails."

Music connects people with who they are, who they have been, what matters most to them and, in so doing, provides a fundamental connection to their identity. So, I began to wonder what might happen if I invited certain patients to share the music that was most meaningful to them as an aspect of their individual psychotherapy in the same way as patients are often asked to share a dream as a component of their treatment.

Recently I have begun to selectively ask patients to bring into therapy music and lyrics that they have found profoundly meaningful. I could cite numerous examples but perhaps a recent experience will illustrate the point. The patient asked me to listen to "Shallow" from the recent film "A Star is Born" with Lady Gaga and Bradley Cooper. For many of you who are not familiar with the lyrics in which she found great meaning, here are a few of the key phrases:

Tell me somethin', girl
Are you happy in this modern world?
Or do you need more?
Is there somethin' else you're searchin' for?
I'm falling
In all the good times I find myself
Longin' for change
And in the bad times I fear myself,
I'm off the deep end, watch as I dive in
I'll never meet the ground
We're far from the shallow now

What is striking, but perhaps not unusual, is that this patient – an elegant married, suburban socialite in her mid-50s – started to cry when she heard this song in the film and had no idea why. She had been carefully trained to maintain a perfect exterior and to suppress any painful emotion so that no one would ever imagine what she was really feeling. She had gradually opened up in therapy but sharing that song with me was a valuable step on her journey. She was ultimately able to admit to me that she had been emotionally disconnected for years. Terrified of the "Shallow," she had used alcohol to numb her painful emotions and her drinking had enabled her to "dive into the deep." She currently acknowledges feeling better about herself than she has in over a decade and now welcomes the opportunity to experience and share a wide range of emotions with me and with significant others in her life.

I have spoken recently to a number of other patients about the impact of music on their lives and how they feel music might be best incorporated or integrated into psychotherapy and these were some of their thoughts and suggestions. One patient said:

- "Music can get me moving and moving is important for people who are depressed. When I am depressed, I often go to a heart-breaking song from James Taylor or Frank Sinatra because the music and the words help me to feel less alone, more connected and less inclined to blame myself for my condition, particularly when I have shared this music with you."

Another patient commented:

- "I have my own playlist and I listen to certain songs intentionally – particularly two hymns: "Be Not Afraid" and "Here I am Lord." Both the music and the words are important. I want to listen to something slow – something which helps me feel what I am feeling. Music helps me to face my emotions not run away from them. The music that is meaningful to me is not a distraction or a diversion."

When people are depressed they find it helpful and healing to listen to songs like “Bridge over Troubled Water” by Simon and Garfunkel; “Lean On Me” by Bill Withers; “Holy Mother” by Eric Clapton or “Through the Storm” by gospel singer Yolanda Adams.

One simplistic strategy immediately rejected by group members was “When you are down, listen to upbeat music.” In fact, patients with whom I discussed this said that when they are depressed they found “upbeat music as irritating as people who tell them to smile, laugh, get over it, or be grateful.” More helpful, they agreed, was listening to music that fit their mood and met them where they were and was consistent with what they were feeling. It helped them to feel understood, validated, connected and less alone. Another patient observed:

- “Songs and lyrics often help me clarify my feelings and help to illuminate the underlying issues and perhaps factors causing my depression. Sharing the music with you has helped me to diminish my pain and shame.” The patient continued:
- “Music helps me to get in touch with the essence of who I am and how I am feeling. To be more specific, when I listen to Pink Floyd, it takes out my guts and puts them on a silver platter and it shows them to me and says, ‘this is what you are made out of.’ It allows me to connect to who I really am and after listening to it I have a better understanding of and connection with myself. Playing this music to you has opened up a huge channel of communication for us.”

My own observation has been that music may enable patients and their therapists to recognize and share emotions that would be inaccessible without the language of music. Indeed, music is a language, but not a language traditionally utilized in psychotherapy.

My experience is that the introduction of music meaningful to the patient, under the proper circumstances, has accelerated and deepened the therapeutic relationship. The music and lyrics have helped me better truly understand what the patient is experiencing.

In one session with a patient I had known over an extended period, she brought in two songs with which I was not familiar, songs that had a profound personal meaning for her. They were “Fallen” sung by Sarah McLachlan and “Hurt,” by Nine Inch Nails – a song about realizing consequence and regret and that there is nothing worse than being stuck with a label, a pain, a sickness that we know beforehand will leave us only wishing that we could change the choices we made. I immediately felt something very profound, myself, coming from her to me through the music and lyrics. I always believed that I understood intellectually how and what she was feeling. However, the music and words took this all to a new level for me.

I profoundly experienced how trapped she felt, how deep and almost immovable was the guilt and shame that she was bearing, and how extraordinarily hard it was for her to permit herself to “shed the skin” of shame and guilt for something she had done a number of years ago.

Music currently plays a relatively small and usually insignificant role in psychotherapy. My point is that perhaps the role of music should be expanded and appropriately utilized as a valuable aspect of both understanding and communicating with our patients. Furthermore, I have found that music can be comfortably and effectively incorporated into traditional psychotherapy.

Now I would like to conclude by asking several questions, which I hope will stimulate a lively response from those of you who have taken the time to read this paper.

1. As music is such a powerful and important factor in our emotional lives, should we not appropriately and creatively incorporate it into our therapeutic work with those patients who relate deeply to music and have throughout their lives – particularly if we ourselves love music?
2. Might it be helpful in opening up a block or a therapeutic impasse particularly when the patient feels that the lyrics or music express an emotion that they otherwise have found difficult to put into words?
3. It has been noted that Sigmund Freud disliked most music and there was little mention of music in the 24-volume Standard Edition. Is there a possibility that Freud’s distaste for music, but fascination with dreams, may have led psychoanalysts to encourage their patients to bring their dreams into treatment but not the music that has played such a meaningful role in their lives?

Finally, I would like to suggest that if dreams are the royal road to the unconscious, perhaps the royal road to the preconscious may lie in music.

Discussion of “Music as a Source of Wellness and as a Useful Adjunct in Psychotherapy”

Gerald P. Perman, MD

Thank you, Dr. Tamarin, for asking me to discuss this clinically-relevant and thought-provoking paper. After reading it several times, there is little with which I disagree. When music is introduced into the therapeutic relationship with our patients, it can indeed enhance the patient’s connection to the therapist, allow for a here-and-now experience that avoids intellectualization, tap into otherwise inaccessible emotional depths, and invite our patients to enter into an alternative universe, activating a part of their brain that is until then lying dormant, but that is immediately ready to make them smile, sometimes cry, want to sing, to sway and to dance, and that connects them to important people and experiences from their past.

I have one patient whom I have seen in treatment for many years. He makes musical instruments as a hobby and suffers from long-standing hypochondriasis. He only sees me a couple times a year but when we meet, he shows me and plays his latest creation. This enhances the bond he feels with me and helps sustain him until his next appointment.

Perhaps one of the most famous quotes about the healing

capacity of music comes from William Congreve in his 1667 play, "The Mourning Bride," when he wrote that "Music hath charms to soothe a savage breast," usually misquoted as "beast." Melanie Klein might have had something to say about this frequent parapraxis. Whereas we have all seen images of the Indian snake charmer playing his punji flute as he appears to hypnotize a deadly cobra, this has nothing to do with the melody being played, but instead only with the rhythmic movement of the flute.

Music can also have the opposite effect on the mood of the listener. Stack and Gundlach, in the September 1992 issue of the journal *Social Forces* found that "the greater the airtime devoted to country music, the greater the white suicide rate," with their model accounting for 51% (!) of the variance in urban white suicide rates.

My own favorite country music singer, Hank Williams Sr., died at the age of 29 from alcoholism and prescription drug abuse. This may have been an unintentional suicide and/or an effort to soothe his chronic back pain caused by congenital spina bifida. One of his most famous lines in his "Long, Gone, Lonesome Blues," in which the protagonist has been ditched by his girlfriend, is "I'm gonna find me a river, one that's cold as ice. And when I find me that river, Lord I'm gonna pay the price. I'm going down in it three times, but I'm only comin' up twice."

Dr. Tamarin asks: "Should we not appropriately and creatively incorporate music into our therapeutic work with those patients who relate deeply to music and have throughout their lives – particularly if we ourselves love music?" He gives examples of how he uses music in his "Depression and Bipolar Support Alliance" groups, as well as for selected patients in his private practice, by asking these patients to create, and at times listen to, song from lists of their favorite, uplifting music. Since reading Dr. Tamarin's paper before this conference, I've done the same thing with one young adult patient who was prone to anxiety attacks and who asked me what she could do between sessions when she has one of her attacks. She was pleased with Dr. Tamarin's suggestion that I shared with her. Dr. Broden described how his empathic responses to patients has been enhanced by his own musical experiences as a child.

I believe that most of us already incorporate, if not music per se, at least lines of poetry, plays and song into our psychotherapeutic work. I find myself turning, not infrequently, to lines from Shakespeare – for example, "Thou doth protest too much, methinks," in *Hamlet*, to capture the idea of reaction formation, and to Cassius's admonition in *Julius Caesar* that "The fault, dear Brutus, lies not within our stars, but within ourselves," that could not have been better articulated by Freud himself to describe patients' use of projection to blame others for their own repressed thoughts and emotions.

Being a musical child of the 1960's and 70's, I sometimes quote lines from early Bob Dylan that resonate with something my patient has said. And I've often used the Steven Stills line, "If you can't be with the one you love, then love the one you're with" to help patients better accept

choices they've made in life. This is a variation on the adage, "The perfect is the enemy of the good."

There can, however, be pitfalls in introducing music into psychotherapy with our patients – as noted above with country music. It is possible for the therapist to believe that it is in the best interest of the patient to introduce a musical component into the therapy when, in fact, this is more an expression of the therapist's exhibitionistic and narcissistic tendencies. I used to keep a guitar in my office closet, and I would on occasion take it out and play and sing a song to a patient that I thought was relevant to their treatment at the time. Almost no patient ever refused my offer, perhaps given the power gradient between myself and my patient, and I don't know that any treatment was damaged by the introduction of this parameter. Maybe some were helped.

After serious self-reflection, however, I decided that doing this might have had more to do with my own narcissism and exhibitionism, and less to do with helping the patient. I solved this dilemma by taking the guitar home, and henceforth conducting psychotherapy in "the old-fashioned way."

Whereas, music can lift patients' moods, and sometimes remind them of things that make them cry, I think we would all agree that words and language are the primary "tools of the trade" of the psychodynamic psychiatrist. As a Lacanian psychodynamic psychotherapist, I note that Jacques Lacan viewed the unconscious as being composed of chains of unconscious signifiers – or words - that relate to one another through metaphor and metonymy – the same linguistic features found in poetry and song, and for this reason too I am more attuned to the poetry, even melody, in my patients' speech than I used to be.

I began my discussion with a brief vignette and I'll end with one as well. A patient had enjoyed his work in Mississippi for a number of years, and he was disappointed when he moved to another state and didn't find a similar ambience at his new job. He spoke about missing his life in Mississippi, and the mistrust that he felt he encountered at his next job. In Lacanian fashion, I said: "You are missing Mississippi, and you mistrust your new colleagues." He broke out into a huge grin and chuckled, "You really have a way with words, Dr. Perman!" Perhaps Lacan would have said that some *jouissance* was released and the patient was less unhappy than before my observation.

So, in addition to formally introducing music into our work with our patients, there is almost always song, and often music, in our patient's speech, if we can only allow ourselves to hear it.



The Coronavirus Pandemic: Observations about Time, Memory, Mourning and the Capacity to be Alone

Eugenio M. Rothe, MD



The enforced confinement brought about by the Coronavirus Pandemic presents a unique opportunity for patients and therapists to reflect on issues of time, memory, mourning and the early attachments that have helped to shape their lives. These self-reflections are often obscured during ordinary times due to the

richness of outside stimuli and fast pace of life characteristic of most modern industrialized societies. In this article I will discuss some psychodynamic observations about the case material brought about by two patients in the course of telephone sessions. These sessions took place during the first two months of isolation of the Coronavirus pandemic without the aid of visual-image technology.

Enforced solitude usually involves separating the person from the stimuli of the outside world that makes life worth living. Parents sometimes discipline their young children by “sending them to their room” and in the case of prisoners, solitary confinement is considered to be a harsh penalty. However, under less stressful and rigorous conditions the isolation of imprisonment has sometimes proven to be fruitful in terms of the promotion of self-reflection, intra-psychoic growth, increased creativity, the achievement of an internal harmonious state, and sometimes for the accomplishment of spiritual or religious self-discovery (Storr, 1988). Donald Winnicott (1969), the British pediatrician-psychoanalyst, regarded the capacity to be alone as an aspect of emotional maturity that resulted from introjecting the attachment figure as a good object and making it part of the person’s inner world. He added that the capacity to be alone was based on the experience of being alone in the presence of the other, and that without a sufficiency of this experience the capacity to be alone cannot develop. From an empirical developmental perspective, the capacity to be alone is equivalent to what John Bowlby (1969-1982) called “secure attachment”, when the child is able to peacefully be by himself in the presence of the mother without the anxiety of her possible departure. In time, the child will be able to introject the mother as a good object and no longer need the constant physical contact with the mother. In psychoanalysis and the other forms of psychodynamic therapies, the patient is often alone in the presence of the analyst.

The use of the couch was designed by Sigmund Freud to avoid eye contact with the analyst, so that the patient would not be distracted or influenced by the body-language of the analyst. In this way, telephone psychotherapy sessions

without the aid of visual facilitating technology also function similarly to the analytic couch. Analysis is also facilitated by the analyst providing a secure milieu for the patient and is not always dependent upon the analysts’ interpretations. The creative process that may occur as a result of solitude, like psychoanalysis, becomes linked with self-discovery, self-realization and with becoming aware of one’s deepest needs, feelings, and impulses. (Storr, 1988). During the process of solitary self-reflection there are moments or episodes that exist in time and that have a beginning, a middle and an end. They may be located in the past remembered, or in the feared or wished-for anticipated future, and these very personal moments are known as Subjective Time, as compared to Objective Time.

Case I

As a result of the isolation imposed by the Coronavirus pandemic, James a 67-year-old male patient experienced deep feelings of sadness, “as sad as I have ever felt in my life”. In trying to identify what could be eliciting these feelings, the patient remembered the divorce from his first wife about 25 years before. He recalled how he felt when he had to move out of his home, leaving behind his soon-to-be ex-wife and their two young children, and the desolation that he felt when he had to move into a studio apartment alone. Now happily married to his second wife and also the father of stepchildren he added that, “I felt then that my loneliness and desolation were all consuming and that they seemed to last forever and would never end. At that time there was a popular song by the musical group ABBA titled, ‘The winner takes it all’ and that really captured my state of affairs back then. I was totally defeated and was left with nothing. Even today, every time I hear that song I am immediately overcome by a profound feeling of sadness”

The experience of time is of central importance in mental life. Time acts as an organizer of the relationship between past, present and future, conveying such concepts as succession, simultaneity and duration, as well as suspended states of time. In psychic life, the concept of time links the past, present and future into a nexus, and this nexus is not one of succession but of interaction. In this sense, the past, present and future do not so much follow the other but shape the other, and there is no irreversibility existing in a linear continuum. We perceive time differently during the different stages of our lives. There is a fluidity of the movement of time in the process of remembering, as in the case of with transference, where not only is the present active in the relationship, but transference is also being shaped by the patient’s past, and the past and the present are potentially shaping the wished for or feared future. This linking activity occurs automatically in everyday life. Sometimes the disruptions in the perception of time, such as in the ‘eternity-like’ states, like in the case of James, can be understood as defenses against anxiety, loss, shame and other unpleasant affects. These can cause in the patient a wish to escape temporal reality, or the perception of being unable to escape this painful temporal reality which becomes

unbearably prolonged (Loewald, 1980). Coming to terms with bereavement takes time, and mourning is often a drawn out process that requires large amounts of psychic energy and can be psychologically and emotionally draining and exhausting (Pollock, 1994).

Case II

Maria, a 71-year-old woman, told her therapist during a telephone session that after about three weeks of the forced isolation caused by the pandemic she found herself overcome by feelings of profound sadness. Initially, she believed that these were caused because she missed her late husband who had passed seven years before, but upon allowing herself to free-associate through her long periods of solitude, she found herself reminiscing about painful memories connected to her aloof, narcissistic mother. The patient remembered that when she was a young girl her mother oftentimes forgot or delayed picking her up at school functions, at birthday parties, and other places where she was left. She was always the last one to leave and experienced shame and embarrassment because she felt that she was imposing on her hosts, and felt a lot of anxiety when her mother didn't arrive at the agreed time, or took a long time to finally arrive to pick her up. She reported that these memories elicited in her sadness, anxiety, anger and even indignation, and she added: "That's why I was always very careful never to do that to my three children, and at work I was always known for being very punctual, very professional and very attentive to detail. Maybe that is also why I've always tried too hard to please other people, and perhaps I've always taken it upon myself to carry a heavier burden than others, so no one could ever say of me that I was imposing on others"

Memory is connected to our entire experience of time, and for this reason, memory is also intimately connected to experiences of separation, mourning, loss and restitution. It allows us to have a past that we experience as loss, and we are also able to experience the irretrievability of the past, yet we can recover the past in another form, because the past would be irretrievably lost without memory. Memory serves as an intrapsychic organizer that allows for a sense of permanence, as well as movement and change to come into our world, giving meaning to the past and helping to shape the future. Memory also allows us to develop a narrative. The Swiss psychologist Jean Piaget (Gruber and Voneche, 1995) described that the capacity of symbolization, which occurs in the child during the Pre-operational Stage of development (3 to 6 years old), alongside the development of language allows the child, for the first time, to develop a story about an event that can be stored as a narrative memory. The parts of the brain responsible for Semantic-Declarative Memory do not become myelinated until the 4th year of life, which is why memories that occur prior to this period are stored as a sensorimotor, non-verbal experience (Eid et al., 2005). Spence (1982) has written about the differences between Historical Truth and Narrative Truth. He explains that Historical Truth refers to the aim of the narrator to come as close as possible to what really

happened in the original event. In contrast, Narrative Truth is an attempt at interpreting and understanding the memory of the event with the conviction that the interpretation given by the narrator must be true. The role of narrative as a characteristic form of psychodynamic and psychoanalytic explanation has also become increasingly common, and the construction of narrative in the clinical encounter is now becoming recognized as an important therapeutic tool (Rothe and Pumariaga, 2020). The psychologically healthy individual is one who is capable of holding a 1) coherent, 2) dynamic, and 3) meaningful narrative of the self. The development of a person's identity also involves an exercise of life-story construction, so psychopathology can be seen as "life stories gone awry". Psychotherapy, which involves the re-construction of the life-narrative, can then be seen as, "an exercise of life-story repair" (Wrigen, 1994). Like in the case of Maria, the therapist and the patient work jointly at creating an alternative story, which is richer and one in which identity is promoted.

In conclusion, conditions of isolation can be fruitful in terms of accomplishing the promotion of self-reflection, increased creativity, intra-psychic growth, and the search of an internal harmonious state. The concept of time and the use of memory create the topography for a map to be drawn by the person's narrative and in the process of remembering, something is reproduced that in some form has become part of our inner life. Through action or affect or in the imagination and ideation, our experiences become connectable and woven into a context and extend into a past and a future, and the continuity of our lives as individuals comes into being (Loewald, 1980). Through psychotherapy and psychoanalysis we become historical beings, and we work to bring our automatic repetitions into conscious awareness. This allows us to understand how we got to be the way we are, and how to shape our future, giving our lives heightened meaning and understanding.

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BOOK REVIEWS



Trump on the Couch: Inside the Mind of the President.

Justin A. Frank MD; AVERY, An Imprint of Penguin Random House, 2018; 304 pp.

Reviewed by Peter A. Olsson, MD

Justin Frank's book about Donald Trump is elegant, lively, and clearly written. In addition, he describes the psychoanalytic theorizing of Melanie Klein in ways an educated

layman can understand. However, Kleinian language tends to project and portray human thoughts, feelings and fantasies in stark monolithic ways. Ordinary mother-infant interactions are cast in terms of good breasts, bad breasts, good mother, and bad or frustrating mother. Klein at times portrays the mother-child interactions as if the mental apparatus of an infant and young child has developed and retained precise perceptions far beyond the actual cognitive and mentalization abilities of its Piagetian phase of development.

Frank does give cogent and perceptive descriptions of the dynamics of racism, the psychology of misogyny, lying, and the psychological implications of persisting dyslexia and reading disability in adults. It is when Frank applies such concepts to Trump that his countertransference anxiety, fear, and dislike of Trump peaks through his theorizing. Frank uses anti-Trump polemical writers and biographers of Trump as sources of 'data' for his speculative, conjecturing, and at times condescending, even theoretical rhapsodizing about our President. For example, after biased speculations about Trump's "birther" concerns about Obama, Frank says on p 97, "While Donny was a legitimate child, he wasn't necessarily one, because he already had an older brother named for their father. No matter how much his father loved him, Donny would never be Fred Trump, Jr.--his father's legitimate namesake."

Does namesake so sweepingly determine legitimacy and destiny? Frank uses such predicate or paleo-logic

often about Trump in his book. (Parenthetically, I could fancifully speculate differently from Frank that Trump was correct about Obama's birth. Psychologically and psychodynamically speaking, Obama may have been born an Indonesian candidate, not Hawaiian-American; whatever his birth certificate indicated.)

Frank describes an emotional rant by Trump on a Fox and Friends TV show on p 232-233. Frank calls Trump's angry ventilating about James Comey, the FBI, CNN and Robert Mueller a "continued paranoid portrayal of himself as victim." A different way of interpreting this response, as valid as Frank's psychoanalytic sanctimony about Trump, is that Trump was appropriately angry about strong emerging evidence that James Comey, Comey's lead investigator Peter Strzok, and Andrew McCabe were like Mueller's legal team, at best heavily biased against Trump. Would Frank want Trump to repress his appropriate ire? Or express his feelings and thoughts with unvarnished directness on the one American network that is not biased against him at every turn. The liberal elite American media and academia have viciously personally attacked without basis, Trump's wife, his young son, and his loyal adult children. Such never occurred with media-adored president Obama and his family.

Frank says toward the end of his book, "The goal of this study has never been to diagnose but to observe, comprehend and provide some context, to improve our understanding of the characteristics of Trump's behavior." In my opinion, Frank is rationalizing and deceiving himself and the reader. It would be more honest if Frank stated openly that his book is an applied clinical psychoanalytic polemical study that is biased and anti-Trump. Frank attempts to sound scientific, objective and clinical, but he uses psychoanalytic concepts as political cudgels against Trump.

Frank weaponizes linguistic analysis, psychoanalytic theory, and psychiatric concepts. Between and in his lines, Frank portrays Trump as an ultimately dangerous, untreatable, malignant narcissist, and psychopathic paranoid, pre-psychotic, with life-long dyslexia, paramnesia, and learning disabilities!

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. American voters are usually exposed to a variety of clever political demagoguery, obfuscations, deceptions, and a spectrum of lies from little white ones to whoppers by politicians. With Donald Trump's bombastic style, a new glossary of terms is needed to understand his evolving policies and predict his way of leading and governing. The new glossary would include words and concepts such as bombast, puffery, braggadocio, sarcasm (cruel at times), overt insults, crude personal verbal attack, hyperbolic impulsive statements to focus large group attention, paradoxical intention in the media, mixed simultaneous use of an object as symbol and reality (i.e. an actual wall, a wall

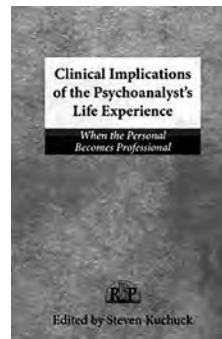
as needed for clear individual and national boundaries and rules of behavior).

In my opinion, 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 egotistical in the commonsense usage of the expression "big ego", but indicates accurate intuition, street-smart intelligence, and good judgement. 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 unpresidential 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.

In my own writing in the domain of applied psychoanalysis and especially in describing politicians and the political domain, 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 policy maker, commander-in-chief, signer and chief enforcer of our laws, who makes important appointments.

We psychoanalysts as citizens are free to express our thoughts and opinions about our president, his leadership style, his personality, and consequences of his words and policies. But, because of our professional training, clinical experience, 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. Medical colleagues, general psychiatrists, and the informed public rely on our clear, objective, reasonable use and explication of our applied psychoanalytic theories. I think my respected colleague Justin Frank has been significantly biased in his conclusions about Donald Trump.

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.



"Clinical Implications of the Psychoanalyst's Life Experience: When the Personal Becomes Professional"
by Steve Kuchuck, LCSW
Routledge, 2014; pp. 247

Reviewed by Abishek Bala, MD

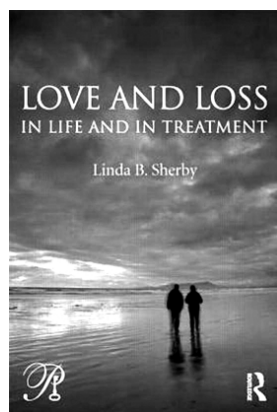
How does a therapist become a therapist? For a person currently in training, this is a question intimidating in its simplicity. Attempting to answer it is an exercise that blurs the line between subjectivity and objectivity. It leaves me with more questions, a craving for guidance and reassurance in my own educational exploration. In "Clinical Implications of the Psychoanalyst's Life Experience: When the Personal Becomes Professional", Steven Kuchuck utilizes a collection of self-reflective essays to demonstrate how an analyst's vulnerabilities can transform into wisdom. This book describes the dynamic nature of a patient encounter by emphasizing the significance of an analyst's own experiences in creating and mending this therapeutic relationship. Personal and professional narratives challenging the fabric of identity, family, social capital and even existence are demonstrated as active forces which shift the realms of clinical theory and practice. It provides a foundation for a meditative endeavor that connects the therapist to therapy. The honesty of its words offers familiar mentorship that reaches far beyond any structured didactic teaching.

Kuchuck divides the book into two sections: "early life events, crises and influences" and "later life events, crises and developmental passages" to contextualize the flow of narratives. While making a disclaimer regarding the "non-linear" nature of the sections, Kuchuck makes the case for how life is implicated in daily practice. In the first section, readers are faced with struggles surrounding loss, belonging, household dynamics and their impacts on professional choices. Authors also convey the impact of extreme violence on their development by describing their experiences with antisemitism and the Holocaust. Overcoming discrimination and inequality in their journey towards an identity is what makes the first half of the book such an enlightening read. As we move to the second half of the book, we are exposed to analysts' later life events through topics like professional mentorship, marriage and parenting to name a few. Readers are presented with themes surrounding identity, loss of power, exposure and their impacts on clinical work. It is refreshing to read such prolific therapists discuss their vulnerabilities and existential struggles. Reading about how they maneuver through advancing age with such humility and self-awareness makes the second part of this book even more enjoyable than the first.

While seeking to treat patients in a world of subjectivity, Kuchuck also makes a case for self disclosure. He offers a valuable perspective for trainees who are constantly faced with the challenge of evaluating their own clinical encounters and professional futures. Inspiring narratives

ranging from a holocaust survivor's journey towards shaping a career in psychoanalysis to an established analyst facing the ripples of a stroke in her family and career are words that every trainee needs to read. They give us an understanding of the bigger picture but also clarify that this reflective journey to overcome vulnerability comes with its share of conflicts involving self-exposure, countertransference and clinical boundaries. Despite these challenges, one is left feeling confident in their ability to overcome these obstacles and grow as clinicians.

In conclusion, Kuchuck effectively demonstrates the role of personal and professional challenges in shaping an analyst's career. It has given me a new sense of appreciation for the complicated factors that contribute to the evolution of the clinician-patient relationship. Reading such exemplary analysts intimately share their journeys in the search for their clinical identities makes me love my job more. Overall, "Clinical Implications of the Psychoanalyst's Life Experience: When the Personal Becomes Professional" by Steve Kuchuck is one book that I will re-examine throughout my career.



Love and Loss in Life and in Treatment.

Dr. Linda B. Sherby PhD.;
Routledge, 2013; 204 pp.

Reviewed by Nicole Rouse, MD.

Love and Loss in Life and Treatment details several patient encounters that highlight the experience of love and loss in many realms of a therapist's career. Dr. Sherby introduces various forms of loss and discusses

how each can affect therapy. She is honest and transparent as she shares how her own personal losses affected therapeutic relationships with patients, either making them stronger or creating a feeling of detachment and insecurity. Disclosure of loss is another persistent theme. Dr. Sherby discusses how it can create both connection with and protection from a patient. She emphasizes that through loss we may find love, growth and connection.

Dr. Sherby discusses three forms of loss: termination of therapy, closing of a practice, and death. She starts with a case detailing a young woman, Alyce, who oscillated between playing the role of a rejecting mother and a needy child. She had grown to become more independent over 4 years of therapy with Dr. Sherby, and felt it was time to terminate her therapy. Dr. Sherby discusses that the termination by Alyce, while depressing, was not devastating. During the time of this termination, Dr. Sherby loved "[her] life, [her] husband and [her] work with other patients." (p. 39) She poses the possibility that this loss may have been more difficult if she herself were more vulnerable. If she were simultaneously dealing with the passing of her husband,

George, would she have felt abandoned or less resilient?

She also discusses forced termination of therapy in the context of closing her practice to move to Florida to be with and to care for George. She details the difficulty of leaving behind her home, patients, support system and friends. She felt it was important to disclose the reason for forced termination to her patients, in an effort to keep them from feeling abandoned. Shared feelings of loss helped patients "feel their pain and grow beyond it...dependent patients found they were not as helpless as they once thought." (p. 72) Dr. Sherby herself felt less alone and less frightened by sharing her feelings of mourning with her patients. Once in Florida and starting her new practice, she found it difficult to connect with her patients which only emphasized her longing for what she once had.

When George passed, Dr. Sherby dealt with the issue of disclosure again. At the time, she decided to tell all of her patients that a family member had passed away and left it to their discretion as to whether or not they would like to know more. In writing this book, she reflects on her decision, analyzing why she chose to say what she did and whether it was appropriate to tell each of her patients the same version of the above. With disclosure, there must be a balance between self-disclosure and protection. She describes how it can increase connection with a patient, and even focus the therapist's attention to the session at hand rather than being distracted by their own stressors. Sharing too much has its drawbacks, however. It can take attention away from the patient and can leave the therapist feeling too vulnerable and exposed. Dr. Sherby voices that there is some need for self-disclosure when a therapist experiences an uncontrolled life event, however, to be careful and take heed as to why particular information is shared or not. In considering her decision to be fair to her patients and tell them all the same disclosure, she reflects that she wishes she had tailored her disclosure, making it personal because while many may have benefitted, some did not.

In the case of Christine, a 45-year-old vice president of a large company, Dr. Sherby describes when disclosure was particularly beneficial. When Christine first heard of George's death, she provided what felt to Dr. Sherby bland and superficial support lacking in connection and genuine feeling. Before their next session, Dr. Sherby received a card in the mail making her aware that Christine had made a charitable donation in George's name. Dr. Sherby thanked her, but then used Christine's actions as a window through which she could see her own disconnection from her emotions. Dr. Sherby used the result of her disclosure as a tool to further Christine's growth.

As an early career psychiatry resident, I appreciate Dr. Sherby's vulnerability and transparency as it has allowed me to have a deeper understanding of psychodynamic therapy from the therapist's perspective through several cases. She also brings up interesting topics of discussion for those experienced in the field as well, including those related to loss and disclosure. Through loss we find life, and through disclosure we find support and growth.

IN MEMORIAM

Remembering Richard C. Friedman, MD



Dr. Richard Friedman was Clinical Professor of Psychiatry at Weill Cornell Medicine, Professor of Psychology at the Derner Institute of Adelphi University, and a faculty member of the Columbia University Center for Psychoanalytic Training and Research. He was a gifted psychodynamic psychiatrist as well as a highly-respected teacher and supervisor. From 2012 to 2020, Dr. Friedman served as Editor-in-Chief of *Psychodynamic Psychiatry*, the only psychiatric journal devoted to the advancement of psychodynamic psychotherapy and psychiatry. He was also the beloved husband of Susan Matorin and father of Jeremiah with his two children, Tess and Theo.

After graduating the University of Rochester School of Medicine, Dr. Friedman completed his residency in psychiatry at the College of Physicians and Surgeons, where he was Chief Resident. During his residency, he was the first investigator to empirically demonstrate that prolonged sleep deprivation adversely effected the performance and mood of physicians. His research led to changes in medical education and delivery of care throughout the United States. Dr. Friedman then carried out research on depression in adolescence and adults and was among the first to demonstrate the combined influences of depression and Borderline Personality Disorder on suicidality in young people.

Dr. Friedman became a world-renowned clinical scholar, especially for his groundbreaking work in the field of human sexuality. As noted by Dr. Francis Lee, MD, PhD, Chair and Psychiatrist-in-Chief at Weill Cornell Medicine, Dr. Friedman “shed light on the fundamental nature of human sexuality.” In this achievement, he helped integrate the biological science of psychiatry with psychodynamic theory and practice.

Specifically, Dr. Friedman accomplished pioneering research on hormonal and psychodynamic influences on sexual orientation. He led an advisory committee for the DSM-III that contributed to the American Psychiatric Association formally depathologizing homosexuality. Dr. Friedman’s scholarly work helped further influence psychoanalysts to adopt a nonpathological view of homosexuality. He was the first psychoanalyst to integrate neurohormonal and psychoanalytic perspectives about sexual orientation. His original thinking bridged psychobiology and psychological development and was summarized in a classic book, *Male Homosexuality: A Contemporary Psychoanalytic Perspective*. Dr. Friedman then collaborated with Dr. Jennifer Downey and the two published a series of articles that emphasized the need for psychoanalysts to integrate new knowledge about the sexual differentiation of brain and behavior with psychoanalytic theory and practice. Their seminal *Sexual Orientation and Psychoanalysis* integrated psychiatry, psychoanalytic psychology, and sexology and is widely used as an educational resource.

Dr. Friedman received the Sigourney Award in 2009 in recognition of distinguished contributions to the field of analysis. More recently in 2017, he received the prestigious Freud Award of the American Society of Psychoanalytic Physicians, a lifetime achievement award in psychoanalysis.

On a personal note, Rick helped mentor and guide my own development as a psychodynamic psychiatrist and psychoanalyst. He was a role model for his originality, determination, and professional and personal courage. Like many of us, I will miss his grace and ironic humor, but keep with me his wisdom and good ways.

Ahron Friedberg, MD



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