ACADEMY FORUM

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The American Academy of Psychodynamic Psychiatry and Psychoanalysis

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by
Scott C. Schwartz, MD

Built in 2007, this little town is based on a late medieval northern European style of architecture using Gothic elements. It measures 4 x 5 inches and is made of scraps of cardboard with trees of staples and napkins, with the cliffs of wet napkins. The interesting parts are the arcade, made by ripping a page from a spiral notebook, the double columns, made by cutting bent staples, and the windows with gauze infillings. Sadly, a ship on the left got stranded on the rocks.

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

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

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MESSAGE FROM THE EDITOR

Ahron Friedberg, MD

As we enter into a recovery phase from the pandemic, with its ebb and flow toward a new normalcy, there are many lessons we as a community of psychodynamic psychiatrists can begin to glean. For every crisis can be an opportunity to learn and grow, professionally and personally.

In her President's Message, Dr. Joanna Chamber reflects on how we are adapting as an organization with virtual meetings and study groups, greater practice of telepsychiatry and teletherapy, and a renewed sense of commitment to our work and our Academy. It is a realistically optimistic and hopeful directive that draws on our adaptability and resilience.

To begin our Reports, Updates and Letters section we are excited to announce our 65th Annual Meeting titled *How to Replenish a Passion for Psychodynamic Psychiatry and Consultation-Liaison Psychiatry*. With over 30% of psychiatrists and other physicians reporting symptoms of burnout, it is hard to think of a more apt subject for our Academy meeting.

Dr. Douglas Ingram's letter and the series of replies from his Study Group on the Therapeutic Space gives a sense of how in ways large and small our practices have changed and are continuing to evolve as we adapt to meet our patients' needs. Even gestures such as how we greet people matter and have their meanings. Commentaries by Drs. David Forrest, Gerald Perman, Alejandra Wortman, Kimberly Best, and Myron Glucksman give a sense that all aspects of treatment, even its frame, have meaning and are worthwhile to consider for both our patients and ourselves.

Our Original Articles section is introduced by Dr. Perman's Presidential Address to the Academy. It is an homage to Sigmund Freud and his seminal achievements as founding father of psychoanalysis. And we owe Dr. Perman our gratitude for his own considerable contributions to our field and, of course, the Academy. His presentation highlights how far we've come as a clinical science in giving a neurobiological basis to the psyche, and how far we have to go. He recognizes that while medications may help alleviate symptoms, the "talking cure" treats the person and his suffering. He also bravely shares of his own experience in becoming a psychodynamic psychiatrist and leader of our Academy.

Dr. Best, a master psychiatric educator, writes about lessons learned about training psychiatry residents during the pandemic. Since psychiatry is a heuristic discipline, her observations are more broadly applicable to our practices. By being open to new ways of learning, we better our approach to teaching and treatment.

In his fascinating paper, Dr. Nate Szajnberg describes with insight and erudition parallels between Maimonides' *Guide for the Perplexed* and Freud's *Interpretation of Dreams*. His explicating commonalities between the hidden meaning of torah and people's dream lives reveals the profound workings of the mind and human nature, It is the first part of a seminal work of scholarship.

Dr. Norman Clemen's piece speaks to us with a professional lifetime of clinical experience and practice. He finds that an integrative approach that incorporates different schools of psychoanalytic theory—Freud (Sigmund and Anna), Klein, Kohut, Winnicott, Bowlby, Fonegy, Kernberg and other luminaries—along side of psychiatry and advances in psychopharmacology to be best and most helpful to his patients. And I and I think most of us would concur.

And last by not least, Dr. Scott Schwartz's article is a gem about the psychodynamic meaning of size as it relates to model making. He draws from his considerable expertise with his own artistic dioramas, one of which graces our cover. Dr. Schwartz aptly analogizes the work we do as psychotherapists to the process of ingenuity and discovery in creative endeavors.

Rounding out this issue is Dr. Cassandra Klyman's engaging review of Maxine Chung's novel of an adolescent girl and her psychiatrist.

We conclude with an In Memoriam of Dr. Matthew Tolchin, a former President of our Academy, revered teacher and supervisor at Mount Sinai, and friend.

MESSAGE FROM THE PRESIDENT

A Time of Fatigue

Joanna E. Chambers, MD

Fatigue is defined by the Merriam Webster dictionary as 'weariness or exhaustion from labor, exertion, or stress; or a state or attitude of indifference or apathy brought on by overexposure.' Over the past 18 months, nothing has been routine. We have all learned how to function in a new world, with new priorities, new stressors, and new ways to cope. Early on in the pandemic, simple trips to the grocery store were stressful. We were risking our lives by being near other people, not yet fully understanding how Covid-19 was contracted. In addition, the most mundane of items such as toilet paper, paper towels, household cleaning products, and masks were all in short supply. In addition to surviving grocery store runs, we had to learn new technology in order to function at work and to connect with loved ones. Many suffered significant losses in their lives. As we adjusted to these changes, we simultaneously were faced with pressures of increasing hours of Zoom meetings, often working in stretches of 8-10 hours per day with only a few interruptions. Many of us had additional responsibilities of supporting our children, attending to their virtual learning and other needs, while attending to our work schedules in the same space. The virtual interactions were a way to stay connected, yet were exhausting at the same time.

Adjusting to change and stress with resilience is easier when there is a known time limit to the stressor. When the pandemic began and everyone was sent home, we hunkered down in our homes, in isolation, and in earnest, finding ways to make it work. We thought it was just for a month or two. However, 18 months later, as we are now entering the fourth wave of the pandemic, our resilience is wearing thin. "How much longer can this go on?" we ask. Patience, empathy, and understanding are more difficult to access when fatigued.

Adapting to change and stress for such an extended period of time can certainly cause fatigue. However, I believe that an additional cause for our fatigue is the social isolation in which we have all found ourselves. Ultimately, it is the relationships at work that make our work meaningful. In psychiatry, this is particularly true, but I believe it is true in any field of work. Connecting to other people is what makes us human. We need human interaction in the same way that we need nutrition. In describing virtual school, my 15-year old daughter eloquently stated "it is like starving and being served a large plate of plastic food." I imagine that in many ways we have all been dealing with our own version of "plastic food" through the past 1.5 years and are left feeling wanting, empty, and … fatigued by the experience. While interacting on screen has its merits, it is not the same as being in the same room with other people. Ultimately, we are left fatigued and 'zoomed out'.

In addition to feeling fatigued, many of us have suffered tremendous losses. Our Academy recently lost a vital member, mentor, and Past President, Dr. Matthew Tolchin, who passed away on May 15, 2021. Dr. Tolchin was President of the Academy from 2001-2002 and he was a dear friend and mentor to many members. Our thoughts and prayers are with his wife, Dr. Joan Tolchin, also member of the Academy, Past President, and recent liaison to OPIFER, as we mourn his loss.

The fatigue we all feel is real and I hope that, like our children who are restarting school in person, we will eventually find our way back to each other, bringing a renewed energy, hope, and inspiration to our work. This may take some time as we will need to first safely endure this current wave of viral infections. Meanwhile, as we recognize the fatigue that is palpable in all of us, I hope that we find ways to rebuild the stamina, endurance, resilience, patience and empathy needed to continue the important mission of our work.

To that end, the Strategic Planning Task Force, led by Dr. Kim Best and Dr. Jeffrey Katzman, is in the process of making their final recommendations for future change. Many of our members have participated in the work of the four subgroups: Membership, Diversity, Finances, and Technology and Communication. We are so grateful for you who have participated in guiding our initiatives in each of these areas in order to move the Academy forward. Your voices and collective vision are imperative to advance the mission of the Academy. I look forward to working with the Executive Council and our President-Elect, Dr. Joe Silvio, to begin implementation of the many wonderful suggestions of our members.

As many of you are aware, the Annual Meeting of the Academy took place virtually over the weekend of April 23 and 24. With the work and leadership of Dr. Joe Silvio, our Chair of Scientific Programs, Dr. Kim Best, Dr. Jessica Eisenberg, and Dr. Sarah Noble, our Program Co-Chairs, and their committee, a virtual program provided opportunities for learning, teaching, and collaborating. The virtual meeting was a huge success and allowed for us to learn together in a new way. Approximately 90 trainees attended the meeting, which was possibly a record for the Academy!

Plans for the 2022 65th Annual meeting are already underway under the leadership of Dr. Cesar Alfonso, Dr. Mary Ann Cohen, Dr. Xavier Jimenez, Dr. Sharon Batista, and Dr. Helen Ullrich. The theme is extremely timely: "How to Replenish a Passion for Medicine: Psychodynamic Psychiatry and Consultation-Liaison Psychiatry." This will also be a virtual meeting as we are still unsure of what the world will look like in the coming year. Like so many of

our experiences through the pandemic, this meeting will be unique in several ways. First, the program will be virtual and unlike previous in-person meetings where two tracks are offered, the virtual format allows for only one track. The five co-Chairs of the Program all have consult-liaison psychiatry experience and interests and therefore took responsibility for developing a part of the program of special interest to each of them, recruiting experts from within the Academy membership as well as outside the Academy to be speakers. This was quite different from our usual program planning process and therefore left little room for additional submissions to the program. Hence, no call for papers will be sent out this fall. It is our hope that anyone who was unable to submit a proposal for the 2022 Annual Program will plan to do so for the 2023 Annual Meeting in San Francisco, which will likely be in person and follow the usual process for submissions. The 2022 Program is sure to be exciting and will undoubtedly invigorate our passions in our field. We very much look forward to meeting virtually in 2022 with hopes of being together in person in 2023.

In addition to the upcoming virtual Annual Meeting, other opportunities for social connectedness and intellectual pursuit have been underway. Dr. Jerry Perman developed an annual schedule of monthly CME presentations, which have been extremely successful. Dr. Perman's musical talents, which mark the end to each presentation, has lent a moment of fun, creativity, and bonding to these virtual meetings. Dr. Perman has already arranged a schedule for the coming academic year. If you have not yet attended one of these presentations, I encourage you to do so. They are intellectually stimulating and a nice way to "see" other members of the Academy. In addition, the following presentations will be open for non-members for CME for a fee. We look forward to welcoming others in the field who may have an interest in psychodynamic and psychoanalytic topics who may not yet have discovered the benefits of the Academy!

In addition to Dr. Perman's initiative, Dr. John Tamerin and I have co-led a Case Conference Series which began in November. Each month, we discuss a case, creating an opportunity for the group members to get to know each other and learn from each other in a warm and collegial way. While this is a closed group, we hope that this will serve as a model for others who may wish to consider engaging in similar virtual groups.

Our publications continue to serve the membership of the Academy through a variety of ways. Dr. Jeffery Tuttle has joined Dr. Alicia McGill as co-Editors of the Academy Newsletter. Psychodynamic Psychiatry, under the expert leadership of Dr. Jennifer Downey and Dr. Cesar Alfonso as Co-Editors in Chief, has undergone many positive changes. Debbie Katz now serves as Deputy Editor. In addition, six Associate Editors have been named (Drs. Clarice Kestenbaum, Richard Brockman, Mary Ann Cohen, Bernard Gorman, Ahron Friedberg, Norman Clemens), along with an International Advisory Board of 16 members to complement the editorial board of 64 members. In addition, we are grateful for Dr. Ahron Friedberg who continues to serve as the Editor of the Forum.

We are also grateful for Dr. Doug Ingram who leads a study group on the therapeutic space. This group will look at the impact that the place or medium may have on the process of therapy. This is an extremely timely project and will explore components of treatment such as empathy, ethnicity and culture, and the use of telepsychiatry, among many other theoretical components of therapeutic space.

Our endeavors in education continue as the Teichner Award provides ongoing support for underserved programs across the US. In addition, Dr. Allan Tasman is leading the Long-Distance Learning Project, with additional support from the Laughlin Fund, with last year's Teichner Award winner. Also in the spirit of working with residents and Early Career Psychiatrists, the Academy has responded to requests by the American Academy of Directors of Residency Training (AADPRT) with a new initiative to begin in the coming year. A monthly Case Conference Series for psychodynamic psychotherapy supervisors will support the programs that need help with psychotherapy supervision and teaching. This series will consist of a panel of Academy members who have an interest in helping supervisors learn how to supervise. This request came about due to the fact that many residency programs place young and often inexperienced faculty in positions of supervision. While these junior faculty want to teach and support their residents, they may not have enough psychodynamic experience to feel competent in their teachings. This will allow them to get to know and learn from members in the Academy.

The Academy Website will be undergoing changes as well. A calendar has been added to the website where anyone can see the dates and times various meetings occur. Part of the rationale for his was to help all of us keep track of the various upcoming meetings, while also increasing transparency and encourage engagement among the members. We hope that you will use the calendar and ask about any meeting that evokes curiosity!

While we have all been affected by many challenges over the past year and half, and though we may be suffering from various forms of fatigue, we are embracing the upcoming changes in our world and I feel extremely grateful to be working with you, the members of the Academy. So many positive changes are occurring in the Academy and with your help, we continue to move forward. Your creativity and insight are very much appreciated as we navigate the future together.

As always, I sincerely invite each and every one of you to contact me at any time with suggestions, with questions, with answers, with your thoughts and sentiments.

Warmly,
Joanna

LETTERS, ANNOUNCEMENTS AND REPORTS

65th Annual AAPDPP Meeting
Virtual Meeting - April 29th and 30th 2022

Meeting Theme: "Ways to Replenish a Passion for Medicine with Psychodynamic Psychiatry and Consultation-Liaison Psychiatry"

Program Co-Chairs: **César A. Alfonso, MD, Mary Ann Cohen, MD, Xavier F. Jiménez, Sharon M. Batista, MD, and Helen E. Ullrich, MD, PhD**

Chair of the Scientific Program Committee: **Joseph R. Silvio, MD**
CME Committee Chair: **Silvia W. Olarte, MD**

Rita Charon, MD
Keynote Speaker

Rebecca W. Brendel, MD, JD
Plenary Speaker

Jennifer Sotsky, MD
Plenary Speaker

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 psychiatrists who understand the complexity of caring for the medically ill. Consultation-liaison psychiatry and the biopsychosocial approach revolutionized medical care over the last seventy-five 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 to care. Changes in systems of healthcare based on market-driven assembly line models of care have begun to magnify both health care disparities and systemic racism, 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 promote wellbeing among physicians, trainees and medical students.

We anticipate interactive sessions that will address a variety of topics, including:

- What medical schools, psychiatric training programs, and psychiatric organizations can do to promote well-being and prevent depression, suicide, and burnout in students, trainees, and psychiatrists.
- Prevention of physician, trainee, and medical student suicides.
- Clinical aspects of physician, trainee, and medical student suicides.
- Mental health stigma and its consequences and recommendations for prevention.

- Personal accounts of how mental health stigma impacts both clinicians and patients.
- Psychodynamic aspects of health care disparities.
- Transcultural psychodynamic psychiatry and collaborative care.
- Narrative medicine.
- 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.
- Countertransference experiences in clinical care.
- Psychodynamic psychotherapy at the end of life.
- The doctor-patient relationship and therapeutic alliance.
- Psychodynamic aspects of the HIV pandemic
- Psychodynamic aspects of the COVID-19 pandemic

The program will consist of a Keynote Address on 'Narrative Medicine' by Dr. Rita Charon, a plenary session on 'Bioethics and Clinical Decision Making in Psychiatry' by APA President-Elect Dr. Rebecca W. Brendel, a plenary session by Early Career Psychiatrist Dr. Jennifer Sotsky on "The Future of Medical Education", a Presidential Address by Dr. Joanna Chambers, clinical workshops, case conferences, round table discussions and clinical symposia, conducted Live over a moderated ZoomÓ A/V platform.

Symposia topics will include *Psychodynamic Psychiatry and Somatic Symptom Disorders*, *Psychodynamic Aspects of Liaison Work*, and *Psychoanalysis and Racism*. Interactive Panels will address *Medical Student Education in Psychiatry- Challenges and Opportunities*, *International Perspectives on the Confluence of Psychodynamic Psychiatry*, *Psychosomatic Medicine and Consultation Liaison Psychiatry*, and *Physician Wellness, Burnout and Moral Injury*. We will have a Teichner Clinical Case Conference on the topic of *Psychiatric Care of the Medically Ill* in addition to a Residents' Workshop on *The Psychodynamics of Psychopharmacology*. Altogether we anticipate having close to 50 speakers/presenters and will allow ample time for interactive discussion with conference registrants during all activities.

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).

The AAPDPP leadership, its program committee, and the co-chairs of this 65th Annual Virtual Meeting 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.

For questions please email the Academy office at info@AAPDP.org or call 888-691-8281.

We look forward to seeing you at our Virtual Annual Meeting in 2022!

On the Matter of Greetings and Goodbyes in Psychodynamic Teletherapy During COVID

By Douglas H. Ingram, MD

Growing up, I learned that everything and anything should be soaked up in the analytic encounter, like a bath sponge that we then wring dry for its meanings. Our friend and colleague David Forrest explored what goes on before and after the formal therapy session in what he called "door work." (Forrest, D.V. 1984). The Art in Analysis. The Analyst's Art. J. Amer. Acad. Psychoanl. 12(3):321-340; (2004). Elements of Dynamics III: The Face and the Couch. J. Amer. Acad. Psychoanal., 32(3):551-564.)

Door work, he contended—and I agree—is as much our concern as the matter that emerges from the patient in the formal domain of the analytic session proper.

My question is, how do we greet patients on the phone or online without the intermediate space that door work provides? What is the new door work, if there is any?

Here's my personal experience: In the good old days (and still when I see patients in my office), I appear in the waiting room usually wearing a deliberately ambiguous smile, nod, and return to my consulting room, my patient following along.

These days, I mostly hover over the keyboard waiting for the notice that a patient is waiting to be admitted. My expectation is that my patients, all of whom have my private Zoom address, will arrive at the appointed time. Once admitted, there may or may not be some exchange of assurances that we can hear each other. Then, the patient begins. Much the same applies to patients who use FaceTIme.

Those who simply phone are a different story. At the appointed time, the phone rings and I answer, "Hello, A [patient's name]." This is different from my usual answer to an unknown caller, which is an announcement, "Hello, Dr. Ingram." But with a scheduled patient I choose to acknowledge immediately and speak the patient's name. To do otherwise feels disrespectful and silly.

Also, many patients have a routine greeting that throws me off. They say in response to my "Hello, A" some variant of, "Hello, how are you?" How to treat their formulaic greeting

creates a quandary. Do I want to answer with a pallid neutral reply? Do I want to turn it back right away with, "How are you, A," or "Fine, tell me how *you* are," or something else? How do I individualize my response to the particular idiom of the relationship? And, does any of this matter?

Then, at the end of the hour, the new door work is also different from the old door work. Instead of simply saying, "We'll stop," or something like that, I find myself adding to it. As if to more certainly counter a separation that is imposed on an already meager digital presence, I find myself saying more, something like, "We'll stop, and I'll see you next week." Continuity is all, even if it is digital continuity. And then, get this, I wave. I wave good-bye! So do they!

That's how I manage it, if you can call it managing. How do you manage it? What constitutes the new 'door work'?

If this evokes eye-rolling at such trivial matter, I won't argue. That bath sponge analogy may be a bit over the top, the sort of thing you tell analytic candidates and figure they will grow out of it when gray (white!) hair arrives. For myself, I haven't outgrown it and may never.

Reply by David V. Forrest, MD

Yes, Zoom differs from the door work of my original interest in the entering and exiting aspects of the in-person performance of psychotherapy. In person in the office, it is a dance of manners, facial emotions, gestures, differences of distance of observation, and blurted out remarks the (usually obsessive) patient may have withheld until imminent escape. We help everyone to comfortable seating and at exit help the elderly and infirm with their coats. On Zoom, instead we have a less analog, more digital signing on and an over-and-out.

Daniel Kahneman has shown that the end of medical procedures determines the emotional tone of the recall of the whole (his example is colonoscopies!). Thus, the affect of both participants at the sign-off warrants care, especially because there will be a turning off like switching a TV channel. As in sitcom plotting, there is an arc of a therapy session in which a conflict is gradually uncovered, with dramatic and intense moments, followed by a denouement and packing away so the end of the session is more neutral. If not, some attention must be paid so things end well. It is good dynamic therapy, not just a nod to our cerebral cognitive therapy colleagues, to epitomize or summarize what has been termed the red thread of the session that is ending. Patients seldom can explain what their therapy was about in any case (so much is non-verbal).

The beginning of the Zoom sessions has been fraught, at first, by unfamiliarity with the new technology. Some of us like to profess ignorance of it, like the medieval physicians who sat on tall stools literally above the "gross mechanick trade" of actual treatment. I like the patients to Zoom me, take initiative, but may need to help some accomplish this. Patients like it when physicians demonstrate mastery, and when we don't, may wonder what other medical science and technology we don't keep up with. Instead of the wise elders we fancy ourselves, we may be seen as just superannuated. Previously, I have emphasized how we appear on TV (in the office we pay attention to dress, hygiene, etc.), that is, preferably not a ghastly prognathic up-nostril specter. Just the same, at the beginning of a session especially, there is a telling vista about the patient. Remember they have made a conscious or unconscious decision about the background their laptop shows. And just this week a patient who is concerned about his recovery from Guilliane-Barre leapt up just as we began to fetch a pillow, and I was able to see and remark upon his recovered agility. Another's protected child on the spectrum appeared suddenly. Possessions, dress, etc. all signify. We are back to the house calls for which Hippocrates gave us guidelines, especially ethical. Patients feel more at ease and unguarded at home, and there is greater intimacy often. Often their dress is more careless; ours should never be.

Reply by Gerald P. Perman, MD

I am pleased to have the opportunity to think and write about this question since it touches on a number of issues in psychodynamic psychiatry - theoretical, technical, and practical - about which I have given much thought over the years.

Early in my career, I remember being told that 90% of the practice of psychiatry is scheduling. While obviously an exaggeration, there is a kernel of truth in this statement, since, if there is not a solid, reliable temporal framework within which to meet with our patients, no psychiatric treatment will take place. How we navigate this temporal framework during the COVID pandemic is the question being raised in this correspondence.

Whereas I have told the above-mentioned quip to many psychiatric resident supervisees, especially when we would hear about their patients not showing up for, or frequently canceling, their appointments, an accompanying analogy that I also use is: "We always want to set the table before we serve the meal." That is, we want to pay careful attention to how we arrange for the patient to meet with us and how we greet our patients at the beginning of their session. As a student of Jacques Lacan, I believe that it is crucially important to pay attention to word choice when we compose our greeting to our patients (setting the table).

Before COVID, when I met with patients in my office, I would wait for them to arrive in my waiting room with my consulting room door open, and stand up, walk to the door, and welcome them in with a "Hello, please come in." I always avoided "outing" the patient by using his or her (or their) name in the greeting in case it was someone other

than whom I was expecting. Among the various dynamics that influence patients arriving - early, on time (although "on time" is so ephemeral that it almost does not exist), or late—has to do with what we have learned from attachment theory, as well as what we know about the patient's defensive structure and clinical state—obsessive, histrionic, passive-aggressive, depressed, manic, paranoid, and so on.

At the beginning of the pandemic, when I first began to meet my patients online, I emailed them a Zoom link and waited for them to join me in the session, or I expected them to call me on FaceTime or phone at the appointed time. As the months passed, I found that many patients, self-quarantined at home, some of whom were retired or unemployed, seemed to lose track of what day of the week, and what time of the day, it was. Given the substantial fees that I charge, I quickly began to feel guilty that they were being charged for time that they were not using, so, after a few minutes, I would phone them and let them know it was time for their session. This was particularly true for college students whose parents were paying for their child's treatment.

Now, for most of my patients with whom I meet once a week, I send each of them an email at the beginning of the day, letting them know in the subject line: "I will email you a Zoom link at 10:40 AM (or 11:30 AM, or 12:45 PM, etc.) today." In the body of the email, I write: "Best regards, Dr. Perman." As I am getting closer to the end of my career, in some ways I am throwing some of the nuanced aspects of psychoanalytic considerations out the window, in favor of getting down and dirty, so to speak, and I just try to make the trains run on time. I believe that more is gained by taking this approach (having full 45-minute sessions) than is lost by not being able to analyze why the patient was late or did not call in for the appointment. At the same time, one size does not fit all, and with my patient with whom I am meeting three times a week, I don't alert her in advance but simply call her on FaceTime at the time of her appointment.

With my Zoom patients, I then email each of them a Zoom invite shortly before the time of their appointment, always activating the "waiting room," and I "let them in" once they enter. The greeting I offer my patients varies based on the nature of the transference-countertransference relationship, how early we are in treatment (whether they still require prompting to free associate), and so on. I also rely on the maxim: "Do for patients what they can't do for themselves, and don't do what they can do." So for some patients I will say nothing or almost nothing when the session begins, because they know exactly what to do—to begin speaking.

At the end of the session, I give most of my patients a standard reply: "It's time to stop now (or "for today") and we'll "pick up" (or "continue") next week. I am quite explicit about ending the sessions this way since it refers to our initial agreement, or verbal contract, that is, to meet for 45 minutes, and this is why the session is ending when it is, not because I am bored with the content of what the patient is saying, or because I have something more important to attend to, or for some other reason. I sometimes inject a message of continuity by adding that "perhaps we will continue where we left off today." Ending on time is respectful of the patient's schedule as well.

Reply by Alejandra Wortman, MD

Certainly, our model of greetings has radically changed with the use of telepsychiatry. Whereas in the past, we were essentially in one simple setting (the same waiting room for all patients), we are now taken into the patients' "waiting rooms".

At the beginning of the pandemic, I made a point of thanking my patients for allowing me the privilege of peeking into their homes. It was surprising to hear how little consideration they had given to the issue of privacy up until that moment.

Something I routinely do when my patients come online is a "Where is Waldo?" kind of question (sometimes, I actually use those words, in a playful manner), because I've noted that some patients log on from different areas of home/dorms, etc. from session to session. Their responses have allowed me an insight into their preferences, their moods, and sometimes their life circumstances. And the patients tend to be less guarded about the question when approached like this. On multiple occasions, patients have been in their cars (parked, of course!) trying desperately to find privacy. College students are typically in their dorm rooms, and we talk about how they navigate asking their roommates to leave for 45 minutes, or how they whisper to not be overheard when they complain about whatever social issue torments them. I've seen patients fully dressed, in bathrobes, dressed only from the top up (only to "accidentally" realize they're underdressed from the waist down). And, depending on circumstances, we manage to have a frank, open discussion about it.

Conversely, having access to a computer is a lot easier than getting physically to my office (I have a part-time practice). On multiple occasions, I had to schedule emergency sessions on days I was at home. While I have an office set up in the house, it's not devoid of the odd picture or personal item that I would not have in an office setting. On such instances, I've used the backgrounds provided by New York Presbyterian Hospital (a room which clearly does not look like my office). Only a few patients have noted it—mostly adults. It seems that adolescents are far more accustomed to seeing teachers or peers using these filters and, therefore, less inclined to comment on it. And in one instance, a patient used a very intricate background filter that led into a discussion of his interest in a particular cartoonist.

The issue of tardiness: I've made it a habit that once a patient's Zoom session starts, I log on and wait for them to join me—as if I had my office door open. Whenever a patient fails to log in after 5 to10 minutes, I send them a text message, making sure they know/remember our appointment. Now, we have to consider the possibility that a) they have no Wifi/internet connection at home; b) they

are in transit and it's dangerous for them to use a video device while driving; c) they're getting dressed or waking up; d) Zoom decided to do an upgrade, and people have to re-download or sign out and sign back in at the last moment, on top of all the other possibilities. Needless to say, some of those elements can now affect us as well. But, invariably, we address them as part of our greeting. And they, too, provide invaluable insight into our patients and ourselves (countertransference has never been so complicated!).

I'm sure there are so many other elements contained in our greetings alone, but those are the ones that have stood out for me so far.

Reply by Kimberly R. Best, MD

Here we are, with well over a year of experience doing tele-psychiatry and tele-therapy. The image of walking on water keeps coming to my mind. I'm surprised to find myself able to do it, and continue to feel unsettled by the unsteadiness of it.

I have a small group of patients whom I see every one to three months. Most of them do not have access to video platforms, so we have been working by telephone. They often forget their appointments with me. Because they are not in the office with me when we make the appointment, I cannot hand them a card to put into their wallets, and I cannot wait with them while they take out their calendars and enter their appointments. I typically call them at their scheduled appointment time. If they do not answer, I leave a message, knowing that they are likely to call me when their supply of medication runs low. Because I do a great deal of administrative work, I am often able to hold the appointment just then, when we reach one another. It has become a very patient-centered style of care. It fits the very difficult, high-challenge and low-resource lives of many patients. Before the pandemic and the increased experience with tele-psychiatry, I would have been much less comfortable with this relatively "boundaryless" care.

I have a group of patients who have long work hours and often irregular schedules. Fortunately, much of my work is administrative, so I am usually able to be flexible in scheduling their appointments. I typically send the Zoom link between two hours and two minutes prior to the session. I do not want to send Zoom links early in the day when they might become buried in a stream of email or text messages. I find the whole setting-up of the video connection to be a bit of work, and it may take me a minute to be ready to fully listen to the patient. Welcoming a patient into my physical office seems more routine and takes less psychic energy.

I try to open the Zoom meeting one minute before the scheduled meeting. For some patients, there is a delay between the time they enter the Zoom meeting and the time their video is fully functional. We are waiting together for their video. This has become a part of the rhythm of the session, and an experience of being together as we quietly wait.

The irregular scheduling is paralleled by irregular locations. Patients may be alone at home, in a parked car, visiting friends or relatives, or in a private space at work. Often the session begins with talking about where the patient is currently located. While patients are freed from the effort of traveling to my office, I am aware that they must do the work of finding a good location for us to meet. I have some sense that they are hosting me.

I end sessions by saying that our time is up. Patients who use the computer have a clock in the corner of their screen. Some of them will remind me when we are very close to the end of the session. At the end of the session, I wait for the patient to leave before I close the Zoom session. Or, I might say, I wait for the patient to disappear. I watch them reach for the button, and then the screen is blank and I am suddenly transported from the virtual world to my own physical office. It is odd how seamlessly we move from the virtual to the tangible.

Reply by Myron L. Glucksman, MD

Opening and closing sessions in-person and on Zoom or Facetime, etc. provides me with an abundance of verbal and non-verbal information. When seeing patients in-person, I always greet them in my waiting room. I note whether they are sitting, standing, walking around, reading, texting on their cell phones or dozing. In particular, I observe how they are dressed, study their facial expressions and body postures. I greet them by name and wait for their response. Some greet me by name, others just nod, while others say nothing. Occasionally, a patient will blurt out "wait until you hear my dream", while another might say "what a terrible week I had", or "I couldn't wait to come in today", etc. By the time we settle into our respective chairs (or couch), I often have a preliminary sense of their emotional state and the possible opening theme of the session.

Closing sessions in-person depends, in large part, on the content of the session, the state of the transference and countertransference, the patient's affective state (sad, happy, confused, angry, etc.), and whether or not there's been a successful or unsuccessful resolution to the issues brought up during the session. I end sessions by saying something to the effect that "we have to stop for today" or "can we continue this next time?" I generally walk with the patient to the door, say "goodbye", or "see you next week", etc. I note whether or not there's a reciprocal response. Sometimes, patients leave in an angry or unhappy mood, and don't respond. Others are preoccupied and silently nod. Some pause at the door and communicate something they had resisted during the session; e.g. "Oh, I forgot to tell you a dream I had last week", or "I should have told you about the argument I had with my boss", etc. Still, others might comment about the

session; e.g. “that was really helpful”, or “I look forward to continuing with this next week”, etc. These exit remarks provide valuable information for the next session.

Opening a session on Zoom or FaceTime, etc. is qualitatively different than in-person. I usually set up and initiate the session. Whether or not the patient is promptly available may be informative. Some individuals have technical difficulties beyond their control, or because of their own problems with technology. One of my patients has a history of visual-spatial difficulties, and often has a problem navigating Zoom. This issue led to an exploration of his lack of physical coordination participating in school athletics. In turn, this brought up painful memories of being ridiculed, as well as feeling ashamed and embarrassed, in front of his schoolmates. Patients are usually in their home setting, which can be informative. For example, one of my single female patients often has her cat sitting with her during sessions. She has a history of failed relationships, and her cat is a source of emotional comfort and loyalty. Another patient is partially demented, and requires her sister to help her sign onto Zoom, as well as to adjust the camera and sound. One of my female patients who dresses somewhat provocatively and is always carefully made up when she comes to sessions in person, does not wear makeup and dresses casually when sessions are on Zoom. Another female patient, who has Borderline Personality Disorder, feels too detached and isolated from me on Zoom, and prefers in-person sessions. As I noted in a previous study regarding the issue of empathy in the context of virtual therapy, several patients with a history of negative attachment experience feel more emotionally connected with in-person sessions.

In general, I find that three dimensional in-person sessions provide more physical and emotional cues that facilitate the therapeutic process. Closing sessions on Zoom or FaceTime preclude the opportunity to personally escort the patient out of the office. As a consequence, parting remarks by the patient are obviated, in contrast to when they physically exit. The sudden blank screen as one leaves the session at the press of a button deprives the patient of a possible meaningful afterthought as they exit. I try to facilitate any afterthoughts by asking the patient at the end of a virtual session whether or not they have anything to add before we stop. Although there are unique advantages and disadvantages to the opening and closing portions of both the in-person and virtual venues, I believe the in-person sessions provide more opportunities for meaningful clinical information.

Illegal Immigrant Parenting and Character Formation in Their Children

By Peter A. Olsson, MD

Dear Editors,

Thomas Babington McCawley once said, “The measure of a man’s character is what he would do if he knew he never would be found out.” During the recent presidential political campaign and subsequently, a frequent question posed is, “What will we do with millions of illegal immigrants already in America? And how about the hundreds more arriving constantly?”

These are the wrong questions. The more precise and important questions are:

“What will good immigrant parents decide to do about their illegal situation and status?”

“What impact over time does a parent’s living in the shadows of illegal, unethical, and criminal status have on their own character structure and by psychological influence, the character structure of their children?”

“Does the shadowy atmosphere of being an “illegal” cause denial of that reality?”

“Does denial or repression about being illegal often cause defiance, rebellion, and a false sense of entitlement?”

Is skipping to the head of the line to gain American citizenship and potential prosperity a violation of personal conscience?

And the like.

Let’s discus personality, character, personality and character disorder as they relate to the parenting processes of illegal immigrant parents and the impact on the character of their children. Little has been written about the unconscious psychosocial aspects of illegal immigrant’s identities and actions as parents.

For psychologists and psychiatrists, personality is the relatively persistent totality or complex array of behavioral and emotional characteristics that distinguishes an individual over time. Character is a core sector of personality. Good character implies adequate intelligence, a good sense of humor/playfulness, personal integrity, ethical consistency, social adaptability, and flexibility during adversity. It has survival value.

In popular use Character implies more emphasis on ethical integrity. Character Disorder is manifested by an individual’s chronic, habitual, repetitive and maladaptive patterns of behavior and emotional reactions. These patterns are relatively inflexible, limit the optimal use of potentialities, and often provoke responses that the person or group want to avoid.

Some personality traits are influenced by genes and inherited. However, “Nature/Nurture” issues arise from the fact that character and character disorder are formed over many years of personality development. Character forms in the context of family and social life in a community. Parental attitudes, parenting style, and values (or lack of them) are clearly shaping factors in personality formation. The quality of emotional, empathic, and nurturing connection between the child and caretakers weave their effects into the developing personality over many years. The child unconsciously identifies with many parental traits or stoutly rebels against them.

The conscious decision to illegally enter America has consequences. Often it leads to some real economic and educational advantages for illegal immigrants and their children. Education and a job in America afford dignity and the ability to send money back home to relatives in the country of origin.

However, the clouds and shadow-side of the illegal entry decision lives on in the unconscious and preconscious mind. It festers in the conscience or lack of conscience formation in an illegal immigrant's mind. The implications of such an illegal immigrant parent's decision results in the intergenerational transmission of guilt and shame to the minds of their children and grandchildren. If there are no overt signs of this cultural class guilt and shame, it is because of massive denial and reaction formation. Shameful and shameless behavior and hidden guilt about it can spawn acting-out behavior. Alcoholism, crime, reckless driving, and shameless predatory sexual behavior can result.

Parents who are illegal immigrants have conscious, preconscious and unconscious impact on their children's minds, morals and character. A parent who is haunted or should be haunted by illegal behavior finds it hard to be an effective role-model and example of moral integrity for his child. The child can repress or suppress the hints about the shadowy family secret. The youth during adolescence can rebel and become defiant. The sense of entitlement and defiance can lead to acting-out and authority conflict. Without a strong parent with good moral character, they push school authorities or the police into roles as stern father-figures.

Earning legal citizenship and a good college education and job is different than expecting it to be handed out as free stuff. Hard work to earn an education builds character as part of the process. "Free education" and other free stuff can promote future generations of sucking dependency upon government entitlement programs.

In conclusion, the shadowy family secret of an illegal immigrant family often gets transmitted over several generations unless or until the truth is faced and resolved. It is alarming to consider how seldom the illegal immigrant's parenting as it effects their children's identity formation is seriously discussed. Even highly successful children of illegal immigrants can understandably have normal pangs of conscience about the illegal behavior of their parents/themselves. Paradoxically, the more personal integrity the child has, the more they will be haunted and hampered psychologically. The psychologically most healthy transform their guilt and shame into effective community service, often in the military or health care fields. As Goethe said, "Truth heals the pain which it evokes."

ORIGINAL ARTICLES

Presidential Address to the Academy An Open Letter to Professor Sigmund Freud

By Gerald P. Perman, M.D.

Dear Members of the Academy and Guests,

I am speaking to you as the Immediate Past President of the Academy, since the 2020 Annual Meeting, when I would have given my address as President, was cancelled due to the coronavirus pandemic. I will use this opportunity to express my debt of gratitude to in an open letter to Sigmund Freud, without whom there would be no Academy.

Dear Professor Freud,

I want to let you know, dear Professor, how your hard-fought-for and penetrating insights into the human mind, and the psychoanalytic science that you created, has had a lasting effect on the world, is the foundation on which this organization, the American Academy of Psychodynamic Psychiatry and Psychoanalysis was built, and has impacted my life both professionally and personally.

Part I: Psychoanalysis Back in the Day

You would be pleased to know that, while the practice of psychoanalysis per se is much less frequent than during the two decades immediately following your death, its ramifications have permeated many aspects of literature, philosophy, the arts in all its forms, and the day-to-day treatment of many patients suffering from neurotic, characterological and even psychotic illness. At the same time, psychoanalysis has continued to undergo many changes, as it had even during your own lifetime, and it has continued to provoke intense controversy.

You were fondly eulogized shortly after your death by W. H. Auden in his poem, "In Memory of Sigmund Freud," in which he credited you with creating "a whole climate of opinion" and that forever prevents us from experiencing the world as it was before you came onto the scene. I believe that you did, indeed, achieve your desired title of "Conquistador."

Along with Darwin and Copernicus, you de-centered our view of ourselves, providing us with the shocking insight that we are not the masters of our minds as we previously believed, but instead that our lives are profoundly influenced by a vast territory of unconscious mental activity into which we have no direct access. I predict that the "the plague" that you told Jung you were "bringing to America," on your voyage to Clark University in Worcester, Massachusetts in 1909, will continue to have a positive impact on the lives of troubled individuals and improve their capacity to work and to love.

When patients of mine ask me what they can expect to obtain from the psychodynamic treatment I offer them, I sometimes quote you, and tell them: "We will attempt to help you exchange your neurotic misery for normal human unhappiness." How beautifully and elegantly expressed! I then tell them that, otherwise put, their conversations with me will help relieve them of their unnecessary emotional baggage.

Sometimes patients also ask: "How does psychodynamic psychotherapy work?" Keeping in mind your topographic and structural theories of the mind, I reply that "I think of our minds as consisting of our conscious, moment-to-moment thoughts, and a much larger part that is unconscious, outside of our awareness, and within which conflicting ideas and affects create turmoil in our daily lives, experienced as depression, anxiety, unwelcome thoughts, and an undesired life course. By helping you become aware of, and able to acknowledge, these conflicting unconscious thoughts and feelings, you will feel better, and your life will improve."

As you continued to develop your theories, Herr Professor, you were attacked from without and from within. The Victorian public and the non-analytic physician community were repelled and appalled by your theories of infantile sexuality, conflicts concerning incest and death wishes, as were some of your early adherents who came up with alternative theories of personality development and psychopathology. You have been disparaged as a mystic, a pervert, even a pedophile and a swindler.

In 1897-98, you did a volte-face and retreated from your "seduction theory," a misnomer because this translation implied that the molested child had a role in her own abuse. You had previously asserted that the neurotic manifestations that you were seeing in your hysterical and obsessive patients resulted from actual childhood sexual trauma. Instead, you then postulated that your patients' neurotic illness was due largely to the role of unconscious fantasy and desire. In the decades that followed your death by euthanasia in 1939, we have come to accept that both, the historical and the narrative truth play crucial roles as causative factors in our patients' neurotic problems, and we have come to increasingly respect the importance of social and biological contributors to psychiatric illness as well.

Part II: Psychoanalytic Psychiatry to the Present

Unfortunately, you were prescient in your 1933 written correspondence with Albert Einstein, titled "Why War?" in which you wrote that the inclination to war was part of being human, that the collective wisdom of a group was needed to prevent it, and about which you were quite pessimistic that this would happen. That same year, we know that the Nazis – pronounced Nazzis by J. Rufus Fears in his superb lecture on Churchill for The Teaching Company - seized your books, among other psychoanalytic and Jewish-authored works, and publicly burned them in Berlin. The Nazis described this book burning as "acting against the soul-destroying glorification of the instinctual life, for the nobility of the human soul!" You commented ironically: "What progress we are making - in the Middle Ages they would have burned me. Now they are content with burning my books." And we know that you emigrated to England on the condition that you sign a statement testifying that the Nazis treated you well. For your response, you quipped: "I can most highly recommend the Gestapo to everyone."

Two weeks after your death, the second great war, World War II, was initiated by Hitler, in which millions died on both sides. Six million Jews – including four of your five sisters – as well as gypsies, homosexuals, and political opponents, were rounded up and put to death in Hitler's extermination camps. Millions more were forever traumatized with physical and emotional injuries, on both sides of the conflict, trauma that has reverberated down through the generations. As a kind of punctuation mark to WWII, the last known living Nazi was recently found to be living in Tennessee at the age of 95 and was deported back to Germany to be held accountable by the German legal system.

My father, Milton, served in Belgium in a non-combatant role during WWII. Magdolna, my wife Martha's mother, survived Auschwitz, and her father, Joseph, survived a Nazi forced-labor camp, although their family lost many relatives in the so-called "concentration camps."

In your correspondence with Einstein, Einstein observed that: "… political power hunger is often supported by the activities of another group whose aspirations are on purely mercenary, economic lines. I have especially in mind that small but determined group, active in every nation, composed of individuals who, indifferent to social considerations and restraints, regard warfare, the manufacture and sale of arms, simply as an occasion to advance their personal interests and enlarge their personal authority. …"

The manufacture and sale of arms is a potent political topic in the United States today, where there has been an epidemic of domestic mass killings using military-style assault weapons, as well as numerous daily incidents of domestic purposeful and accidental shooting deaths, and many acts of suicide by firearms. It often seems as if Thanatos and the Id forces of aggression are winning against the attempts at control by Eros, the Ego, and the Superego.

In addition to the obscene availability of these weapons, many domestic killings in the United States have deep historical roots and are perpetrated by members of traumatized families in which their members have had limited educational and occupational opportunities, and who express their violent aggression toward one another. At the same time, domestic violence, and child abuse, cuts across socio-economic lines.

It was you who said: "The voice of reason is small, but very persistent." Sometimes it seems as if we can only hope that our better angels will prevail.

The 1950's and 1960's were the "golden age" of psychoanalysis in the United States and around the world mostly because yours was the "only game in town" that offered the hope of an effective treatment for mental illness

during that time. Psychopharmacology had not yet fully entered the field of psychiatric treatment and, until then, health insurance, at least in the United States, substantially covered the cost of psychoanalysis. By the 1970's, however, profound changes had taken place in American psychiatry.

You anticipated some of these changes in your "Project for a Scientific Psychology," although even now, in 2021, while there has been a vast amount of exciting research into the biological and genetic causes of mental illness, the hope for "a biochemical cure" still seems far off into the future. Many kinds of somatic treatments, including medication, help palliate symptoms, often significantly, but they do not remedy the causes of patients' psychic suffering. At times though, help through psychopharmacology makes psychotherapy possible.

Part of the decline of psychoanalysis as a treatment today is because it is difficult to prove its effectiveness using present-day scientific methods, compared to studies of briefer, manualized, approaches that have since been developed. As you might imagine, health insurance companies are more willing to help cover weekly treatments lasting 10-20 sessions, and to pay for 15-minute medication evaluations once every several months, than for psychoanalytic treatment.

In 1949, John Cade published his results showing that lithium could prevent episodes of manic-depressive illness and the so-called "psychopharmacology revolution" had begun. Drug companies have since produced thousands of medications to treat symptoms of anxiety, depression, psychosis, obsessions, and compulsions, and what is now called "Attention Deficit Disorder". While these drugs can help alleviate symptoms, they do not treat the underlying condition and almost all of them have short-term, and some of them, potentially long-term, side-effects.

About 10 years ago I published a short paper showing that people who abuse methamphetamines, that manifest their effects through the massive release of dopamine in the brain, later in life are more likely to develop Parkinson's disease and Lewy Body Dementia, both characterized by a deficit of brain dopamine. By extension, stimulant medications, prescribed for Attention Deficit Disorder, and that have the same mechanism-of-action, may turn out to result in these same two serious illnesses decades later.

Psychoanalysis is still widely taught in numerous psychoanalytic institutes around the world, although there have been many changes made to your theories and to your original technical recommendations. In general, the analytic approach to patients has softened and become more humanized, so to speak, following a trend that Sandor Ferenczi began when he was a member of your inner circle in Vienna.

We also know that you did not always follow your own recommendations: you provided a meal to the Rat Man, you lent money to another patient, you offered practical advice, and so on, such that it has even been said that "Freud wasn't so Freudian after all!"

Part III: Psychoanalysis and the Academy

One effect of the Second World War on psychoanalysis was that many German and other European analysts, including yourself in 1938 with the intervention of Ernest Jones, emigrated to the United States and other parts of the world. Your home at 20 Maresfield Gardens in Hampstead, England during the last year of your life became the Freud Museum, in addition to the one that exists in Vienna.

As disenchanted as you were with the United States, America became fertile soil for the acceptance and growth of psychoanalysis. In 1911, the American Psychoanalytic Association was founded by Ernst Jones with your support. Its member organizations included many of the psychoanalytic training institutes that had taken root in cities across the United States.

After several decades, in 1956, a group of psychoanalysts left the American Psychoanalytic Association, believing that it had become overly rigid, authoritarian, and hidebound and was no longer open to ideas that were at variance with the majority opinion. These analysts formed what was then the American Academy of Psychoanalysis and, evolving with the times, is now called the American Academy of Psychodynamic Psychiatry and Psychoanalysis. Today, in our 64th year, we are the only United States medical organization composed entirely of psychiatrists and medical students with an interest in psychodynamic psychiatry and psychoanalysis.

You will be pleased to hear that our relatively small – about 500 members - but robust organization publishes an excellent and well-received journal, "Psychodynamic Psychiatry," a less formal bi-annual magazine, "The Academy Forum," and has an intellectually-stimulating Annual Meeting, in addition to maintaining other thriving educational initiatives. We believe that we are well-situated to continue our work for many years into the future.

Personally, the Academy has provided me with a wide variety of opportunities for which I have been enormously grateful. I learned about the Academy about 15 years ago, when I took over as Editor of a publication of a smaller organization, the Washington, D.C. Chapter of the American Society of Psychoanalytic Physicians. The previous editor had been Richard Chessick, an Academy member who introduced me to the Academy. Soon after joining, I become Co-Editor of the Academy Forum with Mims Cohen, who tragically died of a brain tumor about two years ago. During this time, I volunteered to co-chair several annual meetings, served in various administrative positions, until I was nominated to become President.

Sheila Hafter Gray, a long-time friend and colleague, told me, shortly after I joined the Academy, that one day I could expect to become President. I laughed to myself, thinking that she didn't know what she was talking about.

My membership in the Academy has given me the opportunity to travel and to explore cities I never would have visited otherwise, both here and abroad, and to have made many friends over the decades.

Part IV: Two Patient Vignettes and Conclusion

My view of psychoanalysis and psychodynamic psychiatry is from the "inside," so to speak, and as such I do not question their validity and effectiveness when recommended for appropriate patients. Techniques used have undergone substantial modifications, as I mentioned above, and the indications for psychodynamic and psychoanalytic treatment have expanded dramatically. We now treat patients in so-called supportive, usually less intense, treatment at one end of the spectrum, and in 3-5 times per week psychoanalytic psychotherapy at the other end of this spectrum. The psychotherapies remain essential for the treatment of "the person" and not just the symptoms of illness, and the intensive psychotherapies, including psychoanalysis, continue to be, life-altering, and at times even lifesaving, for those who need it and are able to obtain it.

I will end my letter with two case vignettes neither of which are "evidence-based" by today's scientific community standards.

A young woman came into my care following a near lethal suicide attempt by overdose, not long after I completed my residency training, almost 40 years ago. A history emerged of severe childhood physical and sexual abuse.

Our field of action is our patient's mind and personality, as they interact with our own, primarily through the words that our patients tell us. We usually have no way of knowing what is factually true, but we listen, engage our patients' curiosity about themselves, and from time to time offer interpretations of what we believe to be the unconscious meaning of their discourse. So, I had no way of knowing whether what my patient told me about her traumatic past was the historical truth, but the many scars and burn marks on her hands and arms, her report of previous psychiatric hospitalizations, as well as a phone conversation with a psychiatrist who treated her in adolescence, seemed to me to be at least a partial verification of her narrative history of emotional and physical trauma.

After a year of meeting several times a week, she began to speak in other voices and her body posture changed, both conveying the impression that she was someone other than who she was when we first met. I was incredulous, but I listened, I sought out supervision, and I talked with her and these "alter" personalities. Early on she made frequent anxiety-ridden telephone calls between the sessions, and left me many hand-written notes and letters, written in scripts different from one another. (To let you know, Professor Freud, telephone calls, 40 years ago, were much less expensive than they were in your day.)

While her life often seemed to hang by a thread, she was cultivating miniature bonsai trees and had a menagerie of small animals that required care and attention over a long period of time, suggesting a conflict between her Eros and Thanatos. After several years of intensive psychodynamic psychotherapy, her self-mutilation and suicidal impulses became less frequent and stopped, her alter personalities came less often into the sessions, she resumed her interrupted post-graduate education, she ended a dysfunctional marriage, she practiced her medically- related profession for several years, she became a full-time faculty member at the school where she trained, and she entered into a second, healthier, marriage. She has since retired and is living with her husband and another menagerie of small animals.

This treatment occurred during the 1980's, at a time when the diagnosis of Multiple Personality Disorder, now labeled Dissociative Identity Disorder, was at its height, suggesting a societal contribution to the form that my patient's illness took.

This patient relied on defense mechanisms of repression, dissociation, projection (evidenced by her fearful attitude toward others), introjection, masochism, and repetition compulsion, and she formed an identification with me in the transference manifested by a change in her religion from Christianity, in which she was brought up, to Judaism, even studying for a Bat Mitzvah and attending shul regularly. Later elaborations on your work allow me to conclude that my patient's attachment style was insecure and anxious, she developed a mirroring transference, and I became a healthy self-object that she continues to use today, as evidenced by annual birthday cards. I, too, have not been a blank screen to many of my patients.

This years' birthday card, received last month, reads as follows: "Dear Dr. P., Hope this note finds you and your family doing well and staying healthy. We (she and her husband) are both doing OK and have stayed COVID free. [My husband] continues to decline slowly but all is still manageable. I have thought a lot about our many years together these last few weeks and wanted to wish you the happiest of birthdays and remind you how much you did for us [referring to herself and her alter personalities]. I am grateful for helping "the cracks get glued." Warmest regards, [my former patient]

She gave me permission to report her case to you.

I am going to finish my open letter to you, Professor Freud, with an additional vignette of a patient who I did not treat myself, although I know the patient well.

An adolescent boy had been brought up by loving and well-meaning, but neurotic and characterologically-impaired, parents, and, at 16 years old, he hit an educational roadblock and was experiencing symptoms of depression and intense emotional angst.

He dropped out of high school in the 11th grade and, on the advice of a school psychologist, transferred to an unaccredited school with minimal academic structure. He left this school when he turned 18, lived on his own in Greenwich Village in New York City, where events led him to return home to his parents from whom he had previously estranged himself.

His mother found a psychoanalyst for her son through a cousin of hers. During his late-adolescent analysis, the symptoms that brought him into treatment receded, and the young man obtained a high school equivalency certificate, entered college, and pursued a pre-med curriculum out of his desire to become a psychiatrist and psychoanalyst, following an identification he had formed with his analyst.

He tried twice, unsuccessfully, to get into a U.S. medical school. He then had an epiphany that he could apply to medical schools outside of the United States. He took a crash course in French in Europe, was accepted into the second year of a seven-year French-speaking medical school in Belgium, and, after three years, transferred into the third year of a U.S. medical school. Following medical school graduation, he trained in psychiatry, got married and raised a family.

After completing his psychiatric training, he was rejected by the one psychoanalytic institute to which he applied. This resulted in him entering a second psychoanalysis with the same analyst, Kenneth Grigg, who had treated him in adolescence.

The young man, now in his mid-70's, has since had a successful career in psychodynamic psychiatry for 40 years and that has included his tenure as the immediate Past-President of the American Academy of Psychodynamic Psychiatry and Psychoanalysis.

So, thank you, Professor Freud, for the psychoanalytic science and the treatment you invented that has been, and continues to be, of enormous benefit to many individuals around the world.

And thank you, my fellow members of the Academy and guests, for your attention.

Note: I am appreciative to Drs. David Lopez and Douglas Ingram, Past Presidents of the Academy, who provided helpful comments on an early draft of this address, as well as to Dr. Harold Blum, Executive Director of the Freud Archives, who gave me helpful critiques on my final draft.

Dr. Perman is Immediate Past President of the AAPDPP

Lessons Learned from the COVID Pandemic: Psychiatric Education

Kimberly R. Best, MD

No one will be surprised to hear that the COVID 19 pandemic has had a significant effect on the psychiatric education of medical trainees. Now that COVID cases have a lower prevalence, we can pause to look back and learn from our experiences. Back in the spring of 2020, when we were suddenly in lockdown, classes rapidly migrated to online platforms and much of bedside teaching transitioned to Zoom or Facetime, minimizing the number of healthcare workers who had contact with patients, and conserving scarce personal protective equipment. Medical students were removed from in-person clinical rotations, for their own safety as well as that of the patients. Psychiatry residents were sometimes reassigned to other departments to fill in for clinicians who were on quarantine, or to free up primary care clinicians for more complex work. By late spring and early summer of 2021, there were high vaccination rates among physicians and medical students, and most parts of the country were seeing declining COVID-19 infection rates. We are in a position to take a breath and think about what we have learned about psychiatric education during the pandemic.

Protecting a Space for Painful Feelings

As I reviewed the early literature on education of psychiatric trainees during the pandemic, I recognized that many of the papers were upbeat. They acknowledged obstacles and losses and moved on to speak of resilience. They reported success in maintaining educational progress. As we know, successful interventions are more likely to be published than unsuccessful interventions.

With that being true, one of the things that dynamic psychiatry teaches us is to notice what is not being said. Has there been a resolutely upbeat quality to what we publish and talk about?

During the acute stage of any crisis, a specific set of defenses is needed. Suppressing awareness of loss and danger are important survival strategies in an emergency situation. During an emergency we need to stay focused on what needs to be done and put off thinking about the meaning of what is happening. At the beginning of the pandemic, our hospital organized support groups for frontline workers. No one came, regardless of how convenient we made it. It just was not the time to think about vulnerability.

Here we are, well beyond the initial acute phase of the pandemic. We need to shift our defenses. Keeping painful feelings out of view does not work well in the long term. This is what we are seeing when we encounter patients with PTSD who experience emotional numbing. If we and our trainees do not engage in a real way with disappointment and loss, we become less able to deeply hear our patients when they express painful feelings. Some of us have had no choice, we have had to deal with loss fully and directly. We have lost loved ones or have been quite ill ourselves. For many of us, however, we have been able to keep ourselves distracted.

While we need to use suppression and isolation of affect in the acute phases of a crisis, for the long term we need other strategies, and we need to be able to role model these for our trainees. We need to pause and stay with painful feelings, without rushing to say that things are, after all, okay.

If case rates continue to drop, we can breathe a sigh of relief and turn to designing the "new normal". While turning our attention toward the future is expectable and necessary, we would miss an important opportunity for post-traumatic growth if we did not reflect on the painful experiences that we recently encountered. We should talk about the qualities that allow us to manage in the presence of pain. Qualities that would broadly be grouped under the category of altruism: courage, stoicism, endurance. The qualities that help us keep on doing the right thing, even when it feels bad.

Supporting Deep Doctor-Patient Relationships

We have completed more than a year of teaching during the pandemic. I think that we can agree that we have found ways to teach medical students, residents, and fellows a great deal of psychiatry.

By winter of 2020 I was feeling pretty good about how our educational program was running in the new COVID world. We were caring for patients. We were holding classes for residents. Medical students had returned. We had oriented new interns, held a meaningful graduation on Zoom, and we were well into what appeared to be an effective process of all-virtual recruitment

Then I was called to cover an inpatient unit over the holidays. The residents and I together evaluated patients and updated the treatment plans based on our findings. The residents gathered in a socially distanced workroom where I was able to teach and expand on clinical points. The care of the patients moved forward, the residents were learning. It all seemed to be working well.

After a few days I realized that this was the whole experience of the intern during her formative months in psychiatry. She stayed 6 feet or more from patients. She was advised to spend 15 minutes or less with patients, and basically see them for the minimum time necessary to carry out treatment. She and the patients were all masked. How will her understanding of doctor-patient relationships be impacted in these, her formative months?

I invite all of us to be thoughtful about the habits and routines our youngest trainees are being exposed to. In the early stages of the pandemic, we needed to survive and take care of patients. Then we needed to teach enough that trainees could do their current jobs. Now we need to think about the learning that was missed, things that might not show up on a multiple-choice exam.

Let's have the wisdom to notice the parts of education that are interrupted by the pandemic. If we can't fix them now, let's bookmark them so we can come back to them. Let's be especially attentive to helping trainees learn to have rich doctor-patient relationships.

Protecting Group Experiences

We have been able to adapt some types of learning for the pandemic. Lectures for trainees, including large groups, seem to work well. We have needed to learn some new techniques, such as asking learners to keep their cameras on so the speaker has immediate feedback, but for the most part virtual lectures work well.

Psychotherapy case conferences work less well. With a psychotherapy case conference, I want each resident to be actively thinking and participating. I want the case conference to be a workshop in which each resident practices the skill of thinking about the meaning of what is happening and what intervention might be useful. With classes in a virtual format, it is hard to read the room, and difficult to take turns. For resident cohorts in which cohesiveness is well established, we mostly do well enough. For newer cohorts, the hesitation to speak is accentuated by the virtual format. I must often call on individual learners.

Highly unstructured classes are even more difficult to manage in a virtual format. This would include classes that have a prominent experiential component, such as experiential groups. It is difficult to sit together as tiles on the screen, relate to one another, and to form and explore an experiential group process. It is especially difficult with early residents, or those who do not have a few years of experience relating to their residency cohort. We will need to be very attentive to providing opportunities for experiential groups and similar kinds of learning as the pandemic abates and we are once again able to be together.

It is necessary, even with well-established resident cohorts, to provide time to be together in a way that is unstructured. Our PGY 3 residents, working from home doing telepsychiatry, felt isolated. However, they did not want another hour of Zoom time for a Happy Hour, so I blocked out some of their didactic hours to be social hours. They are required to be present just as they would for any didactics. This gives them time to be together and chat, as they would in the hallways before or after class or going to lunch. It supports the cohesiveness of the group. A sense of belonging is important and undergirds much of the way we develop a sense of professionalism.

Learning that depends on being part of a group is especially at risk in a virtual format. We need to be attentive to protecting the opportunity to be in groups.

Post-graduate learners, physicians in practice are faced with many of the same problems as the trainees. Readers of this essay will not have trouble keeping up with content that can be taught in lectures, and joining virtual meetings can help us stay abreast of scientific developments.

Yet something important is missing when we can't gather in person. Residents need to be together in groups with other residents. They need to have a sense of belonging, a sense "this is my group, this is my home". Out of that sense of belonging come values and professionalism, camaraderie when doing difficult things, and joy in shared mastery. We don't outgrow the need to be part of a group. We need our national organizations as our "professional homes". Just as deep doctor-patient relationships are important, so too are deep doctor-doctor relationships. As the pandemic abates, we need to be careful not to let ourselves be convinced that the less expensive virtual meetings are good enough.

Conclusion

These points are all tied together by the idea of relationships, of attachment. I've read hundreds of personal statements written by residency applicants. They all talk about going into psychiatry because the relationship with patients is the most rewarding part of being a doctor. That is true for all of us practicing doctors as well. We missed being together, with our patients and with each other. Let's commit to connecting every way we can, and to being together in the future.

Maimonides' *Guide of The Perplexed* as a Medieval Precursor to Freud's *Interpretation of Dreams.*

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Abstract: **Maimonides' *Guide of The Perplexed,*— the twelfth century final work by this neo-Aristotelian rabbi and physician—[1]demonstrates prescient parallels with Freud's model of dream work and interpretive technique. The "literary" structure of both *Torah* and *Guide its* remarkably similar to Freud's account of dream work's Unconscious structure (and Preconscious/Conscious secondary revision). The Unconscious *both conceals and reveals,* using distortions, symbols, metaphors *to hide and inform* the dreamer and analyst about hidden conflicts. I recount the methods used by Maimonides to write this unique book: he intended both to reveal the secrets of the *Torah*,[2] while also conceal them from "ordinary" readers, or critics, specifically rabbis, who would have excommunicated him. There is a long tradition of "esoteric," concealing/ revealing writing from Homer and Torah through Plato until at least the early Enlightenment (Strauss (2013) and Meltzer (2014). Maimonides fits within this tradition. As does Freud's reading of dreams.**

I suggest *analogies* between Maimonides and Freud, focusing on Maimonides elegant understanding of inner psychic mechanisms as revealed in literary structure. I do not suggest that Freud read this work, nor that there are continuities from Medieval to modern times.[3] There is active debate in the history of knowledge between those who seek linearity or continuities in ideas versus considering history as one of "…radical ruptures and hidden as well as open continuities; there are as many by-ways as highways. (Gilman, personal communication 2020; Makari, 2015). We assume the latter, more modest stance.

This article is divided in two parts for the Journal.

Freud attributed many of his ideas about mental life to mostly nineteenth century writers (Makari, 2008, 2015). However, previous works have described Dante's account of his working relationships with Virgil as a *model for the transference* and its working through (Szajnberg, 1996; 2010). Rousseau's *Confessions*, the first autobiography, is a model for how early *development* influences later life (Szajnberg, 1992). The Biblical account of Joseph offers the first known description of the *Ego Ideal* (Szajnberg, 2019). These papers develop the concept of psychoanalysis as an aesthetic discipline (Szajnberg, 1997), with clear rules—such as balancing clarity and ambiguity—to judge the quality of the work (Szajnberg, 2011).

The paper reaches back to Medieval wisdom to find an account that presages Freud's view of Unconscious/Preconscious dream work. We argue that Maimonides presaged Freud, not that Freud read Maimonides, nor a continuity from Maimonides to Freud. Rather, we argue for analogies. Aristotle described man as a hopper, leaping to reach the heavens then brought back to earth by gravity (Y. Klein, 1968). Occasional geniuses like Maimonides or Freud reach the "heavens" of understanding inner life; we aspire to what they learn as they limn the heavens of inner life.

We describe four prescient descriptions of 'mental' mechanisms for hiding/ revealing by Maimonides of *Torah* text—prescient of Freud's account of dream work.[4]

These are:

1. An emotionally important text (*Torah/*dream) has both latent and manifest (hidden) meanings;
2. Oral recounting is the best method to uncover hidden meanings, although one may "settle" for written recounting;
3. There is a logical to hide manifest texts, which contains revealing hints *for those well-trained;*
4. What is hidden is unacceptable to the reader/dreamer *and even to society, which would reject, even excommunicate the revealer.* For the dreamer, "excommunication" involves repression, or suppression or splitting off.

Maimonides describes four pathways of concealment/ revelation parallel to dream work:

1. how the visual in the Torah hides the word which hides the abstract concept;
2. how we can discover the content hidden within the text;
3. how Maimonides, in a calculated leap of genius, wrote the Guide meticulously to confound with specific techniques (mirroring dream work). Maimonides' intent was to hide from most readers, yet reveal to those most scholarly in discovery the secrets of his book, which in turn reveal the secrets of the Torah. Maimonides, so to speak, used "defense mechanisms" to protect himself and the reader;

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(1) Written for only one of his students, the most learned. Iin this sense, we are privileged to have access.
(2) I use Torah rather than "Bible," so there is no confusion that I am referring to the original text.
(3) Fishbane (2003) suggests the concept that "topological comparisons may underscore simi-larities….without the need to assert or presume hidden influences in the absence of evidence (pp. 207-8)
(4) We are aware that dream research has progressed subsequent to Freud's work, as summa-rized by Blechner, (2013) "Psychoanalysis has greatly revised its theory of dream formation and the clinical approach to working with dreams, including the role of disguise in dream for-mation and the need for associations in dream understanding. Both the Freudian and the acti-vation-synthesis models of dream formation are two-stage; neither two-stage model may best account for the data." For this paper, we focus on Freud's early ideas about dream work. Nevertheless, as Stimmel summarizes (1996, p.77) ""The central challenge of dream analysis is how to bridge the gap between these very different modes of thought…and impose *waking meaning* on *sleeping thought*."

4. And, significantly, a fundamental underlying principle of Torah that parallels Freud's view of dreams/inner life is that there are layers from manifest "text" to deeper, more hidden and more meaningful latent "text."

But first, an abbreviated recounting of Freud's dream work will help us see the remarkable parallels to Maimonides. Dream work "transforms the latent dream-thoughts into the manifest dream" (Auchinclass and Samberg, 2012). In his topographic model, Freud attributes to the Ucs. archaic primary process thinking, which produces wishes and fantasies striving for satisfaction but repressed during waking life.

Three types of dream regression, facilitates dream formation:

1. *Topographic*, "towards the sensory...reaching the perceptual…" (Freud, 1900);
2. *Formal*, primitive particularly visual methods of representation;
3. *Temporal*, to older psychic structures, particularly early memories.

And primary process as manifested in dream work consists of three types:

1. *Condensation* (ideas/images compressed);
2. *Displacement* (one thing substituted for another);
3. Symbolic *representation* (Ucs. image substitution).

We emphasize this important parallel to the *Guide*: "these *mechanisms …disguise and distort the original unconscious dream-thoughts and wishes." (*Auchinclass & Samberg *p.64).*

An additional form of repressibility (an abstract idea represented by a concrete pictorial image) is that dream formation is influenced by secondary revision (elaboration), which is influenced by secondary process and rearranges the dream so it feels more logical. The Preconscious and Conscious Systems work on the dream to make it more linear/plausible.[5]

The psychoanalytic reader is familiar with the abstract structural and dynamic mechanisms or terms for dream work. Free association is a complementary technique for dream interpretation. That is, Freud offers specific dream content to describe dream work and later associations to describe the untangling of metaphor and simile of the dream. As he discovers how dreams are constructed, he discovers or creates techniques to uncover them. His technique was iterative and reciprocal; the more he interpreted, the more he learned about dream construction.[6]

We recall Freud's Irma dream as a paradigm of dream content and the work it entailed and dream interpretation and its work. (Blechner, (2013) summarizes post-Freud development of ideas about dreams. This goes beyond this paper. The basic ideas remain fundamentally the same: "impose *waking meaning* on *sleeping thought."* (Stimmel in Blechner, 2013)

This paper's primary approach is comparing Maimonides's account (of the "work" of the *Torah and* his *Guide)* with Freud's description of dream work. We will review allusions to techniques (Maimonides' and Freud's) for unravelling what is hidden in both texts. In fact, Maimonides uses the the Hebrew *histir* — hidden or secret—for content in both *Torah* and the *Guide*. In this analogy, Freud's dreams are like Maimonides' *Torah:* Freud's interpretative techniques are like the *Guide.* This is paradoxical for Maimonides, who *both conceals*, yet also offers techniques to *reveal* the hidden truths. Maimonides, we can say, is doing "textual" analysis, a form of analytic explication pre-Freud.

Dreams are a version of "secret" communication (to ourselves). The nature of secrets and secrecy is that tension is built into them (Szajnberg, 1991). Unlike privacy (which lacks this tension), the secret is something held *and withheld;* the secret hints at both its value and that it can be revealed...but only to the proper or deserving audience (Szajnberg, ibid.). Like the sacred (versus the profane), the secret is precious ground and differs from the mundane (Durkheim, 2008; Eliade, 1987). Only valuables are kept hidden or secret, such as the family jewels. Maimonides' thesis: while much of the *Torah* is overtly understandable (e.g. the Ten Commandments), there are precious jewels embedded within the *Torah*. Further— bringing us closer to Freud's dream book— Maimonides knew that if he were to overtly reveal the hidden secrets of the Torah, he risked excommunication.[7] (There is a long tradition of esoteric secrets ranging[8] in parables — "I have yet many things to say to you, but *you cannot bear them now*." John 16:12.) —through Galileo writing

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(5) Freud pulled back from this position, but reinstated it in later works. (Auchinclass and Sam-berg, p. 64).

(6) We might consider Freud's process as iterative, reciprocal, however: as he tried out different dream uncovering techniques, he uncovered more about how dreams are constructed

(7) So too, Freud felt 'excommunicated' by both colleagues and members of polite Viennese so-ciety after his outrageous statements about our inner lives and wishes. Some analytic histori-ans dispute the degree of Freud's isolation. (Gay,1998; Makari, 2008, 2013). We recall that even in the (early) Enlightenment, Galileo tried to hide his discoveries from the Church by writ-ing in mirror handwriting, a technique not sufficient to keep the Church from condemning him to home quarantine. Much earlier, Jesus stated that he spoke in parables for the public, but spoke the "truth" to his disciples. "I speak to them (the hoi palloi) in parables, because seeing they do not see, and hearing, they do not hear, nor do they understand." (Matt. 13:10-12). Earlier these words were "borrowed" and transformed from Psalms 135:16, Isaiah 6;10-10; Proverbs 23:9) as is often the case in New Testament (unattributed) quotes. As analysts, we are not surprised that the oppressed (Jesus and his disciples) would over time become the oppressor (The Church and Galileo, the Church's immolation of Giordano Bruno among others). Yet, Freud believed that true mastery of dream interpretation took place in the dialogue of the clinical setting, more so than in a written text on technique. Maimonides states strongly in the introduction to his *Guide that the proper way to transmit such knowledge is by dialogue*. His written text is a compromise, pressed by the diaspora and the persecution of Jews within both the Islamic Maghreb and also Christian states.

(9) That is, even for his treasured disciple, Yossef, Maimonides not only disguised the *Guide* from the common man, but *even* from his own disciple. Yossef would have to study avidly to understand all or most of what Maimonides hid and hinted. Further, Maimonides argued that the Torah was written in this manner. And in *New Testament*, Jesus say overtly to his own twelve disciples, "I have yet many things to say to you, but *you cannot bear them now*." John 16:12.)

in mirror script, up to Freud and the present.) Therefore, Maimonides wrote the *Guide* esoterically, using parable, metaphor and contradictions in order to both conceal and reveal the secrets within.[9] Like Freud, Maimonides offered techniques to guide us to understanding our nether world, embedded within *Torah/*dreams.

One reason to study Maimonides' *Guide* is that it contains wisdom of the human soul, at least the wisdom of a twelfth century genius. Is this outdated? Let us hold judgment on that. But for now, recall that Freud considered himself a healer of the 'soul,' the Greek Psyche, which has been Americanized into psychic conflict. Further, Murray Wax (1992), an anthropologist and psychoanalyst, has argued persuasively that the human mind has evolved slowly in the past few millennia.[10] We are still captured by the human tales of Shakespeare's Hamlet or Lear, of King David's lust for Bathsheva and his son Absalom's betrayal, of Abraham and Sarah's barren yearning for a child, and of course, Oedipus's patricide and incestuous acts. Ancient tales resonate with something human inside us despite their antique origins. I will develop further that Maimonides's thoughts about the *structure* of the Torah and *how to reveal its secrets* carry similarities to Freud's ideas about dream structure and how to reveal truths that lie within.

The architecture of this paper is as follows. I rely heavily on one of several papers by Leo Strauss, as well Pines' English translation of the *Guide*. Strauss's 654 page volume of papers on Maimonides reveals his lifelong interest, even preoccupation with this thinker.

Three papers, foundational to this essay, are entitled "The Literary Character of *The Guide of the Perplexed* (1941); *Introduction to The Guide of the Perplexed* (1960); and *How to Begin to Study the Guide of the Perplexed* (1963).

This paper will depend primarily on the "Literary Character" study. Like Alter's brilliant single-handed translation of the *TANACH (Torah, Nevi'im and Ketuvim)*, Strauss treats the *Guide* as a work of literature.[11] This permits Strauss to study semantics, syntax, characters, plot lines and overall structure, like any great literary narrative.[12] He studies the architecture of the book's construction. This contrasts to religious studies of texts, which the orthodox treat as holy, the word of God and hence incomparable.[13]

As Alter points out, as did Strauss, using a literary framework permits the student of the *Torah* or *Guide* to side-step the arguments over the *Torah* was written by God, or by the hand of man guided by God (or even by the hand of man alone). Shifts in literary style and contradictions exist within the Torah. A fine writer (or adroit editors) can introduce stylistic changes, contradictions even developmental shifts in greater knowledge as stylistic techniques that teach us something about the text. And in the humanistic studies, when we study a great text (*Torah* or *New Testament*, Virgil or Dante, Shakespeare) we learn something about the human soul that resonates and enlarges our understanding of ourselves and humankind. This is why Bloom referred to these texts as "wisdom literature" (Bloom, 2008). Aristotle pointed out that tragedy permits us vicarious emotional experiences. This is true for great literature.

We benefit from Ricoeur's hermeneutic approach to Freud's writing: studying the text of the *Interpretation of Dreams* as if it were a text with embedded meanings that an hermeneutic approach can help unveil (Ricoeur, 1977; Szajnberg, 2018). By approaching both Freud's *Interpretation of Dreams* and Maimonides' *Guide* as literary texts, we can avail ourselves of hermeneutic comparisons. Yet, as we describe below, matters of the mind are not so simple—neither Freud's nor Maimonides'.

Begin with two fundamental commonalities between Maimonides' Guide and Freud's Irma dream in particular on representations in dreams.

First, Maimonides, like Freud, believe that oral dialogue is by far preferable to study either *Torah* or dreams (Strauss, P. 351).[14,15] Socrates dialogue or Aristotle as the peripatetic philosopher would have been known to Maimonides. This peripatia contrasts with psychoanalytic technique, but takes us beyond this paper for the time being. The written is a *forme fruste*, a degraded version of the oral dialogue and not as dynamic. Freud even asked that his patients not write down their dreams. Strunk and White's *Elements of Style* (2005), would repeat this thrice, to emphasize its importance: the oral/aural method gives us greater access to the poetic. In fact, the *Talmud*, while written, is written as a series of dialogues, even arguments. The Torah is read aloud thrice weekly and some study Talmud at double desks for debate.

A second feature of both texts—the *Guide*, the dream book— is that they are *fundamentally about uncovering hidden* "*secrets."* Visual images are a specific technique of hiding matters in both Guide/Torah and dreams. The visual hides secrets *and* in order to understand the meaning behind the visual, one must articulate this into intelligible speech. Maimonides states at the beginning of his lengthy *Guide* that he will cover only two major passages: the Creation of the world and Ezekiel's (hallucinatory)[16] dream. Both passages are highly visual: like a dream reporter and analyzer, Maimonides concentrates on translating these into words and further into interpretations of the narratives. Dreams are

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(10) Yuval Harrari's *Sapiens* (2014) suggests that over millenia, there are some shifts in human behavior and thinking such as from hunter/gatherer to agricultural existence.

(11) One of his better known teachers is Emil Fackenheim and his colleague (of his refugee Chi-cago years) Allan Bloom.

(12) Borges in *This Craft of Verse*, (2002) also treated Torah with the same respect as he did other great literary works, permitting cross-comparisons.

(13) However, the religious will compare their own holy text to others, generally in unfavorable ways. For instance, a religious Christian will read the *Torah* as a *forme fruste* of the New Testament; the *Torah* predicts the truth of the New Testament (Auerbach, 2013).

(14) That Socrates engaged in dialogue and Aristotle was known as the peripatetic philosopher would have been known to Maimonides. This peripatia contrasts with psychoanalytic tech-nique, but takes us beyond this paper for the time being.

(15) "The inferiority of writing is also indicated by the designation of those biblical works which had not been composed by prophets proper as 'writings.'" (Strauss, 351).

(16) "Hallucinatory" is Alter's (2019) term for the Ezekiel's highly visual account of his traveling to heaven and seeing God enthroned.

ambiguous: they both conceal and reveal, just as Maimonides showed that *Torah (*and his *Guide)* both conceal and reveal. This is a cognitive/emotional shift (upwards) from the more primitive visual to the developmentally advanced representation of words, speech, and stories. I will elaborate these two principles further, but fundamentally they underly the commonalities of these two texts. Or in fact three texts. For Maimonides *Guide* sees the *Torah* as also a text filled with secrets.

Here is another way to explicate the parallels between Maimonides' view of *Torah* and Freud's view of dreams. For Freud, explicated (remembered) dreams are manifest. The latent lies beneath and can be discovered with specific techniques. And the latent is more meaningful than the manifest.[17] For Maimonides, the *Torah* is a manifest presentation (with laws that should be followed); hidden beneath is latent meaning, which can be explicated using the techniques described (but in a hidden format) by Maimonides. Yet, Erikson's (1954) profound contribution was that we can find hidden meaning even in the manifest. And this explication can be accessed and used only by a select few who are highly trained. The latter description could have been applied to psychoanalytic training at one time, and certainly is applicable to those who would know the Torah by heart, know Talmud and also know Aristotle's reason and science.

For the moment, heuristically to stimulate our further investigation, let's consider this analogy: the *Torah is to dreams as the Guide is to Freud*'*s dream book, c*hapters five through seven. While many dream interpreters prior to Freud suggested that dream symbols show *how one should live one*'*s life* (the dream as prophetic), Freud introduced the concept that dreams are visual manifestations of hidden interior wishes, thoughts, feelings, to be used to understand one's inner life. That is, Freud's idea about the visua[118] dream is that it "joins" the long history of esoteric "literature": narratives that have meanings that are hidden, yet also contain revealing information for the "educated." (Strauss; Halbertal, 2007) Paradoxically, Freud pointed out that the dream is more determined by our ancient past (and a day residue) and is "predictive" of our futures if uninterpreted, not understood. On the other hand, an understood (interpreted) dream "predicts" a future less encumbered by Unconscious wishes or impulses. So too, Maimonides believed that the *Torah* had an explicit text about how to live one's life, what to "do", versus his *Guide*'*s* view that the *Torah* had hidden meanings about how to think and believe. More specifically, to follow (without understanding) the Torah commandments and prohibitions, is to follow out of fear of God. It is transactional: do good and you'll get good; do bad and you'll be punished. In contrast, to follow the subtleties of Torah—subtleties revealed through greater knowledge (including scientific knowledge) is to follow Torah out of love of God, as well as a more humble stance vis vis the universe: man is decentered form the universe one the tis not a *quid pro quo* transactional relationship with God (Halbertal, ibid.)

The analogy is not strictly accurate: Maimonides was renown for his earlier *Mishne Torah*, which explicated the Torah's laws and how to do them. He goes further with the Guide, about how to think about the Torah. But both books—the *Guide*, the *Interpretation of Dreams*—are about interpretative techniques to uncover the hidden and more meaningful. A significant difference is that Maimonides revealed how to discover the hiddenTorah; Freud allegedly revealed in writing how two discover the hidden (prohibited topics in Victorian Vienna), despite concern that the would be criticized or ostracized. I note "in writing" because I suggest that Freud revealed more of the fundamentals of interpretation embedded within transference in his analyses.

One additional perhaps more subtle parallel among the texts (*Torah, Guide*, Dream book): while much takes place in dreams (and *Torah*) with visual images, it is predominately, perhaps *only* via articulated words between humans that the underlying meanings are understood. That is, a fundamental "translation" must happen from image to word (and further to understanding the concept and feeling beneath the word) that full understanding of the Biblical story/dream can take place. In practice, the Torah is read aloud in a community. And, as Walter Benjamin remarked, *traduttore, traditore,* translation is a traitor. How often do we hear from analysands (or ourselves) that the dream report lacks something from the dream remembered and experienced?

A further parallel between Maimonides' attitude towards the Biblical text and Freud's towards the "psychoanalytic text", whether dream or parapraxis. Psychoanalysts are a suspicious sort: any dream, slip, remark, means both itself and something (more meaningful often) that is not stated, or stated in disguise. Maimonides turns our view of the Bible around, or at least makes it more complex: each Biblical remark certainly means what it says ("Thou shalt not kill"), yet *also speaks in parables, enigmas*. For Maimonides, as he is trying to teach us, to fully understand the *Torah* means to decode its parabolic and enigmatic layers. Both Freud and Maimonides are on a trail of the unspoken, the hidden, the disguised, to reach *the more meaningful.* Before turning to specific techniques of concealment in the *Torah*/*Guide* that anticipate Freud's comments on dream work (and subsequent interpretation to "undo" the work), let us look at Maimonides' account of why he wrote this *Guide*.

To be clear, we are suggesting here that there may be something inherent in the more hallucinatory or imaginative visual images we create that in order to understand them, we must narrate these into word stories. This was an insight for both Maimonides and Freud.

Maimonides was previously known for writing the *Mishne Torah*[19], his detailed account of all 613 laws in the *Torah* and how to follow on both prohibitions and commandments, the negatives and positives. How does the *Guide* differ? The

(17) Erikson's (1954) profound contribution was that we can find hidden meaning even in the manifest dream; his paper was so controversial, that Anna Freud blocked its publication for several years.
(18) Freud commented that speech in dreams was less frequent and often represented some-thing heard during the day.
(19) He wrote this masterpiece after writing the commentary in his mid-twenties (Halbertal, op. cit.).

Mishne Torah is *halacha,* the "science of the law," (p. 344) of praxis. The *Guide* is *agada,* the *true* science of the law, which *tells the reasons* beneath commands and prohibitions. The Hebrew root of *Halacha* is *holech,* to walk, or how to walk through life in a "lawful" novel manner (Strauss, p.344). There is hidden wisdom in the root of *Halacha* akin to Aristotle's perpatetic.

The Hebrew root of *agada*, is *l'hagid,* to tell, as in to tell a story. And stories are to be spoken, for Maimonides, the preferable way to teach. The premise of the *Guide*, is to reconcile *praxis*, the actions of the law, with reason, which for Maimonides meant Aristotle. In different terms, the Torah is about what to *do*; the Guide is about what *to think and believe*. (Maimonides 2.10; II a-b, 3-5; Strauss, p. 344)).[20,21] And of the many secrets of *Torah,* the two major secrets the entire *Guide* tackles (both concealing and revealing) are the *ma'aseh bereshit (*the matter (or "doing") of Creation) and the *ma'aseh merkavah,* the matter (or "doing") of the chariot)*.* The Chariot story alludes to Ezekiel's vision of ascending to heaven on a fiery chariot and seeing the Lord seated on a throne. Alter refers to the latter as the most hallucinatory in the *Tanach*. Let us accept that for Maimonides, creation was the greatest of miracles (and if one includes the Adam and Eve story, prophetic of mankind); the Ezekiel story, one of the more remarkable of prophetic visions, topping Isaiah's. For Maimonides, these two visions are equivalent to Freud's Irma dream: remarkable visual narratives which can be translated into narratives, thereby revealing what's hidden within. Freud turned to other dreams in the dream book, but he devoted an entire chapter to the Irma dream, and kept returning to it. In *Torah,* how *visual* is the story of creation (*tohu v'vohu (*emptiness and void); the sky, the seas separated from the earth; flying or other animals, the serpent first on legs, then condemned to belly-crawl; the nakedness of Adam and Eve—its visual revelation leading to their exile). These are parallel to Freud's dream images.

Further, these two stories, per Maimonides, cover two fundamental disciplines: physics (the creation of the world, including the laws of physics that govern us) and metaphysics (the Chariot story that brings us closer to understanding God and his angels).

Here, we will offer only a gloss on the *Guide* to demonstrate some parallels to the Dream book. To give an understanding of the *Guide*, as Strauss confesses, would take a book-length study. (But, a psychoanalyst might say the same of understanding the inner life of humankind.)

Freud offers early in his dream book, how the dream work proceeds: with predominately visual, hidden symbols and metaphors, even parables that both conceal and reveal (Freud, 1900). *For Freud, thoughts are made conscious through words/language.* Well, let us then begin with examples from Maimonides of how the *Bible* (and his *Guide)* engage in the same kind of "visually revelatory" "work" of concealment.

First, a breathtaking statement by Maimonides that matches Freud's dictum that dreams are mostly visual (and hence a way of hiding words or more so, thoughts, feelings, and particularly wishes). A complementary idea from Freud is that thoughts are made conscious through words/language. Dan Stern (1985) describing the development of four levels of self, articulated the paradoxic that the fourth level is with full speech: upon achieving speech, there is a *distancing* from earlier levels of self. Maimonides states that *all Torah visual descriptions* of God, particularly anything alluding to human characteristics, are misleading, are *not true.* He challenges popular (mis)understandings of the *Torah* further, stating that *God can only be understood by what he is not.* Most *Torah* readers might respond (in surprise) that the *Torah* states that God created man in his image; that God is described visually as sitting upon a throne, Moses was shown the back of God; for Ezekiel, God sits on his throne. Misleading balderdash, Maimonides might state. He argues that God is like no other being on earth nor in the universe: any human description of him is but a symbol or metaphor to facilitate humankind's understanding of God. *And, these visual images also mislead our understanding*. This paradox haunts the *Torah* reader through the *Guide*. We come to another paradoxical premise of the *Guide.* Maimonides states that he will explore the reasons behind the commandments and prohibitions. Yet, one of the prohibitions in the *Torah*, is that an entire set of laws, *Khukim*, should not be explained! How does Maimonides, an observant Jew, address this prohibition? He sidesteps it by not calling the *Guide* a book, rather in Judeo-Arabic a *maquala (ma'amar* in proper Hebrew). *Ma'amar*, is from the Hebrew root, *amar,* to say, or a speech. Both *agada* and *ma'amar* put Maimonides *Guide* in the realm of the spoken. And for Maimonides, hints are more easily embedded in oral teaching and more valuable than the explicit statement of written texts. The *Guide* is Maimonides' "attempt to revive the oral discussion." (Strauss p. 353). This reminds us of psychoanalysis as an oral discussion of the patient's unconscious (which we can think of as an esoteric text/narrative) manifest through dreams, fantasies, transference and other components.[22]

Maimonides major premise is that the *Torah* is wrought with hidden secrets and the *Guide* will aid the educated student to uncover the secrets embedded within the text. Therefore, a major component of the *Guide* is to describe how secrets are hidden. I ask the psychoanalytic reader to listen with an inner (or third) ear to hear parallels to Freud's account of Dream Work—the mechanisms by which the Ego hides Unconscious, unacceptable, secret, wishes. You will find a remarkable resonance with this prescient, Medieval text.

One technique used in Bible to hide matters is *repetition or rather variations on a theme*. For instance, in the "Job" story,

(20) Maimonides distinguishes different types of "law." Here he uses the Arabic, fiqh", the "true science of the law that is what man out to think and believe" (rather than only behave (Strauss, op. cit.) (Szajnberg's italics added).
(21) There may be hidden wisdom in the root of Halacha; here as with Aristotle, is a form of the peripatetic.
(22) I thank Sandor Gilman for this brief summary of psychoanalysis as well as his commentary throughout this paper.

he has four "friends" who visit him at the same time and try to convince him to renounce God after Job's entire family and livestock have been wiped out. But, Eliphaz, Bildad, Zophar and Elihu appear to give the same reasons to convince Job. Yet, Maimonides asks us to read more carefully, and we find that there are variations amongst the arguments of the four friends.[23] And—here Maimonides is a prescient Freud—tells us that it is *within the slippage of the apparently minor differences that we will find the true message* of the Bible. Another Maimonides example is the repetition of the creation story, but with variations. And a further example is how Ezekiel repeats his hallucinatory celestial vision, but with slight variation. And Ezekiel's vision is a variation of Isaiah's earlier vision. Rather than see this as "errors" in the Bible's account, like the analyst, Maimonides seeks meaning in the variations, even "slips" of repetition. We might call these textual parapraxes.

This reminds us of Freud's (1900) suggestion that when a dream seems unclear to us, we ask the dreamer to repeat it: when we hear variations, we can suspect that the ego hinting at significant material in those shears of the dream's layers. Asking the analysand to repeat the dream will reveal slight slippages, variations, along which we will discover fuller meaning. Explore the shears to get more readily at what is being concealed/revealed by the ego.

As Strauss (1960) puts it, Maimonides sees the *Torah* (and writes his *Guide*) as "repeating conventional statements ...*to hide the disclosure*... of unconventional views."(p. 367, author's italics) So too, we can say, Freud saw in the mundane (parapraxes, dreams) ways of hiding disclosure of unconventional views. Further, Maimonides believes that "to grasp the totality...(one must) grasp each word which occurs..." (368-9). Again, these are techniques familiar to good psychoanalytic work.

Maimonides offers three other techniques of Biblical obfuscation of hidden meaning: *secrets, contradictions and irregularities.*

As *secrets* are the most complex of techniques, let us start with the simpler, irregularities. In a long series of chapters on God's place and types of movement, the *Guide* interrupts with a section on the meaning of "man." In *Judges,* mourning laws are inserted. These irregularities happen in *Torah*, for instance in the over forty chapters of the "Joseph" story. Suddenly, after Joseph is sold into slavery by his brothers (they reconsidering their plan to murder him), there is an entire chapter on Judah's virtual incest with Tamar after her deceit of him. Without entering the details of Maimonides' exploration of the meaning of these interruptions, let us say that, like Freud, he finds meaning hidden and betrayed to reveal "a deeper order, meaning." (Strauss, 2013, p. 363). Alter, an astute scholar of the *Torah,* is puzzled by the Judah/Tamar chapter. In a recent book on Jacob and Joseph (Szajnberg, 2018) the Szajnberg suggests that this intrusive tale tells us what happens when that overseer, Joseph, is removed from the family. Yet, it also tells us the power of this near-incest: Judah, the father-in-law impregnates Tamar, whose two husbands (Judah's sons) died shortly after her wedding them (specifically after intercourse) and generations later, the fruit of her womb is King David.[24] This nuanced tale hints at both the transgressive act and its fortunate (redemptive?) outcome. This Judah/Tamar interlude puzzled Alter (2019), an astute literary scholar. But, (Szajnberg, ibid.) offers an explanation from a psychoanalytic perspective. With this, let's return to Maimonides and Freud.

Pause to look at how Maimonides understood the literary structure of the *Torah,* before we can explore the hiding methods further.

For Maimonides, the *Torah,* is mostly written as parables and enigmas. In fact, Strauss uses the term "parabolic" to describe Maimonides view of *Torah* structure. And a parabola is an indirect way to connect two points. While it is not as simple as a line, it has geometric laws governing its path (y=x squared), as do the parables or enigmas of the Torah. It is the "formulas" for the parables or enigmas of the Torah that guides the Guide. So too, Maimonides explored the geometry, the logic, that uncover the laws that govern the writing of the *Torah.*

Now the method of the *Guide*. Maimonides deliberately chooses *not* to write it in parables or enigmas, as this would simply copy the *Torah*'*s* structure. Rather, he chose to write with obscurity and brevity. Also, *contradictions* can be a substitute for parables. And Maimonides' contradictions are elaborate, complex (Strauss, (1960). Finally, Maimonides insists that parsimony will more likely lead to the truth.

Here is an obvious *contradiction*. Maimonides states that the *Guide* covers two subjects and two subjects only: *ma*'*aseh bereshit and ma*'*aseh merkava,* the story of creation and the story of the chariot (Ezekiel's visions), both are highly visual, even hallucinatory events "translated" or transformed into words. He further states that studying *ma*'*aseh bereshit* is like studying physics; studying *ma*'*aseh merkava,* is studying metaphysics (by which he means Divine knowledge (of God and the angels)). Then, he states that the Guide *will not* be about physics nor metaphysics! Strauss offers some guidance. When there are contradictions, the answer must be one or the other (not some compromise in between). And since we know from reading the Guide that it is almost entirely about what Maimonides considered the two greatest miracles or prophetic visions—the creation of the universe and Ezekiel's dream/hallucination—we know that Maimonides is writing about them and hence about physics and metaphysics. But, why write this contradiction? As mentioned, Maimonides wrote in an era when to write about certain aspects of the Torah, to explain it (including God's incorporeal being) would result in his being excom-

(23) To detail these here, just to detail Freud's associations to the Irma dream, would go beyond the bounds of this paper.
(24) This tale is predated in the Book of Ruth, albeit more delicately. Ruth's husband dies, leav-ing her childless. Like Tamar, she dresses up to seduce Boaz, a relative (like Judah). Her off-spring, most famously is Jesse, David's father. That is both in Tamar/Judah and Ruth/Boaz, infertility is remedied by a pseudo incest (an extension of Leverage marriage) and the forerun-ners of King David, a great redeemer of the Jewish nation, and a man who transgresses fur-ther by wedding Bath-sheva after purposely sending her husband to die in battle.

municated (placed on a *kherem).* His contradictions offer deniability, some protection (Meltzer, 2014).[25] This may be similar to Freud's efforts in his work with hysteria at a time when hysteria was almost an anathema topic and certainly thought to be a physical ailment, popularized by one of Freud's teachers, Charcot.

Strauss identifies at least six ways in which Maimonides conceals via contradictions. We ask the reader to bear with brief descriptions of the *mechanisms* used by Maimonides to hide contradictions (and simultaneously leaves crumbs for us to follow the paths to revealing secrets). As we list these six techniques, let us keep in mind how much they resonate with Freud's account of how in dreams (and parapraxes) significant meanings are both hidden and revealed.

First, one can speak of the same subject in a contradictory manner, but in pages far from each other. Second, a variation: make "one of the two contradictory statements in passing" (Strauss, p. 373). (Here, consider of Freud's focusing on the "passing" remark in his Irma dream "at once" and focuses on this brief phrase.) Third, contradict an initial statement by contradicting its implications (by indirection). Fourth, contradicting by repeating the statement, but with a meaningful omission or addition.[26] Fifth, a variation on the fourth, is to place an intermediary remark between two contradictory statements, such that the intermediate statement points the reader towards Maimonides true meaning. Sixth, to use ambiguous words (and the category of ambiguous words is expanded later by Maimonides. Of course, the nature of ambiguity (words or statements) is one of Freud's major clinical discoveries from the Dream book onwards.

We give but one example here of how to figure out which of the two statements are true. Maimonides states that a fundamental basis for all contradictions in the *Guide* (and hence a hint to decoding these) is the contradiction between *true teaching based on reason* versus *untrue teaching based on imagination.* And, true teachings are secret, and are rare. Therefore, if we read two apparently contradictory statements in the Guide, we can ferret out that the *statement that is less frequent or even stated once is the secret and hence true statement.* Maimonides gives two examples of this from *Tanach.*

1. The belief in resurrection of the dead (Maimonides believes this is true at the end of times) is stated only *once* in *Tanach*, in two verses of Daniel.
2. The statement, "The Lord is one," upon which Maimonides basis the unity of God, is *not* repeated in the *Torah*.

Let us turn to one other (of many) techniques that Maimonides identifies in the *Torah* and uses in his *Guide* to disguise and reveal truths, the use of hints. Maimonides gives four examples of hints used in words alone (there are more techniques used in sentences or paragraphs).

1. Secret words used in ambiguous ways. For instance, a single word can pivot us from one category of thought to another. *Al-af-al*—meaning actions from the commandments—is a pivotal term that shifts our attention from sections on *opinions* to sections on *actions*. Or, the ambiguous Arabo-Judaic term '*amr,* can mean either a thing or a command. (This is similar to the Hebrew *davar* which may mean "word" or "thing." It is famously used in the Jacob Joseph story after Joseph's second dream of having the moon, sun and elven stars bow to him. He is first reprimanded by Jacob, then we are told that Jacob kept this *davar,* (word, thing) in mind.) But, we recall that Freud believed that "words" brings "things" into consciousness.
2. *Apostrophes* or *mottoes*: these are used in the original Greek sense. An apostrophe is an exclamatory address to a dead or absent subject, as well a turning away, an elision; mottoes are prefixed to words and these short phrases encapsulate a belief or ideal.
3. Silence or omission. For instance, Maimonides partially quotes from Aristotle to mislead the uniformed reader to think that Maimonides agrees with Aristotle's belief that touch is a bad thing. But, the scholar (of Aristotle) would know that a full quote reveals that Maimonides believes the opposite, disagrees with Aristotle, based on Jewish beliefs.
4. Chapter headings that allude to or misdirect the casual reader. Maimonides' historical situation explains his technique. Rabbis insisted that the secrets of the Torah can only be alluded to by chapter headings (not full explication). Maimonides does a minuet around this, risking excommunication. He gives chapter headings pregnant with meaning; writes chapters which are allusive.

In Part two we turn to Freud's Irma dream to see one parallel between both Freud's explication of how "distorting" dream work happens *and* how Freud's interpretative technique untangles the hidden meaning. We will see a parallel to Maimonides technique of critical reading of the *Torah*, and his technique of hiding/revealing in the *Guide*.

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(25) Meltzer's Philosophy Between the Lines: the Lost History of Esoteric Writings (2014) is a panoramic sweeping perspective on esoteric (that is, hidden/revealing) writing from the time of Bible and Plato until about the early eighteenth century, when, as Goethe lamented, secre-tive/hidden writing was abandoned, even abhorred in liberal, democratic societies, even as it continues to be used both in totalitarian regimes, and more subtly, in academic disciplines and democratic societies. He cites Leo Strauss, who escaped the Nazi regime, for recognizing the degree to which hidden/revealed writing has been used in the past and the four different moti-vations for such writing between the lines, and hence the importance of learning how to read between the lines to understand the Szajnberg's honest intent. That is, per Strauss, serious writing is written in layers, a concept familiar to psychoanalysts.
(26) Strauss offers as an example how Maimonides, a scholar of Aristotle, first quotes Aristotle and later repeats the quote with a meaningful omission that reverses the meaning of Aristotle, a reversal that accords with Maimonides' meaning.

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A Half-Century of Experiencing Psychoanalytic Theory

By Norman A. Clemens, M.D.

When we begin an encounter with a patient, we each have an implicit model of the mind somewhere in the back of our mind. We have been building it since as kids we began to think about how people think. Our model may be founded on early life experience, religious teachings, the liberal arts, academic psychology, and the complex biology learned from neurology and general medicine, but most of all it has been enriched by entering the mental life of patients. We are further imbued with the scientific theories and studies of our time – biological, sociological, behavioral, and now, psychoanalytic. But ultimately our model has been enriched and verified by introspection and entering the mental life of patients.

Out of this mass of information, we have tried to figure out what makes sense because it works. We try to find some objective anchor points in a vast, swirling subjective field of experience. We have studied the writings of those who have gone before us and found the unfolding, sequentially more complex formulations of the psychoanalysts, starting with Freud's studies of the 1890's. From all of this we build our own theory of the mind. It is always provisional, open to question.

Here is how my working psychoanalytic theory of the mind grew. My career in psychiatry began in 1960. That is half of the 122 years from Sigmund Freud's publication of The Interpretation of Dreams to this moment. After exposure to some notable psychoanalysts as a student at Harvard Medical School, I interned in Medicine at University Hospitals in Cleveland. I saw the importance of mental health issues there in my medical patients, and I chose Psychiatry over Medicine.

I stayed in Cleveland because it is a beautiful city for living and the arts, and because Western Reserve Medical School had pioneered a dynamic, integrated new curriculum that had been the (unacknowledged) experimental model for my first year at Harvard Med. University Hospitals of Cleveland had initiated a psychoanalytically-oriented residency program that entailed active interaction between psychiatry and other services. Psychotherapy was taught throughout the residency, along with ECT and the earliest psychotropic medications for depression, anxiety, and psychosis. Faculty member Brian Bird's book, Talking with Patients, became a model for practical, wise clinical consultation and engagement with patients.

Our chairman, Douglas Bond, had served with the US Air Force in England during World War II and been able to learn about psychoanalysis with Anna Freud in London. He had worked psychodynamically with flyers who had returned

from harrowing flights and suffered from what we now call PTSD. He had published his findings as a book, The Love and Fear of Flying. He brought a group who had worked with Anna Freud to Cleveland to establish a pioneering therapeutic nursery school, which still exists. Miss Freud gave her ongoing support and made several visits. I recall a memorable talk that she gave to the Western Reserve medical students about why people are motivated to become various kinds of doctors. One of our sons "met" Miss Freud as a four-year-old student in the Hanna Perkins nursery school, where she was quietly observing. (He off-handedly reported to us, "Miss Ford. She had lines on her face.") Child development was a major focus in our psychoanalytic community. The Cleveland Psychoanalytic Institute had formed in the Department. Morale was high.

I enjoyed engaging with patients. Given the influence of Anna Freud—and other analysts in Cleveland who had studied with Anna or Sigmund Freud and other giants—my growing, personal psychoanalytic model of the mind reflected the prevailing structural model of dynamic interaction between Id, Ego, and Superego. Though this was the new shiny object, we were also aware of the topographic model that underlaid it—Cs, Cs, Pre-Cs, repression, etc. Those basic processes are still clinically relevant. Whatever we do in analytic work, we bring some of the Ucs mind through Pre-Cs into Cs (consciousness). We sense the driving forces of libido and aggression. We distinguish primary process from secondary process thinking. We identify conflicts and defenses and bring clarity through releasing thought from repression and giving it words.

If we have been fortunate enough to read Freud's The Interpretation of Dreams, we marvel at the process of associations on the mind and brain. We also see the displacements, condensations, reversals and so on—and realize how the associative process affects our everyday thinking. Being in psychoanalysis makes you even more aware of that. One of the most useful analytic works that I have ever read was written by a Harvard classmate and friend, the late Anton Kris: Free Association. A major goal of undergoing psychoanalysis, in Kris's view, is to allow oneself to be conscious of what comes to mind and, in therapy, to speak of it. It is useful, though difficult, to be honest with ourselves. This self-awareness is a gain in its own right, not just as a means for deepening the work. We enable analysands to achieve it largely by creating a safe place, attentive listening, and helping them to listen to themselves.

The topographical model also introduces child developmental themes, such as persistent wishes from infantile strivings and subsequent Oedipal longings, the evolution of primary process into secondary process, the role of repression, psychic conflict, the repetition compulsion, and neurosis. This is groundwork for what follows in our model of the mind.

The structural model goes beyond that to recognize the ego that introduces logical thinking, engagement with the environment, self-control, mastery of impulses, and organization—a host of functions necessary for survival. Beyond that is the superego, which serves values, morality, standards, and critical thinking. These functions are in constant dynamic interplay with the biologically driven forces (libido and aggression) that are essential to life but potentially destructive if not managed. This sets the stage for conflict, defenses, reality testing, rational thinking, and a lifetime scenario of maturation and dealing with all the challenges of the life cycle. When conflictual forces are too complicated or overwhelming to be resolved, the ego uses patterns we call psychological defense mechanisms which reduce anxiety or distress—but do not necessarily solve the problem. These unresolved conflicts show themselves as subjective symptoms and patterns we call neurosis—the classic psychoanalytic patient. The hierarchy of defenses that Anna Freud and others identified explained a great deal of maladaptive human thought and behavior. Interpretation, insight, and working through in the transference are key modes of technique developed from ego psychology.

The patterns of resolution of conflict may solidify as personality traits, a life pattern of behavior that may or may not be adaptive and ego syntonic. If not, these people settle into personality disorders; some may eventually ask for our help.

Heinz Hartman defined a metapsychology that comprised the dynamic, topographic, economic, and structural theoretical perspectives, to which he added the adaptational perspective. Such a dimensional approach strikes me as a precursor of today's dimensional approach to organizing models of the mind that appears in Auchincloss's book, the Psychoanalytic Diagnostic Manual, or the Alternative DSM V model for personality disorders.

Ego psychology contributes to our understanding of the phases of child development, originally named for their association with successive forms of libidinal gratification—oral, anal, phallic, and oedipal. These are associated with biological maturation of the nervous system, but highly dependent on interaction with parents and other caretakers as the child matures. Maturation of the aggressive drive occurs in parallel. All of this was intensely studied in the field of child development guided by the thinking of Anna Freud and many others. In sum, ego psychology was the predominant basis of psychoanalytic practice in the heyday of the mid-1900s, as I developed as a psychoanalyst and psychiatrist.

However, in Cleveland, as the older leaders died off, our child therapists became intrigued with the English Kleinians, the followers of Melanie Klein. Some leading lights in the study of object relations were brought over from England for weekend conferences. The Kleinian view of early child development from the Paranoid Position to the Depressive Position annoyed me by using adult psychiatric terminology this way. Yet I could see that as a different way of delineating the maturational process through which the child achieves self- and object-awareness, critical thinking, mastery of impulses, and conscience as the child matures. The core of its success is the self-object relationship in which the mother supplies love, nurturance, protection, guidance, modeling—

"good-enough" mothering and (I would add) fathering. Bion and others defined the experience of containment in helping the infant feel secure enough to integrate and master fear and aggression and ultimately achieve autonomy.

Winnicott gave us the terms of the "holding environment," and the "good enough" mother. Mahler defined the infant's need for object constancy and outlined separation-individuation as a developmental process. Failures of these parental relationships leave people who never quite became autonomous and loving selves and who have difficulty forming self-object relationships with another. They may seek to reactivate the process in a transference relationship. Bowlby added attachment theory to the study of relationships and autonomy.

Some bruising experiences with patients tormented by borderline personality disorder helped me get my head around the concept of projective identification, so confusing in its blurring of the sense of self and other. To a therapist who needs to maintain clear boundaries between self and other, or to keep very sharp definitions between real and unreal, this is very unsettling. One must learn to suspend judgment, play a bit, or be open to fantasy if we seek to be attuned to another. I felt that Winnicott captured this in his description of the analytic third, a shared state of mind in which an illusory third presence or state exists between the two persons and becomes a blended experience that can be mutually understood. Other analysts might view this as a mutually subjective experience of transference/countertransference. Both may be right.

Kernberg and Kohut have greatly extended the scope of object relations theory and developed important new treatment methods: Kernberg with Transference-Focused Psychotherapy; Kohut through mobilizing narcissistic transferences (mirror and idealizing). Bateman and Fonagy extended object-relations thinking to Mentalization therapy.

Heinz Kohut went on to define the realm of Self Psychology, the most recent nucleus of psychoanalytic theory. This revolves around pathologic Narcissism and normal self-esteem and sense of self. Ironically, his writing about analysis of the Self was ultimately based on his own self-analysis. Central to his vision of cure was empathy. (Could we even begin the work we do without empathy? Kohut took it to center stage for these patients.) He gave us many insights into narcissistic personality disorders. Many other studies address the development and restoration of healthy self-esteem. Issues of self-esteem and narcissism deserve notice with every patient. Closely related is the affect of shame in its many manifestations, in addition to guilt.

Other major schools of psychoanalytic theory have not emerged since the 1980s. However, all the theoretical positions of the overall model of the mind have successively been the basis of new or modified approaches to technique. Auchincloss considers the Relational Psychoanalysis movement to be a modification of technique largely based on object-relations theory rather than a model of the mind.

For me, the concept of transference has evolved beyond the repetition of archaic relationships and conflicts within the current analytic situation, to be interpreted and worked through with a neutral and abstinent therapist. Any psychotherapeutic relationship is potentially a new, actual selfobject relationship in real time, often with a sense of its own "analytic third". Not just understanding it but living it out together in a safe environment is an agent of change. The depth and degree of engagement enhances the likelihood of understanding and maturation. The core process is what is happening now in real time between two self-objects, within the safety of the analytic frame—even as it may revisit past relationships within the transference. As therapists, we are engaged, and we change, too, with some therapeutic relationships. We do this within a defined and trusted role, offering ourselves to serve for a time as self-object to the patient, that has a potential for benefit or harm and that necessarily has limits of scope and duration—the analytic frame.

Auchincloss's model of the mind is a dimensional model. Each successive model provided another perspective, another tomographic slice of the multi-dimensional mind. As with the three planes of 3 D tomography, all are needed (not to exclude the biological perspective) to have a comprehensive view. I found that in my own thoughts about a patient, one model or another would emerge to provide understanding of the moment in our analytic matrix, but others could round out the matrix. Each model builds upon the preceding one and may add depth of understanding. It is not a detached, intellectual exercise; it may have a strong affective charge.

On the other hand, Auchincloss cautions the reader about over-reliance on such integration of theoretical schools of psychoanalytic thought. Each model has its own coherence that is part of its power. Can we pick and choose a model without disrupting it? Probably, for each of us, one model that we grew up with as analysts will color all the rest; I am sure you have divined that I'm an ego psychologist at heart. Yet the object-relational perspective has affectively enlivened my therapeutic work. It helps to assure that "there is a there there," as Gertrude Stein would put it. Each dimension of psychoanalytic thought presents possible pathways to understanding our patients and steering our course, and we can sense what fits the patient.

This paper was based on Dr. Clemens' introductory presentation to his panel "Approaches to Integration in Psychodynamic Theory and Practice" for the AAPDP Annual Meeting, 2021. He credits Dr. Elizabeth Auchincloss's superb *The Psychoanalytic Model of the Mind* (American Psychiatric Publishing, 2015) for its inspiration.

Miniaturization: Dynamic Consideration

Scott C. Schwartz, MD

Size has always played a significant role in the creative achievements of every civilization since the earliest times and has through this means fulfilled psychological strivings and effects conceived, but of massive import. Though familiar and seen in literature, politics and theology, and significant throughout the age ranges of people, there have been few formal attempts to examine this universal phenomenon through a psychodynamic lens.

As far back as is known, governmental and religious buildings were created on a grand scale, many times larger than necessary, in particular given the technology of the time. The city gates in Sumer, Assyria, Egypt and Asian civilizations were huge and imposing, even to our view today, so we can only imagine the effect they would have had on a population used to living in small huts barely large enough to stand up in. We can only imagine a medieval peasant gazing at the West Portal of Amiens Cathedral for the first time, surrounded by carved Saints fifteen feet high praying to the Trinity 40 feet above. There is no great humility in such faith! The tomb of a Pharaoh 400 feet high next to a huge sphinx certainly bespeaks the divine imposing importance of the ruler within. In modern times, government buildings, from the U.S. Capitol to Hitler's Reichstag, have huge interior spaces designed to inspire awe, belief, and deference to the power of the government. Statues of heroes and Saints are invariably rendered much larger than life and are mounted on bases elevating their status even more. Similarly, monsters, ogres, and diabolical forces from Satan himself through fierce dragons, evil giants and Jabba the Hut are also huge images, created to inspire terror, hopelessness, or a sense of mortal danger. The tendency to enlarge is congruent with instilling blind obedience to a force that can easily overwhelm and destroy a human. Enlargement then can be seen to create psychological passivity, compliance and self- reduction.

As much as enlargement exaggerates our helplessness, miniaturization augments our sense of control and dominance. Historians write of paintings of wild animals as far back as the Lascaux caves done on a smaller scale to reduce their potential danger for the viewer. As much as huge buildings and statues were erected to stimulate our awe, anxieties, and obedience, miniature creations - dolls, models, statuettes, tiny paintings in prayerbooks duplicating the great frescos, and model doll houses or weapons of destruction - give us a sense of greater control over these frightening images. A deity is less scary if it fits in your pocket! Everywhere, since antiquity, people have adored cute little puppies, kittens, even baby lion cubs, much more than fully-grown, potentially ferocious animals. The act of miniaturization reduces the implied danger and changes the locus of control onto us.

On a more dynamic level, it allows us to play out our fantasies and desires. Creating dollhouse interiors allows for a home that has no leaks, doesn't get mortgage, and doesn't allow unwelcome visitors. A model bomber never runs out of fuel and crashes into a mountainside. The people it bombs fall over but don't really die, and like bowling pins can be set up again. When we build a model, we are the commander, the ruler, the general, or the pilot with no need to win an election or defeat an enemy. Scholars make mention of the attraction in literary history of the Lilliputians, a race of tiny beings. In early Superman comic-book stories, Kandor was a section of the destroyed planet of Krypton, made tiny and preserved in an oxygen-filled flask. Miniaturization is a challenge to the artistry of the creator. We stand in awe looking at a detailed model of a clipper ship, so much more if there are well-turned fittings and ornament, all perfectly crafted on a small scale. The skill of the artist mixes with the fantasy of dominance to transport the viewer into a magical world that mirrors the internal reality, rather than forcing adaptation to a world that may be too big and complex to be comprehended in a satisfying way. We decide what goes where and what color it is to be painted and how elaborate it is to be.

Over the centuries, miniature painting tested the skill of artists and the fantasy of owners. Portraits, prayerbooks, ivories, and sculptures tested the limits of artistic virtuosity and were always highly valued. In early Hebrew manuscripts, the concept of micrography or tiny writing created worlds of meaning beyond the main text. With the invention of eyeglasses in the 13th Century and the rise of universities, the microscopic script found in medieval texts was a means of fitting more text in a given space and a display of calligraphic mastery. Even in our high-tech world of photo-reduction, the tiny Bibles of the 13th Century with up to 18 handwritten lines to the inch remain unparalleled. In popular music throughout centuries, expressing in diminutive terms increases the desirability of the love object, while magnification creates repulsion. "This Little Girl of Mine" and "Little Iddy, Biddy One" come to mind like "Hey Little Freshman" and "Party Doll" among thousands of others. Elvis' "Big Boss Man" and "Mr. Big Shot" or "What's the Big Deal" through exaggeration bring out the intrinsic ugliness of a person or situation. The word "big" takes on a sarcastic overtone with Big Fuss, Huge Problem, Big Nothing etc. Rendering the external world created the need to make it understandable. Maps gradually evolved from showing Medieval symbolic representations

of theological concepts to creating the accuracy necessary for navigators, therefore requiring an elaboration of specific details and careful directions. Later, military strategy had to be based on correct awareness of terrain and cities, and the miniaturization of sections of a given territory became vital to planning battles and attacks. These dioramas can be seen as a 3-dimensional maps specific to familiarizing armies with a given area. With the development of the airplane for military and civilian uses, such dioramas provided more comprehensive information than a map, perhaps setting the stage for the aerial videos and panoramic productions so common today on the computer. As attractive and accurate aerial photography has become, there is a sense of absence of the concrete object in front of you. You can see a natural wonder from the air on a video, but you lose the actual physical contact with a modeled representation of the place. So, despite the vastness and comprehensiveness of the aerial photography, the charm is removed. Many museums of history provide dioramas of the rolling hills and the old buildings and structures on the given area.

Personal history

As a creator of models of ancient towns, I study these museum exhibits for inspiration, inaccuracies, technical ideas, and the sheer pleasure of enjoying creation on a tiny scale. It reduces the near infinite to conceivable chunks. For me, this becomes the main attraction of miniaturization: the shifting role of ourselves within our environment. When we are small children, a chair seat is as high as our shoulders and a tabletop is barely reachable. Some years later these perceptions disappear. Though it feels like that huge chair somehow got smaller, in fact it is our body that has imperceptibly enlarged. A well-crafted model creates a greater power differential for us seeing the accurate representation in tiny terms. Perhaps this is the appeal that models have with children. They universally enjoy model cars and trains, doll houses, and all manner of miniatures, the more detailed and realistic, the better. Parenthetical to this is the recent emphasis in modeling on weathering; removing the sparkle and sheen of a new object and creating dusty, rusty, broken, and filthy areas to appear closer to what it might be under actual atmospheric conditions. Experts will tell you that only two surfaces have natural shine: water and glass. Good modeling entails removing the shine from all other surfaces. There are available paints and powders called "rust", "grime", "dust" etc. meant to be painted on models to age them. This art, almost universally practiced today, no longer serves to idealize or glorify and object, but to recreate which be an actual slice of the world.

Like many other children, I built models of ships, planes, military vehicles, or rockets. I have always admired and studied different classes of vehicles. But my modeling life was altered when I saw at The Metropolitan Museum of Art a reconstruction of the Acropolis as it might have appeared in the time of Pericles. It included people and foliage. I was stunned! This was so much more elaborate than an F-86 Sabrejet! I had to build a perfect little world starting with the glorious Parthenon. The roof and Architrave were no problem; but try to get 70 columns exactly straight without a jig or brace. Impossible! So, the Acropolis got relegated to the "Can't do" category. Over the years I figured out how to build tiny castles, even on islands, but somehow, they never satisfied me. But a Gothic cathedral would be fine! So, I started building progressively more complex and detailed Medieval cathedrals and their surrounding towns. Each one utilized some new material or technique, and each one was more and more refined.

Psycho-social considerations

I have found that patients were intrigued and inspired by watching the progress of the cathedrals I would build early in the morning before the clinic opened. I also realized that to build these structures, I used no premade parts or commercial ingredients; everything was created from scrap and trash. Since in our inner-city clinics, the patients were considered to be society's scrap and trash, I created a metaphor for the supportive and constructivist therapy I was doing: With care and work, even that which people throw away can be reworked into items of beauty. The same applies to human beings as much as to artistic creations. Patients and colleagues found that message to be inspiring. As time moved on, I found I could use the models in treatment by getting patients' opinions on whether a tree would look good here, or a stream there. This evolved into using the scenes as projective identifiers of inner fantasy. One young man thought it would be hilarious to place inside a Gothic cathedral a large firecracker and enjoy the explosion. That was exceptionally rageful. Generally, patients want to know "where that place is" and "whether one can go there." I note the projective identification of their own gradual headway with the progress of the project, including the mistakes I have made. Many have offered to buy them. I respond that they are unaffordable but could be built for less than one dollar. They tend t belie impatience and the frequent tendency these days to devalue actual effort and resolve desires through money alone. Some have expressed an interest in trying to construct a project of their own. I tend to us that notion to emphasize small steps and simple beginnings. Rarely, people may be induced to visit similar places and even learn about architecture. Perhaps more than anything, there is a sharing of affect. The patient is able to see my own interest and frustration, my passion and approach, and not simply feel like someone being observed. Everyone enjoys genuine effort. It is central to many theories of Neo-Freudian dynamics. It moves away from merely looking at pathology and analyzing it into sharing a human interest in the creative process. Karen Horney was a psychoanalyst who questioned the validity of Freudian thought. She spoke of the concept of self-realization, the innate ability to grow into a deeper level of harmony and self-awareness, congruent with utilizing potential. The ability to take that which is discarded and rework it into something of artistic merit is a metaphor for the therapeutic process.

Technical Questions

Many people have attempted to build model train layouts. The general direction here is to build the base, a table or a series of supports, then add a track and wire it, and then add the scenery to create an environment. My approach in creating dioramas is the reverse, and, in my opinion, closer to the process of reality: I create the scenic terrain first, and then add the man-made elements. Like nature, I cannot predict exactly what I am going to build or where it will go, just as a real builder would need to base the work on the actual terrain, though I have a general idea of what I plan: a gorge, a riverside, or a flatland. The amount of flat area determines the size of the buildings I will make. The hardest part of building is the very first step. Without exception, these projects are complex and even frustrating, and thinking about starting causes resistant inertia. So, you lay down the bases of the terrain, and the imagination starts to flow! In enlarging this idea to other areas of endeavor, such as composing a sextet, or writing a paper, or even doing a psychiatric evaluation for Social Security benefits, I find that people, even devoted and assiduous ones, tend to forestall the project at the beginning, feeling inertia and resentment about taking on a big task until they start, when it flows uninterrupted thereafter. The unspoken lesson here, which certainly applies to creating complicated and frustration models as well, is to start! Many specific techniques of building and designing get elaborated, not necessary to describe here, but that create an addiction to keep on working and do "just one more house/tree/detail" before putting it aside for the night. Often, it is the first thing I do after the alarm clock rings in the morning. The idea of "unfinished" becomes a stimulus to continue. Many people are surprised, including me, at how fast these complex structures can be built, but the answer lies in that stimulus.

Clinical Vignette and Factors

In general, psychiatric patients attending inner-city clinics are poor, ill-educated, disenfranchised, plagued with poorly consistent external objects, both in their families and in their treatment. Welfare, Social Security and Medicaid offices often can be dehumanizing, disrespectful, and ineffective. Emergency services, psychiatric clinics, and agencies are rushed, inattentive, and uninterested. Patients are seen as a "factory commodity" with no real willingness to hear their story or support constructivity. Therefore, the value of this work embodies the metaphor that we are taking pure "rubbish" and creating something beautiful from it. Like the patient's narrative, I cannot envision the final result nor imagine how long each section will take. The scene unfolds, and the beauty lies in watching the progress and deciding the next step. This is quite different from building models from kits. There, on the box cover, one usually sees a picture of how the completed model will look. The closer you get to the box cover art, the more accurate the piece is. So, your airplane or ship model will attempt to follow the color and detail scheme pictured on the box. Here, we have no idea what the end product will be, and the evolution of the model requires a discerning eye to follow the progress and modify what doesn't look right. Similarly, in working with patients, I prefer to avoid the dehumanizing "short term goals" or "discharge criteria" in outpatient work. We can be very surprised with the way the unexpected crops up in our patients' lives as a result of trauma, joy, relationships, job changes, and other external circumstances. The fun of therapy is watching the drama unfold. My little towns get new streams, cliffs, buildings, or forests and evolve until I think they have reached where I want them.

BOOK REVIEWS

***The Eighth Girl: A Novel* by Maxine Mei-Fung Chung (William Morrow Press, Harper Collins)**

Book Review by Cassandra M. Klyman, MD

The most common defenses against trauma are repression, dissociation and the repetition compulsion. The latter provides a rich source of an audience for commercial predators of victims and voyeurs. Ms.Chung, a therapist at the Bowlby Center in London, has written a novel designed as chapters alternatively devoted to a young Asian photo-journalist in out-patient individual therapy with her intrigued Dr. Rosenstein. He treats her Dissociative Identity Disorder from his office at Glenview, a residential psychiatric hospital. Both characters are high-functioning but have damaging pasts that intrude and fragment their identities. The reader believes we are taken inside their minds and their therapeutic relationship. As therapists ourselves we find ourselves critiquing the therapy and the therapist but not the overall psychodynamics upon which this novel rests. It is an exciting course that develops and its resolution was a surprise turning this into a good thriller. How did I miss the clues? Was it such a good story that I was just carried along? The answer is "yes" and "yes" and that is why I'd recommend it.

Intertwined with the treatment narrative is the dark web

of the international sex-trafficking trade of underage Asian girls. We are exposed to painful ethical dilemmas on a micro- and macro-level. Do poor Chinese parents actually sell their daughters or self-delude that they sacrifice themselves to provide a better life for them in the West?

When Dr. Rosenstein hears that his patient is getting involved should he have done more than listen, question and reflect? And then do less than seek her out when she was a "no-show"? And what is the role of our "informal consultants", our friends and supervisors when they see us or our patients getting involved in high-risk behavior? How will this play out going forward as we continue to see patients virtually? How and should we at all be "preachy" or only interpretative when we hear patients express their bigotry, patronage of pornography and/or prostitution? Should we advocate tolerance, safe-sex and/or abstinence?

I have had several patients during my professional career whose personalities were so fragmented after a trauma as to qualify for the diagnosis of Multiple Personalities. Certainly none were as painstakingly explored as Fromm-Reichman's patient in "I Never Promised You a Rose Garden". Or Sybil in "Three Faces of Eve" but they were memorable nevertheless at a time when this diagnoses was very suspect. There were many more cases of women who suffered childhood sexual abuse who survived wounded but not experiencing total vertical splits and lost time in their personal histories. They were depressed, felt like imposters though they carried advanced degrees.

One patient I remembering asking for an analysis to feel "optimal". She had already been seen for a decade in the Community Mental Health System after the V.A. referred her when she first claimed that as an African American Army recruit she had been raped by her Drill Sergeant in Basic Training. She was disbelieved, transferred and then got a medical discharge due to her subsequent aggressive misconduct. She had a decent job in the inner city; was a caregiver for her mother and disabled son but relied solely on public transportation which had deposited her 1.5 miles from my home-office which she declared she would walk "Winter or Summer". She had researched and only wanted to see me, a woman analyst, who was about her age. "Optimal" for her was to get back the spontaneity of her young adulthood. She wanted to "lay down on the couch and go back in time" . I reviewed her CMH records and her earlier presentations as the struggling victim. The personality that presented to me was the rugged , idealistic soldier who could walk thru any Mid-Western storms to come to appointments, even make Metro busses run on time to my suburban location. I complimented the work she had done with her previous retiring therapist and recommended that she return to that institution . It was an organized structure, an army of people who had treated her well unlike the Military and could provide a safe, hospital time-out, if necessary. I cautioned her that returning to review the past might be destructive to all the gains she had made. And I silently reminded myself of the very high suicide rate of 70% that DID carried. I felt that I was handing out a Purple Heart medal and she accepted my decision.

I see two patients now with Dissociative Disorder although one is diagnosed as PTSD and the other as DID. Ironically the latter only presents as the host person to me and tells me what the others are up to –she does share her alters with her therapist and I'm managing her medication. The woman who declared her definitive diagnosis was PTSD is getting compensated by the Catholic Church on behalf of the convicted priest who abused her and several other children. She is, no doubt, having several alters and is on SSDI as a result of other situations in which she was a victim. Because her finances don't permit intensive treatment even changing her diagnosis seems like a threat to her tenuous identity at the present time when we are working virtually. She and I are holding her rage and channeling her positive feelings of her 10,18, and 38 year old selves into making protective face masks during the pandemic.

Another patient was a junior executive for a Utility Company on her way to a good career advancement when her toddler began to show signs of autism with temper tantrums and loss of speech. His incoherent rage triggered her repressed memory of being molested in her uncle's funeral parlor. She manifestly would just have periods of mutism and forgetfulness. Only hypnosis lifted her amnesia and brought the memory closer to her awareness so we could work on it. So the diagnosis, selection or rejection of such patients, consideration of the reality of their circumstances all need thoughtful consideration before therapy can ensue. But we are not investigative reporters so how can we be certain of the patient's support system. We cannot and the author of this novel reminds us of our fallibility.

There is a certain amount of suspension of disbelief , entering into an altered dimension of consciousness into which we surrender ourselves when we enter the theater of our consulting room. It is called by many names. The Field theorists, like Civatarese,(2008) and Ogden (2004) call it reverie, the analytic third , where we use our somatic and mental perceptions to inform our awareness as the product of a unique dialectic generated by/between the separate subjectivities of analyst and analysand within the analytic setting. All of this is an elaboration of projective identification that spawned intersubjectivity. A successful psychoanalytic process involve the superseding of the unconscious third and the re-appropriation of the (transformed) subjectivities by the participants as separate and yet interdependent individuals. This novel doesn't take us to this happy conclusion but does set this trajectory in the right direction as Alexa Wu, patient and host, finally trust their doctor to see all her personas. And the doctor ,too, has changed. As one of my CAPA students said: It is like sugar and tea, once you put the sugar in the tea it is now sweetened tea—both elements transformed and never the same again. The reader is left to speculate as to how each of them evolve. Just like in real life.

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IN MEMORIUM

Remembering Matthew A. Tolchin, MD

It is with sorrow that I report the passing of our esteemed colleague and friend Dr. Matthew Tolchin. He was a consummate clinician, dedicated teacher, and family man.

Dr. Tolchin, mathematically gifted, studied mechanical and electrical engineering at Rensselaer Polytechnic Institute. He was drawn to psychology and psychiatry by a desire to better understand the workings of his own mind and others. Freudian psychoanalysis offered him a royal road to better understand human mental life. He completed medical school at NYU, psychiatric residency and consult-liaison fellowship at Albert Einstein College of Medicine, and psychoanalytic training at the New York Psychoanalytic Institute.

During residency Dr. Tolchin fell in love with Joan Tolchin, who became his wife. He also supported and encouraged her to seek medical and psychiatric training, and she too became a leader psychodynamic psychiatry and President of our Academy. His son Benjamin and younger sister Rima were also inspired to follow in his medical footsteps. During the Vietnam war, Dr. Tolchin served as a Captain in the Army Reserve Medical Corps.

Dr. Tolchin was very dedicated to his patients and to the practice of psychodynamic psychiatry and psychoanalysis. He was a leader in the field, and served as President of our Academy, 2001-2002 as well as on the Editorial Board of Psychodynamic Psychiatry. He was revered as a teacher and supervisor in the Department of Psychiatry at Mount Sinai. Dr. Tolchin gave lectures internationally in Europe and China. And he continued to see patients up to two months before his passing.

His son Dr. Benjamin Tolchin fondly recalls how devoted his father was to him and his family—reading great literature together, rambling walks through Central Park puzzling about the human nature, road trips to Vermont. Ben remembers what his father valued most was his work and family life, not necessarily in that order. And, of course, the love of his life Joan.

I first heard about the Academy through Dr. Tolchin in my own psychiatry residency. He was leading a case conference in which he would first interview a patient and then have one of us do the same. I volunteered to follow him. Dr. Tolchin was a master at putting patients at ease and having them tell their stories. After the conference, perhaps trying to curry favor, I said so. He replied, in the most gracious and generous way, that I did even better. As you can imagine, that meant a lot to me in my training and becoming a psychodynamic psychiatrist.

Ahron Friedberg, MD

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