

ACADEMY FORUM

Vol. 66, No. 1 - Spring 2021



The American Academy of Psychodynamic Psychiatry and Psychoanalysis

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Cover Photo
by
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While walking along the water’s edge on a hazy breezeless morning, I saw 2 common terns huddled together on a stump. I focused my camera on them for what was going to be a rather mundane shot, when they both stood tall, flared their wings and began to cry out. From the mundane to the sublime!

Editorial Policy for THE ACADEMY FORUM

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

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

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

Criteria for Submission:

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

- b. If you want more than one space, use the tab.
- c. Space once before or after using a parenthesis. For example: (1) Freud or Freud (1)
- d. Space once before and after using a quotation mark. For example: John said, "Your epigenetic model was spot on." Then the research ended.
- e. Any articles that contain pictures of any kind must include the actual picture file in addition to the article.
- f. If something comes up at the last minute, call or email to see if you still have time to submit your article for that issue.

Deadlines for Article and Ad Submission

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

ADVERTISING

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

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

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

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MESSAGE FROM THE EDITOR

Ahron Friedberg, MD



Hope all's well for you and your families. With over 500,000 COVID-19 related deaths in our country, almost all our lives and practices have been impacted directly or indirectly by the pandemic. While we can be strengthened by overcoming adversity, many of its challenges continue to force us to adapt our practices and ourselves in unexpected ways. This issue of our

Academy Forum reflects some of the resourcefulness and resilience we are showing as clinicians and members of the Academy.

Dr. Joanna Chamber's continues her tremendous work in guiding our Academy through such a challenging time. She speaks to some of the adaptations the Academy is making with regard to membership, diversity, technology and communication. We're fortunate, indeed, to have her at the helm, steering us through this climate of dramatic change in how we function as an organization and practice as clinicians. We owe her a debt of gratitude for those efforts on our behalf.

As the new Editors of *Psychodynamic Psychiatry*, Dr. Jennifer Downey and Dr. César Alfonso update us on the amazing work they, along with Deputy Editor Debra Katz, have already done and are doing. By expanding the Editorial Board to include six Associate Editors, a new International Advisory Board with 16 members, and online access to all issues of the Journal, they give us a formidable presence for advancing science, academic excellence, and scholarship in the field.

Dr. Peter Olsen's letter both extends our conversation about the role of psychodynamic views in politics and offers us some closure as we welcome a new national President and Administration. No doubt the dialogue about our role as observers and commentators on the political landscape will continue.

Dr. Arnold Richard's letter to psychoanalytic candidates captures some of the history of psychoanalytic training, in both its promise and peril. As Former Editor of the Journal of the American Psychoanalytic Association (JAPA), his perspective—informed by a professional lifetime of experience—is wise and worldly.

Dr. Barry Fisher's excellent report from the APA Assembly Meeting (November 2020) details some of the challenges that organization is dealing with during the pandemic: annual revenues decreased over 10 percent, meetings are virtual, and visas for foreign medical students and residents harder to obtain. So, not surprisingly, there is a push by the APA for greater transparency in the organization and expansion of telehealth services.

We're excited about the upcoming AAPDPP's 64th Annual Meeting on April 23 and 24. The theme is "Examining Relationships and Connections". The Chairs Kimberly Best, Sarah Nobel and Jessica Eisenberg have organized a terrific program with input from the Scientific Session Committee,

chaired by Dr. Joe Silvio. It's the first virtual annual meeting in our Academy's history. We hope all of you will register and attend.

Dr. Gerald Perman reports on his superb new monthly series of Zoom presentations titled *From Monsters to Medications: Current Topics in Psychodynamic Psychiatry During the Coronavirus Pandemic*. He, indeed, continues to do our Academy and community of psychodynamic practitioners a great service with excellent and timely presentations on psychopharmacology, consultation-liaison psychiatry, psychiatry and law, and other crucial topics during this challenging period. Having attended several presentations and published two in this Forum issue, I can most highly recommend it to our readers.

In fact, the next article stems from a presentation given at Dr. Perman's series. Dr. Lawrence Mobley and William Butler's paper titled "Psychodynamic Psychiatry and the Law in the Digital Age" is an important contribution to this subject with its excellent discussion and literature review. One take away is the importance of having malpractice insurance that covers teletherapy as we adapt to these new technologies and changing times.

Dr. Reimer Hinrichs' excellent case study on the toxic patient is a lesson for us all. While most of us chose not to work with sociopathic patients, it is important to identify them early in treatment, ideally during the initial consultation, and handle it both professionally and in a self-protective manner.

Dr. Henry Lothane's original work reviews the history of the Freudian idea of hysteria and introduces his concept of dramatology (the other side of the coin being narratology) as a method for treating psychodynamic symptoms. The paper is a *tour de force* of psychoanalytic scholarship and thinking.

My own modest contribution reflects on my clinical experience and changes in practice during the pandemic. It draws from my forthcoming book *Through a Screen Darkly: Psychoanalytic Reflections During the Pandemic* (Routledge 2021).

This issue includes a book review by Cassandra M. Klyman, MD of *All We Can Save: Truth, Courage, and Solutions for the Climate Crisis*, 2020 edited by Ayana Elizabeth Johnson and Katherine K. Wilkinson as well as a dazzling review with illustration of *Psychotherapy and Personal Change: Two Minds in a Mirror* by Ahron Friedberg, MD.

MESSAGE FROM THE PRESIDENT

Joanna E. Chambers, MD



As we approach the one-year mark of a global pandemic, we are in a time of anticipated change; a space in between, where we know change is coming, but has not happened yet. This space can often carry tension, anxiety and fear. Fortunately, this space also provides hope, excitement, and anticipation. We have all experienced loss over the past

year in one way or another and we have worked hard to adapt to new ways of living, with isolation, zoom, and masks, among others. With the advent of vaccines and other adjustments in our community, we are now preparing for life in a post-Covid world. The change has not occurred, yet we know it is coming. We both fear and welcome some of the ways in which Covid has permanently changed us. While we have adjusted to effects of a pandemic, other changes have occurred as well. The political unrest over the past year has been unsettling and will undoubtedly lead to social and possibly socioeconomic shifts in our society. These social changes are needed, yet they have not fully taken place. Everywhere, it seems, we are waiting for change to occur; though we don't really know what the upcoming changes will mean for us personally or professionally. We are living in unprecedented and uncertain times.

Psychiatry, along with the rest of medicine, is evolving as well, directly affecting the Academy. Neuroscience continues to advance with new methods of treatment, including electrical stimulation, pharmacological infusions, and other means that change how mental illness will be viewed and treated going forward. However, all changes aside, we are still humans and therefore the relationships we develop with our patients will remain at the core of any psychiatric treatment. The essence of 'being with' our patients in their pain and suffering, in their yearning to be understood, and their need for human connection will remain the focal point of any psychiatric healing. In the Academy, we understand this and it is what binds us together as colleagues and is what makes the Academy so vital in the future of our field.

The Academy has served such an important role as a collegial and intellectual home for so many psychoanalysts and psychodynamic psychiatrists whose interests have embraced the deeper understanding of our patients. This continues to be of great importance. Yet it is also important that we serve in this way for early career psychiatrists and trainees who now find themselves practicing in a field that looks very different from that of their mentors. So how does an organization change to accommodate the next generation, yet remain recognizable as the organization it has been? How do we meet the needs of new members while holding on to the foundation on which the Academy was built? The practice landscape of today is vastly different from what it was even twenty years ago. In addition, we must also serve as a home to mid-career psychiatrists who have witnessed the field changing, leaving them feeling frustrated in their efforts to fight a faulty system and attempting to reinvent themselves in an ever changing world. As one can see, the

needs of our members are diverse and wide-ranging.

This is our challenge in the Academy today. The answer is not a simple one, yet in a way, it is. We must find ways to connect, to meet the needs of many, to be flexible, and to adapt. While we encourage the younger generation to join us in thinking psychodynamically about patients, we must also maintain a place of camaraderie, intellectual pursuit and support for psychiatrists in our field with psychoanalytic practices and deeper psychodynamic interests. We must embrace psychoanalysis as the life-changing gold-standard that it is, while also embracing the neurobiology that supports and challenges our thinking. This has always been the strength of the Academy. Whether it is changing the name of our organization, allowing new concepts to be presented in publication, or encouraging healthy debate in our meetings, the Academy has always been a place of progressive thought and adaptation. We must draw upon this strength of the Academy and move forward.

To this end, much has already been done by the Strategic Planning Task Force led by Dr. Kim Best and Dr. Jeffrey Katzman. In the fall of 2020, a SWOT analysis was done to better understand what you, our members, felt were the strengths, weaknesses, opportunities, and challenges of the Academy. While many strengths were mentioned, four significant areas emerged that need our attention: Membership, Diversity, Finances, and Technology and Communication. While the Task Force did a significant amount of work to develop goals for these areas of attention based on SWOT analysis, we need you, our members, to help guide our initiatives in each of these areas in order to move the Academy forward. We sincerely hope that you will each be moved to sign up for the brainstorming sessions. Your voices and collective vision is imperative to advance the mission of the Academy. Be on the lookout for opportunities to sign up!

The Annual Meeting of the Academy will take 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 will provide opportunities for learning, teaching, and collaborating. To be sure, this virtual meeting is not intended to replace the in-person Annual Meeting and we hope that you will join us for this unique virtual experience. We all miss the warmth of being in each other's presence and it is our hope that we will be together again in the Spring of 2022 in New Orleans.

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 marks 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 next academic year, which will begin in June 2021. 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 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 agreed to serve as co-Editor, together with Dr. Alicia McGill, of the Academy Newsletter. The Journal, *Psychodynamic Psychiatry*, has experienced several changes over the past few months. Under the expert leadership of Dr. Jennifer Downey and Dr. Cesar Alfonso, Co-Editors in Chief, 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, Dr. Ahron Friedberg continues to serve as the Editor of the Forum.

Our endeavors in education continue as the Teichner Award continues to provide 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 September of 2021. A monthly Case Conference Series

will begin in September for psychodynamic psychotherapy supervisors. 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. Already, a calendar has been added to the website where anyone can see the dates and times various meetings occur. Part of the rationale for this was to help all of us keep track of the various upcoming meetings. The other reason was to increase transparency and encourage engagement among the members. We hope that you will use the calendar and ask about any meeting that evokes curiosity!

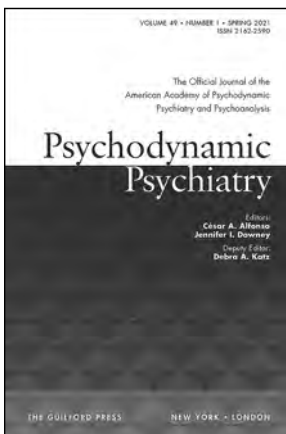
While we have all been affected by unprecedented extreme challenges over the past year, and we are embracing the upcoming changes in our world, I feel extremely grateful to be working with you, our members of the Academy. Though we have faced much adversity over the past year, many positive changes are 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

Update from the Editors of *Psychodynamic Psychiatry*

Jennifer I. Downey, MD and César A. Alfonso, MD



The American Academy of Psychodynamic Psychiatry and Psychoanalysis has published a peer-reviewed quarterly scholarly journal for 49 years. Next year will be the 50th Anniversary of the Journal! In the next issue of the Academy Forum, we will detail publication plans for the 50th Anniversary Special Issue of the Journal. The title of the Journal changed over time to reflect changes in the name of the Academy. Since 2012 the Academy's Journal has

been called *Psychodynamic Psychiatry*. This title was chosen to reflect psychodynamic psychiatry as a new discipline combining not only developmental and psychoanalytic psychology but up-to-date findings from academic psychiatry and the neurosciences. The Academy has always led the way in including knowledge beyond classical psychoanalysis as part of its focus. In fact, the very first editorial written for the Journal in 1973 by the then editor, Silvano Arieti, discussed the broad knowledge required to understand the mind. He wrote: Many changes are occurring in our society

and culture which stimulate a reassessment and re-evaluation of many concepts, even those embraced by most schools of psychoanalysis. The new biological findings and cultural innovations appear to be intimately related to the core of the human psyche and therefore to be of great concern to psychoanalysis.

Beginning in January of 2021 we, Jennifer Downey and César Alfonso, have become the new editors of *Psychodynamic Psychiatry*. We're very proud to serve the Academy in this role. We're also very proud of the Journal and honored to assume editorial leadership from Richard C. Friedman, who edited it from 2012 to 2020. *Psychodynamic Psychiatry* is internationally read and listed in seven different indices, including Index Medicus/Medline, PsychoINFO, and Pub Med. Over the next few months, we will be communicating with you about new features of the Journal.

In the meantime, even before you receive the printed copy of the Spring 2021 issue, you can access the first issue of the journal edited by us --(49(1))—by going to *Psychodynamic Psychiatry's* Home Page on Guilford Press's website: <https://guilfordjournals.com/loi/pdps>. Find the sign-in box at the upper right corner of the page. Log in by typing AAPDP in the email address box. Enter PDPS as the password. This will lead you to our newest issue 49(1), which you can browse at leisure. You'll also find that as a new benefit of

Academy membership, you will be able to access all issues of the Journal in their entirety going back to the first issue of the Journal in 1973!

In this initial Forum announcement, we'd like to share with you information about our editorial team so that you know who we are.



César Alfonso serves as Editor of Psychodynamic Psychiatry with Jennifer Downey. He is Clinical Professor of Psychiatry at Columbia University and holds professorships at the University of Indonesia in Jakarta and the National University of Malaysia in Kuala Lumpur. He is Chair of the Psychotherapy section of the World Psychiatric Association.

Recent work has been on psychodynamic determinants of treatment adherence, biopsychosocial aspects of suicide, and the clinical care of persons with low vision and medical comorbidities.



Jennifer Downey is Editor of Psychodynamic Psychiatry with César Alfonso. She is Clinical Professor of Psychiatry at Columbia University in New York and also on the faculty of the Columbia University Center for Psychoanalytic Training and Research. With Richard C. Friedman she has written about sexual orientation, sexual fantasies, and sexual minorities.

Her current interests include women's health, sexuality in people with psychiatric disorders, individuals with gender dysphoria and non-binary gender identities, and individuals with medical illness. Both Dr. Alfonso and Downey are interested in psychotherapy training in residency and post-graduate programs.



We are pleased to announce that Debra Katz has become Deputy Editor of Psychodynamic Psychiatry. She is Clinical Professor of Psychiatry at the University of Kentucky College of Medicine in Lexington, KY. She is also a Training and Supervising Analyst at the Cincinnati Psychoanalytic Institute in Cincinnati. Dr. Katz served as a residency program

director for many years. She has published in the areas of trauma, child development, the interface of medical and psychiatric illness, grief and loss, and psychotherapy education and psychoanalysis.

As Editors we have appointed six Associate Editors to assist us with the work of producing *Psychodynamic Psychiatry*, each chosen for their expertise in a particular area. They include Richard Brockman (neuroscience),

Norman Clemens (psychoanalysis), Mary Ann Cohen (consultation-liaison psychiatry, bioethics, geriatrics and addiction), Ahron Friedberg (psychoanalysis, book review editor and editor of the Forum), Bernard Gorman (statistics and research design), and Clarice Kestenbaum (child and adolescent psychiatry). Among other responsibilities, they will provide liaison with our Editorial Board.

The Journal's 62 Editorial Board members will be offered reappointment for another quinquennium. They include: Stewart Adelson, Abby Altman, Roman Anshin, Michael Aronoff, Alan Barasch, Sharon Batista, Gail Berry, Michael Blumenfeld, James Bozzuto, Norman Camp, Joanna Chambers, Marilyn Charles, Richard Chessick, Richard Chefetz, Juan Raul Condemarin, Sergio Dazzi, Michael Feldman, Barry Fisher, David Forrest, Volney Gay, Kareem Ghalib, Myron Glucksman, Elizabeth Haase, Sheila Hafter Gray, Richard Hersh, Aerin Hyun, Alan Kagan, Thomas Kalman, Craig Katz, Sherry Katz-Bearnot, David Lopez, Benjamin McCommon, Alicia McGill, Joseph Merlino, David Mintz, Autumn Ning, Sarah Noble, Silvia Olarte, Gerald Perman, Christopher Perry, Eric Plakun, Daniel Plotkin, Maurice Preter, Arnold Richards, Eugenio Rothe, Klaus Schreiber, Ann-Louise Silver, Jane Simon, Elise Snyder, Moshe Halevi Spero, Margaret Spinelli, John Stine, Michael Stone, Allan Tasman, Elizabeth Tillinghast, Joan Tolchin, Matthew Tolchin, Ronald Turco, Helen Ullrich, Wilfried Ver Eecke, Ralph Wharton, and Kathryn Zerbe. We are fortunate to have such an extensive board of experienced clinicians and scholars, and grateful for their service to the Journal and the field.

Psychodynamic Psychiatry also has a new International Advisory Board of 16 psychodynamic psychiatrists from every continent. Each has agreed to serve for five years and during that time to write an article for the Journal about psychodynamic psychiatry and psychoanalysis in their country. The first person to do this is Michel Botbol from France whose article, "Psychoanalysis and Psychodynamic Psychiatry in France", can be found in our Spring 2021 issue. The Advisory Board Members with their countries are: Graciela Onofrio (Argentina), Patrick Luyten (Belgium), Mario Edouardo Costa Pereira (Brazil), Zhengjia Ren (China), Katerina Duchonova (Czech Republic), Michel Botbol (France), Maria Ammon (Germany), Sylvia Detri Elvira (Indonesia), Petrin Redayani Lukman (Indonesia), Saman Tavakoli (Iran), Alvise Orlandini (Italy), Hachem Tyal (Morocco), Constantine Della (Philippines), Alma Lucindo Jimenez (Philippines), David Teo (Singapore), and Rasmon Kalayasiri (Thailand).

In essence, welcome to the new *Psychodynamic Psychiatry*, which we hope retains the excellence of our heritage and challenges you with new features and topics! We welcome your comments about the Journal. Please address them to César Alfonso

(caa2105@cumc.columbia.edu) and Jennifer Downey (jid1@cumc.columbia.edu).

Queries about Psychodynamic Psychiatry such as how to access the on-line version, and how to submit manuscripts can be addressed by our Editorial Assistant, Ms. Sara Elsdén, at the Academy office in Connecticut. Her email address is selsden@ssmgt.com.

Letter by Peter Olsen, MD

Dear Editors:

I read with great interest Dr. Graeme Taylor's response to my critical opinion discussion of his essay "The Alternative Universe of the Trump Administration". Taylor's response is in some ways highlighting the alternative universes of opinion psychologists, psychiatrists, psychoanalysts, political scientists, and journalists have about President Donald Trump. In regard to American journalistic bias, I have found Mark R. Levin's book, *Unfreedom of the Press*, very well cited and enlightening. The liberal American press has been biased against American conservative political thinking long before President Trump's unorthodox administration.

Rather than continuing further detailed exchanges with Dr. Taylor in the hybrid domain of the universes of applied psychoanalytic theorizing and political science truth-seeking, I will respect Taylor's statement, "I do not want to engage in a prolonged debate about the Trump administration..."

I think Taylor and my exchanges, as well as the lively exchanges of mine with Dr. Moore and Dr. Turco in our Forum (Vol. 65, No. 1 Spring 2020), provide the type of dialogue and professional conversations that Dr. Richard C. Friedman would have respected and valued on this difficult topic.

Respectfully,
Peter A. Olsson, MD

Letter to a Candidate by Arnold Richards, MD

Letter to a Candidate,

I feel very fortunate about time that I entered this field. I think I can assert that from a very early age I wanted to become a psychoanalyst. My earliest lexical memory is reading about the death of Freud in the *Yiddish Forward*. Psychoanalysis combined for me and many of my cohorts the virtues both of science and the humanities. It is a field that one never tires of. The clinical and scientific challenges never end.

During my training at the New York Psychoanalytic Institute some of us referred to it as the Church of Rome. It was the bastion of Freudian orthodoxy. It had a distinguished faculty that included a group that emigrated from Central Europe just before World War II. They had been trained by the cohort who had been analyzed by Freud or analyzed by others who had been analyzed by Freud or his close followers. We were very fortunate because the faculty, who were a Who's Who in psychoanalysis at the time, included Heinz Hartmann, Rudolph Lowenstein, Margaret Mahler, Young, George Gero, Ruth Eissler, Martin Stein, Lily Busell, Charles Brenner, Jack Arlow, Otto Isakower Herman Nunberg, Ken Calder and Charles Fisher.

In 1989 the *Encyclopedia Britannica* published an article I wrote, "Psychoanalysis: Burgeoning and Beleaguered." When I started my analytic training in 1964 psychoanalysis was burgeoning. In the article, I referred to this time as the psychoanalysis of plenty – there were plenty of candidates and plenty of patients. Not only was psychoanalysis, as Auden wrote, a climate of opinion it was also, at the time, the most important therapeutic approach.

The experience of being a candidate and the challenges that a candidate faces today are very different from what they were then. On the positive side today is that in the APsAs, unlike in the past, non-physicians are welcomed. There is also the positive impact of psychoanalytic pluralism. I finished my training before Heinz Kohut published *The Analysis of the Self*. Melanie Klein, Winnicott, and Bowlby were not included in the reading lists for my classes. There was to some extent a stultifying Freudian orthodoxy at the NYPSI, advocated by the European emigres but opposed, to some extent, by some of the Americans, particularly Jack Arlow and Charles Brenner.

However, the organizational rigidity and the structure and policies of exclusion remain to this day in some institutes. Candidates are naturally interested in graduating, and advancing in their institutes after graduation, and in being in a position to get referrals; opposing institutional rigidity can, and likely will, work against a candidate. There is no easy solution to this situation and I am not sure what advice I can give. Certainly, diversification of affiliation can be helpful post-graduation. But I do know of several analysts who have had to move to another city to find a more congenial home. In the end, we need to try to be true to ourselves, to our principles and our beliefs. And it is important to remember that this is part of the best analytic attitude.

In the years after my training, I have been very proud of my success in nurturing the writing of younger colleagues, candidates and students. Psychoanalysis offers many pleasures and satisfactions—treating patients, teaching, politics. Every analysis is a voyage of discovery for the patient, and the analyst. The analytic couple learn how the mind works and this knowledge fosters healing and life change. The field's intellectual and clinical satisfactions remain for a dedicated few. Whatever the hardships involved in training for this profession and in its practice, the stakes could not be more significant. In a segment on PBS about psychoanalysis that I produced, we interviewed Charles Brenner. When we asked him about the importance of what the analyst does, he said, "It can be a matter of life" — pause— "or death." To all prospective candidates, welcome.

Arnold Richards, MD

Editor, *International Journal of Controversial Discussions*
Former Editor, *Journal of the American Psychoanalytic Association*

Report on APA Assembly Meeting November 2020

Barry L. Fisher, MD

The following are outcomes from the APA Assembly Meeting November 2020. The meeting was conducted online on November 7th and 8th. There were several recurring themes that came up over the course of the meeting.

First, the APA, like many organizations, is facing decreased revenue because of COVID related impacts on revenue generating activities like the decision to move the annual meeting online. Historically, the annual meeting has been a large money maker for the APA. In addition, contributions to the APA Foundation are down 60% from 2019. The organization faces a \$2,900,000 deficit this year out of an overall budget of approximately \$21,000,000 and is moving forward with \$2,700,000 in permanent cuts to the budget that seem to be fairly evenly distributed across all the programs of the APA. Because of a covenant in the APA's mortgage on the APA's new headquarters in downtown Washington, DC, the APA is required to have a balanced budget going forward. This will likely effect programming somewhat in the future, but hopefully not a large impact.

Second, there was a great deal of concern expressed by many members of The Assembly that the APA administration and the Board of the APA operate without sufficient transparency. This issue came up in relation to current budget issues as well as spending priorities of the organization that are determined by the administration and the Board. A motion passed the Assembly requesting that the administration provide a more detailed report on the spending practices and decision making practices of the organization each year.

Similarly, the administration and the Board both underwent extensive studies evaluating institutional racism within both groups. There was an informal request to the current APA President to release the details and conclusions/recommendations of those studies and it was proposed at the end of the meeting that the Assembly approve a similar study for itself. Saul Levin, the CEO of the APA, met privately with the ACROSS delegation, of which we, the AAPPDP, are a member, and expressed his desire to release some, not all of the information from the report. He expressed concern that there are extensive sections of the report based on feedback from members of the APA administrative staff and that if this information became public, it would decrease feedback from staff in the future. Dr. Levin did encourage the member organizations of ACROSS undergo a similar evaluation of institutional racism in each of our organizations. I asked Dr. Levin if the APA could provide tools for our organizations to use in pursuing such a process. The meeting ended before he could respond. A position statement was approved supporting research on the specific factors associated with suicide in black youth and to look for effective interventions to address this issue.

A third issue that came up several times in different ways involved current policies by US immigration and customs enforcement. There is a new rule for J-1 visas which effect all students and medical residents of foreign nationality. In the past, students/residents only had to apply once for this visa and it was valid through the length of their academic or training program. The new rule requires reapplication yearly and would particularly effect resident physicians who will no longer be able to continue their training programs in

July of each year and will be burdensome to the students/residents effected by this rule change. It will have the effect of decreasing applications and enrollment in programs from students who reside outside the US. APA is appealing this rule change and working with other academic institutions to have this rule overturned. Two position statements were approved involving US immigration. One involved the sexual abuse of migrant children in ICE custody. According to the position statement more than 6,000 complaints about sexual abuse of children in migrant shelters was reported in 2019 alone. The position statement strongly opposes current detention practices and supports measures to ensure the safety and dignity of families fleeing danger, and that these families be treated in a humane manner while in custody. The second position statement addresses the growing fear over coronavirus spread and the mental health impact in ICE detention centers. This position statement also asks for more humane treatment of a population that is vulnerable to distress, asserting that most are a low public safety risk and would be better served by being released from detention. The statement also asks for adequate screening and treatment of those infected and isolation of the infected from the general detention population.

Other issues of note, several action papers passed that may be of interest to members of the Academy. One paper endorsed expanding telehealth services and removing barriers to telehealth services. Another paper requests the APA endorse access to housing and employment for all people with psychiatric illnesses. Another paper requests the APA endorse opposing misogyny, gender bias and the adverse effects on the health of women and members of the LGBTQ community.

Several other topics of interest. The reference committee and the Assembly approved the addition of a new diagnosis to the next edition of the DSM, Prolonged Grief Disorder with evidence-based criteria for the diagnosis. The rationale for the new diagnosis is that it does not pathologize prolonged bereavement. The Assembly voted to form a task force to study a potential name change to the organization from The American Psychiatric Association, to the proposed alternatives The American Psychiatric Physicians Association or The American Psychiatric Medical Association to distinguish psychiatrists as medical doctors from other groups that treat mental health issues, but are not medical doctors, including psychologists, nurse practitioners and physician assistants. Along these lines, the APA is opposing a bill in Congress sponsored by Susan Collins of Maine, among others, that would define psychologist as physicians and allow equal compensation from Medicare. And, the APA succeeded in defeating a congressional proposal to authorize psychologists' to prescribe to veterans.

Lastly, the Maintenance of Certification committee relates that the ABPN (the American Board of Psychiatry and Neurology) has agreed to offer as a permanent alternative to the 10 year recertification exam, a review of between 30-40 articles every 10 years with questions at the end of each article that must be answered correctly to receive recertification. This change by the ABPN has occurred in response to pressure from the APA and other organizations that the promotion of long-term learning should be

supportive, not punitive. A number of other changes are being considered by the ABPN including changing the requirement from a reevaluation every 10 years to a reevaluation every five years. And, they are considering adding new requirements to ensure documentation of quality care within one's medical practice. Many on the committee feel these new requirements will be unnecessarily burdensome and contribute to physician burnout. An action

paper has been proposed for the spring 2021 Assembly meeting with three criteria: 1) Recognizing the initial board certification shall be adequate, 2) Discouraging employers from demanding Maintenance of Certification, and 3) MOC be a voluntary rather than a mandatory requirement.

Overall, the meeting went smoothly as everyone adapts to online interactions and discussions. All meetings in 2021 will be virtual in response to the current COVID pandemic.

AAPDPP's 64th Annual Meeting

Kim Best, MD



Kimberly Best, MD

Sarah Noble, MD

Jessica Eisenberg, MD

The upcoming annual meeting of the American Academy of Psychodynamic Psychiatry and Psychoanalysis will be like no previous annual meeting. A long-awaited meeting, it will be held while still in the pandemic that caused the cancellation of the previous year's annual meeting. This year's live-streamed presentations and discussions will give us a welcome opportunity to learn, discuss ideas, and spend time together while remaining safe in the face of the pandemic. The annual meeting Co-chairs, Drs. Sarah Noble, Jessica Eisenberg, and myself, leaned heavily on input from the Scientific Sessions Committee, Chaired by Dr. Joe Silvio, and from our President, Dr. Joanna Chambers. We got many good ideas about how to plan a virtual meeting that will be well suited to the Academy, its members and culture.

We were all disappointed that the 2020 meeting in Philadelphia was canceled. We missed seeing one another, and were sorry that we could not hear the scheduled presentations. A number of the presenters scheduled to speak at the 2020 meeting will be delivering their presentations this April, and we hope that others will speak at the 2022 meeting, or at the monthly presentations, "Current Topics in Psychodynamic and Psychoanalytic Psychiatry", being organized and scheduled by Dr. Gerald Perman.

This year, rather than running concurrent sessions, we will run one session at a time. This will reduce the risk of disruption by technical issues and lend an additional cohesiveness to the experience of the meeting. Looking forward to opportunities for interaction, we have asked presenters to leave time for discussion. We anticipate that most attendees will be working from home, so we have scheduled multiple short breaks throughout the day to allow for stretching, grabbing a cup of coffee, or letting the dog out.

The theme of the meeting, "Examining Relationships and Connections", carries forward the theme of the cancelled 2020 meeting, while also addressing issues that have become immediately important to us this year. A number of presentations directly address the impact of COVID-19, or include topics related to diversity, equity, and inclusion. Even those presentations planned prior to the start of the epidemic are likely to be modified by the experiences of the past year.

To highlight a few presentations, Dr. Gerald Perman, President at the time of the cancelled 2020 meeting, will bring us a talk, "Reflections of a Past-President". "Peer Psychopharmacology Workshop", a yearly favorite event, will be led by Drs. Joseph Silvio and Raul Condemarin. On Friday evening we will hold a social event. Details to come! On Saturday evening, Dr. Richard Brockman will cap the meeting with the Presidential Address "Safety: From the Paris Morgue to Oxytocin". I hope you are as intrigued as I am!

Please follow the link below for the full details of the program, and to register. While attending, remember to consider your time zone. The published times are for the United States Eastern time zone. We hope you will register and join us for this historic all-live-stream annual meeting.

ORIGINAL ARTICLES

From Monsters to Medications: Current Topics in Psychodynamic Psychiatry During the Coronavirus Pandemic

Gerald P. Perman, MD

In October 2020, the Academy began a series of monthly evening CME Zoom presentations that continue through April 2021. This educational initiative was one of the Academy's several important efforts to maintain a sense of educational and social continuity in response to the need to cancel our 2020 Annual Meeting in Philadelphia, PA because of the coronavirus pandemic. A decision was subsequently made to cancel the spring 2021 in-person Academy Annual Meeting in Los Angeles, CA for the same reason. The organizers for this meeting are putting together an online substitution.

Six abstracts were selected among those submitted for the monthly Zoom presentations that began in November 2020. The October 29, 2020 meeting had previously been decided upon and was included under the umbrella theme for this series titled "Current Topics in Psychodynamic Psychiatry During the Coronavirus Pandemic." In this communication, I will provide a summary of each of these informative and educational presentations.

Jeffery Katzman, MD, led off our series with "The Zombie" on Thursday, October 29, 2020 – just in time for that iconic American fall festival of Halloween, sacred (scared, scary?) to the children and their parents. Zombies are "infected individuals destined to roam the earth with no life force or purpose other than to feed upon the lives of other human beings" (from Dr. Katzman's publicity for his presentation). This resonates with the coronavirus pandemic that continues to ravage the world. Dr. Katzman used clips from the scripted cable show *The Walking Dead* to illustrate the concept of "psychic deadness" from the perspective of the psychodynamic literature, and how this concept is relevant to society today, in particular, during the coronavirus pandemic.

Note: The concept of the zombie plays a role in philosophy in which the concept of the zombie is used to illuminate problems about consciousness and the physical world. Zombies are literary and Hollywood creatures that act without self-reflection, and thus serve as a model for patients who lack a superego or conscience, and without a second thought about the damage and destruction they may cause. For self-castigating patients, filled with a sense of guilt, the goal of treatment is to help them become more zombie-like and, for patients who are more sociopathic without a sufficient sense of guilt about how they hurt others, the treatment goal is to help them become more self-reflective, empathic and less zombie-like.

William Butler, a fourth-year medical student, and Lawrence Mobley, MD, both at Florida State University College of Medicine, presented "The Digital Age: Psychodynamic Psychiatry and the Law" to review the legal and ethical aspects of psychodynamic approaches during the digital age. They state that "telemental health" is a general term for mental health support services, such as psychotherapy, via electronic video meetings, whereas "telepsychiatry" is specific to medication management over

the internet. They note that the legal and fiscal standards of this relatively new application have not yet been established. They reviewed the literature to facilitate discussion on the benefits and limitations of virtual healthcare and made recommendations to improve the therapeutic alliance through virtual telemental health and telepsychiatry sessions.

J.J. Rasimas discussed "The 'Capacity' for Consultation-Liaison Psychiatry During a Pandemic." Requests to evaluate patients' capacity to make medical decisions are a routine aspect of Consultation-Liaison (C-L) practice. At his hospital, there was a sudden increase in requests for assessment of decision-making capacity in the wake of the SARS-CoV-2 outbreak. There were a number of relational and psychodynamic themes accompanying the change. He hypothesized that restriction of hospital visitation in the interest of curtailing spread of the pandemic was a factor. Internists and surgeons were concerned that, with the absence of visitors, the patient's voice had lost an amplifier in the form of support from loved ones present at the bedside and concerns about "doing the right thing" were heightened. There was more pressure to perform medical work in a way that not only helped patients and fit with a professional sense of duty, but also that held up under ethical scrutiny.

Dr. Rasimas hypothesized that, metaphorically and dynamically, medical teams feared that they lack some "capacity" during this time of the pandemic. They may have worried more about making the wrong decisions when the emergence of a new disease leaves standards unclear. Physicians themselves (ourselves?) may lack capacity to manage uncertainties inherent to caring for the sick and vulnerable when the close physical contacts doctors share with their patients to gather information and solidify the bonds of their working relationships are limited. Dr. Rasimas believed that his C-L service had been asked to contain more distress through a veiled communication of these concerns in the form of increased requests for capacity evaluations. His team decided that such requests reflected a need for which they must exhibit the capacity to be present and helpful to patients and their care teams on multiple levels.

Daniela Polese, MD, Rome, Italy, described "The crucial interpretation of the negative transference in the psychodynamic psychotherapeutic relationship before and after the pandemic emergency." From Dr. Polese's abstract, the value of the negative transference might be underestimated in the psychodynamic psychotherapeutic practice, while its comprehension and verbalization is a crucial point in order to obtain a therapeutic response. In particular, the identification of the negative transference by the psychotherapist and the verbalization to the patient constitute a fundamental step for the evolution of the psychotherapy.

Dr. Polese described how specific aspects of the negative transference are also present in online psychotherapy. She gave several clinical examples to examine how the negatively perceived therapist has meaning and can be interpreted. She showed how crucial interpretations of the negative transference could lead to understanding and modifying unconscious pathological dynamics characteristic of the patient.

Ahron Friedberg, MD, presented on "Resilience During the Pandemic," noting that COVID-19 had presented unique challenges to mental health professionals both in terms of dealing with acute stresses to our patients and to ourselves.

He found that applying resilience principles such as adaptability and flexibility, community and family support, exercise and wellness practices, realistic optimism and hope, etc., integrated with traditional psychodynamic psychiatry with insight and understanding and psychopharmacology, was especially helpful. Dr. Friedberg offered clinical vignettes from each stage of the pandemic to illustrate his approach. He also discussed how modifications to his practice using video- and tele-therapy were useful in treating patients and better served their unmet needs.

Helen Ullrich, MD, PhD, who practices in New Orleans, LA, presented on “Mother-Daughter Relationships in a South Indian Village.” She described how, over the past 55 years, the position of women in the South India village, Totagadde, had changed from socialized passivity to more appropriate assertiveness. The culturally invisible mothers wanted a different life for their daughters so they postponed the time when daughters would be socialized to passivity and encouraged their daughters’ education.

These mothers, who had married from between the ages 10 to 25, regarded their relationship with daughters as significant. In this society, mothers and older sisters are protective of their daughters and younger sisters. These mothers often addressed their daughters as “younger sister,” suggesting a generational slide and an idealized close tie between sisters.

Case studies presented by Dr. Ullrich creatively contrasted Totagadde mother-daughter relationships with the Demeter-Persephone relationship in Greek mythology to illustrate different adaptations of passive mothers to daughters’ individuation. Persephone is the daughter of Zeus and Demeter, goddess of the earth. Hades, the brother of Zeus and god of the underworld, abducts the young goddess as she is gathering flowers by a stream. Demeter goes in search of her daughter but is unable to find her. Some mothers, like Demeter, experience a pathological response to a daughter’s marriage. This contrasts with western mother-daughter relationships in which the assumption has been that of equality, common interests, egalitarianism, and intimacy. Dr. Ullrich’s South India study showed the impact of decreased patriarchal control and different Indian and Western assumptions on the mother-daughter relationship.

Finally, Joseph Silvio, MD, will present on the importance of psychodynamic factors in psychopharmacology. Although psychotropic medications are often helpful, they don’t work nearly as often as we would expect them to or work as well as we would like. The hoped-for ability to make a specific diagnosis and prescribe the correct medication to treat it has not yet arrived, despite claims to the contrary by pharmaceutical companies and our more biological colleagues.

Rutherford et al have noted that “the average difference between active antidepressant and placebo in published double blind studies has fallen from 6 points on the HAM-D scale for depression in 1982 to 3 points in 2008. Consequently, for most of the currently approved antidepressants, less than half of the efficacy trials filed with the FDA for regulatory approval found the active drug to be superior to placebo.” This indicates that non-pharmacologic factors have significant antidepressant action, sparking interest in how to enhance these positive or placebo effects. At the same time, a number of studies have shown that negative non-pharmacologic effects can diminish or

complicate drug efficacy, and there has been interest in how to mitigate these negative or nocebo effects. Further complicating the picture of medication, Leeman cites surveys that up to 50% of patients across all demographic lines are non-compliant with their doctors’ prescribed treatments.

The importance of a psychodynamic approach to psychopharmacology stems from the strong suggestion that these positive and negative non-pharmacologic effects and non-compliance are mediated psychologically. This presentation attempted to review current understanding in this field and how thinking dynamically can improve our work as prescribing psychiatrists. Dr. Silvio looked at three sets of factors: placebo vs nocebo effect; compliance vs noncompliance; and positive vs negative therapeutic alliance.

This was a pilot study that has been so well-received by Academy attendees that we have organized a second set of Thursday evening CME Zoom presentations to begin in June 2021 and continue through April 2022, skipping August 2021. The theme will be “The Many Faces of Psychodynamic Psychiatry.” I hope that each of you will join us for the second series of monthly Zoom presentations for what I believe will be equally engaging, educational, and interactional Academy experience

Psychodynamic Psychiatry and the Law in the Digital Age

**William Butler, BS and
Lawrence Mobley, MD**

Literature Review

Due to the recent COVID-19 pandemic, the shift toward telemental health has increased rapidly (Zhou et al., 2020). In the literature, telemental health is a general term for mental health support services (i.e., psychotherapy) provided via the internet. Telepsychiatry is more specific and describes medication management services offered via similar platforms. Some providers incorporate aspects of both in a virtual environment. However, the legal and fiscal standards of this relatively new application have yet to be firmly established.

Atezaz et al. (2015) first outlined the emerging field of telepsychiatry in psychodynamic psychiatry. They explained that the direct benefits of telepsychiatry include increased delivery of care, reduction in the stigma of receiving mental health services, reduced socioeconomic disparities, improved convenience, reduced isolation, improved coordination of care, and improved education of mental health professionals. In the current age of COVID-19, these factors have shown to be assets to the field (Zhou et al., 2020). In addition, Atezaz et. al (2015) alluded to the unique barriers of increasing telepsychiatry practice including cost and legal issues.

The literature on the legal and ethical aspects of telepsychiatry is expanding. Luxton et al. (2016) offers general recommendations to ensure safety plans and safeguarding client privacy for telemental health. This includes providing electronic consent forms and establishing boundaries during a first meeting. The ability to record sessions may be helpful in documenting understanding without dividing attention to administrative notetaking. Concerns regarding a possible Hawthorn effect do not seem to be empirically substantiated (Brown et al., 2013).

Regardless, due to the sensitive nature of a psychodynamic psychiatry approach, professionalism and privacy are the chief concerns in the digital age.

In legal studies, these issues are typically divided into negligence and malpractice. Negligence describes a mistake causing unintended harm while malpractice is when a provider knowingly did not follow through on proper standards of care (Bal, 2009). Compared to other areas of medicine, there is little documentation on the rate of medical negligence and malpractice suites regarding psychiatry in general. This is especially true for telemental health in which the rates are currently unknown (Fogel et al., 2019). It is estimated that psychiatrists make up roughly 1-2% of the total malpractice claims against physicians (Slawson & Guggenheim, 2006). The amount of cases that award financial compensation are even lower (Martin-Fumado et al., 2015). The causes vary from injuries related to procedures and medications to unprofessional behavior.

Discussion

Inappropriate professionalism, including confidentiality and sexual misconduct, represent a large portion of claims brought against psychiatrists (Conte & Karasu, 1990). Cases such as *Roy v. Hartogs* (1975) have established that psychotherapy clients are unable to consent and renders all sexual and romantic relationships inappropriate and damaging. In this case, a patient successfully sued her psychiatrist after alleging the physician had sexual relations with her as part of her "treatment." While the legal specifications on this vary, the American Psychiatric Association Principles of Medical Ethics (2013) fully prohibits any unprofessional relationship with a client at any time. As the popular mantra goes, "once a patient, always a patient." Inappropriate provider-patient relationships in the virtual environment are an undocumented issue in the literature. However, this is a chief cause of malpractice within the larger field of psychiatry. It is expected that the ease and legally ambiguous definitions of these relationships may lead to further study in the virtual arena in the future.

Breaches of confidentiality is an area that is particularly relevant in the evolving healthcare environment with the advent of electronic medical records; privacy of healthcare information has taken center stage of reform policy. The Health Insurance Portability and Accountability Act, (HIPAA) in addition to the Health Information Technology for Economic and Clinical Health Act, are major forces with special considerations for mental health records (Francis et al., 2016). These legislative acts overhauled the healthcare system to protect patient information while increasing the utility of electronic medical records. Because of the sensitive nature of these records (i.e., sharing information that no one else may know), electronic medical records provide unique challenges for psychodynamic psychiatrists. In addition, the virtual landscape of medicine, and psychiatry, has changed significantly since 1996 when HIPAA was signed into law.

Psychiatric opinion in recent years on electronic documentation has been mixed (Mangalmurti et al., 2010). Some of the concerns among providers are the automated functions of a note, the privacy of certain information (even among other healthcare providers), and the role it plays in the therapeutic alliance (Lewis et al., 2011). A common concern is that electronic medical records mostly benefit insurance

companies and not providers. For this reason, the copy-forward function is often important to save time between encounters. For psychodynamic interviews, this function has little utility. Each session is unique and often goes deeper than the one before. While privacy is a concern for most specialties, it has unique issues in the work of psychiatry. For example, sharing a patient's information among internal medicine subspecialties at the same organization is common practice. The rationale is that it allows for more efficient care when professionals are discussing cases. However, there are additional considerations for psychiatry (Drake et al., 2010). Many patients do not want other providers to judge them based on psychiatric diagnoses (i.e., personality disorders), violent symptomatology, or substance abuse. Negotiating which information to include in a chart and for what purpose remains a controversial issue.

One issue is the lack of clear understanding of the effectiveness or appropriate use of virtual healthcare visits in mental health (Garcia-Lizana & Munoz-Mayorga, 2010). Currently, there is growing empirical evidence regarding the effectiveness of telepsychiatry in the management of mental illness (Smith et al., 2020). A unique challenge is establishing if a professional relationship exists when using electronic communication (Maheu & Gordon, 2000). This is a prerequisite for liability claims and the lines are blurred when communicating with multiple professionals, some may have never met in person (Barnett & Scheetz, 2003). This can complicate the appropriate marketing of virtual psychiatric services and its role in emergency situations.

Emergency situations, such as a patient presenting as a harm to themselves or others, has led to broad societal, ethical, and medical concerns. Currently, the United Nations convention on the Rights of Persons with Disabilities has championed the discussion regarding involuntary treatment (Kelly, 2014). The rights of persons with disabilities includes humane treatment and the least restrictive treatment for the shortest duration possible. In practice, this ideal is often lacking and has led to a varying local and regional laws within the United States. In most states, involuntary treatment is mandatory if a patient states a plan to harm themselves or others with reasonable intent. This presents a unique challenge in the virtual environment, which is less controlled than a hospital setting. Detailed intake, including the identification of local resources for emergency situations, is recommended to practice ethical virtual psychodynamic psychiatry. Recent innovations in partial or virtual inpatient hospitalizations seem promising during COVID-19, although more research is needed to determine its effectiveness (Hom et al., 2020).

Further concerns include regarding virtual psychodynamic psychiatry includes the therapeutic alliance, nonverbal communication, and rapport. Many therapists report a negative outlook on virtual mental health regarding the effectiveness compared to face to face therapy (Przeworski, et al., 2012). These concerns highlight the belief that many psychological problems have been aggravated by our increasingly technological world. The fear is that virtual mental health support turns therapy into another commodity. This can be illustrated as being similar to fast food (which, like virtual psychotherapy, is efficient and affordable) versus a fine dining experience.

Recommendations

In general, there is a fragmented representation on psychiatry and the law in the literature. This paper aims to address some of this fragmentation, but more research will likely follow the recent increased interest in virtual psychotherapy. As interest in this area grows exponentially due to the recent global pandemic, more research in this area will continue to evolve. In the meantime, a review of the literature yields the following recommendations:

- Keeping up to date on these topics as there is currently an incomplete understanding in the literature through continuing education and academic materials.
- Carrying appropriate malpractice insurance that includes telepsychiatry coverage. Individual plans vary as some require additional coverage. Providers should be aware of their individual policies on this emerging area (Chen et al., 2020; APA, 2018; Recupero, 2014).
- Carefully evaluating commercial platforms which advertise “increased security.”
- The federal government requires access control, encryption, and an audit trail (U.S. Department of Health & Human Services, 2020).
- Discuss consent, terms of what constitutes a professional relationship, and appropriate boundaries.
- Recording sessions may not impair the therapeutic relationship as patients often forget that they are being recorded.
- Establish and make policies readily available regarding emergency situations.
- Research geographically relevant resources for patients in case of emergency and for continued in person support (Barnett & Scheetz, 2003).

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The Toxic Patient in Therapeutic Relationships Reimer Hinrichs, MD

Summary

“Toxic person” is another term for sociopaths, psychopaths, persons with a narcissistic personality disorder, dis-social and antisocial personal disorder, neurotic character, or some forms of Borderline structure. Typically, toxic people -at first - use a shining, intelligent and even empathic and eloquent pattern of communication, only to later misuse other people like business partners, family members and friends or acquaintances. Their purpose is to gain power by exploitation of other people.

In legal business, we can find them among politicians and financial advisers; in forensics, they can range from marriage

dodgers to stalkers, deceivers and serial killers. However, we rarely see them as patients in psychotherapy; and if we do, it is usually because they seek attention and have manipulative plans which are not of therapeutic value. Sometimes their pattern of purpose is to be the winner over the therapist, who is not allowed to react on a toxic level or in any other form of unethical revenge. That is what the toxic patients are aware of. As patients, they try to manipulate the therapist.

This paper tries to show effective ways for the therapist how to deal with the challenge of having accepted a toxic patient, or getting rid of her/him after having accepted such a person by mistake as a patient.

Epidemiology

Jane and Tim McGregor (2013) estimate that the prevalence of sociopaths is about 1-4% of the population in the Western hemisphere; both authors summarize every kind of toxic personality under the term of "sociopath". Kevin Dutton (2013) still calls all of them them "psychopaths". The authors McGregor also state that up to 25% of US-American prison inmates are toxic personalities.

Most toxic people -on the surface- are seemingly reluctant, in reality lurking, and superficially polite in the beginning of contact, just to learn and discover the weak side of their victims, especially the victim's empathy and readiness to support and help - and only after this learning they start their manipulations.

Especially, this pattern brings us to the therapist, who is supposed to be empathic, honest, and helpful, and, thus, he/she is in a special dangerous situation when meeting a toxic patient. And with this relationship we are dealing here. Maybe the term of "emotional indolence" summarizes all the toxic aspects and is their common denominator.

The Encounter with a toxic Patient

From a Berlin psychotherapeutic institute in which I am a member since 1984, I got an email message early in 2019 with the question if I can offer a diagnostic appointment or even a place for therapy for a 37 year old male patient who was reaching out for the institute's help in finding a place for psychotherapy.

On the time of the appointment in my office, a young, good looking, elegantly dressed and open man in his mid-30s came to me with a big smile, and was asking me -in very loud words -to "help him to get rid of his depression" in the middle of the waiting room with a lot of listening other patients from other medical offices.

The anamnestic interview in my room revealed that he was a law school drop out (10 years ago), that did not work since then, however he did use cannabis for many years and lives on welfare.

He also had discontinued an outpatient psychotherapy in 2009. He was in debt of the equivalent of 20,000 USD in Euros, and did not explain how these debts were built. His daily course of living was "tweeting and meditation". His parents and siblings lived nearby in Berlin, and all were in contact to each other.

At the end of the interview I told him that I don't see an indication for psychotherapy, but that he can come back any time if he needs help in further directing him to another therapist. That was in February, 2019.

In May, 2019, he wrote an email to the referring institute which brought him in connection with me. He complained about my behavior in the February meeting and told the institute to put his message of complaints into their files.

He mentioned his surprise that I answered his past cannabis consumption with the remark: "Don't worry, I did take heroin for many years". He also stated his surprise that I asked him about the cancellation of his psychotherapy in 2009 and the circumstances; he stated in his mail to the institute (in May) that I continued to ask him (in February) if he had a sexual relationship to his female therapist, and how the details were. His impression was that I was going too far in this.

The institute did send his email to me, asking me to comment on that. I answered, that we did talk about his cannabis history, and the disconnection of his therapy in 2009, but that all other statements in his email are untrue. I also said that I had no idea whether he was in therapy with a male or female therapist when he discontinued this therapy. Then I added that my impression of him was that of a toxic person, and I explained shortly my view on this term and matter.

The institute confirmed my email and that they put the conversation in their files of the patient. They told me that this patient was led to another therapist one year earlier in the summer of 2018 by the institute, which I didn't know when I met him in 2019, and that he now may be waiting a long time to find a new therapist, because this was his demand: the institute should further help him to get a place for therapy.

It was interesting that he called my office (which I share with two internists) twice in May, demanding to speak to me personally on the phone. We talked during his second call, and he asked me to confirm all he wrote to the institute. I answered that I can't do that, because my memory of our February interview was different from the contents of his email in May to the institute about our February meeting. He was laughing at the phone and said he felt pity that I don't have the guts to confess the truth to the institute.

Discussion

First, the toxic patient must be differentiated from other structures, i.e. against the patient with low intelligence or with lacking life patterns of honesty and social responsibility.

However, in toxic patients we are dealing with a different category, which can be really dangerous for the therapist. It is not a matter of rewarding versus frustrating work, but a question of the jeopardy of forensic and ethical integrity of the therapist, who has fallen into a toxic patient's trap.

Searles (1976) talks about a special matter of the toxic person's way of communication: changing levels of communication is a very quick and confusing way, a method, which, for therapeutic reasons, a hypnotherapist may use. The toxic patient uses it destructively against the therapist for the disintegration of the therapist's personal coherence. One of many methods is "gas lighting". Gas lighting is a slow method of gradually destroying another person's mind and mental orientation.

Hervy M. Cleckley (1941,1951), a US psychiatrist, was probably the first expert shedding light on the matter, as quoted by McGregor + McGregor (2013):

Superficial charm, lack of affects like fear or guilt,

dishonesty, inability to cherish lasting personal relationships, poverty in emotions, indifference about the consequences of his/her acting, as long as he/she has no advantages from it. According to Cleckley, these patterns are present, no matter whether the toxic person works inside or outside of the law.

The therapist's honesty and empathy, for the toxic patient, are very welcome attributes as weaknesses of the therapist, making him or her an easy target.

Toxic patient are chronic liars, not only in telling untruthful matters, but also in hiding important informations. In the patient's lies, dramatic and unusual circumstances about his life story are common. This activates the therapist's interest and compassion, and is the first step into the toxic patient's trap.

The therapist has to question everything the toxic patient says, or he may use the technique of creating an atmosphere of endless boredom, which is an easy way out, because the toxic patient, in this case, quickly loses interest in further meetings.

Listening to his countertransference reactions here is especially helpful for the therapist. A diffuse feeling of discomfort is a typical reaction in the presence of a toxic patient. The therapist can also feel an uneasy, but strong diffuse emotion, that he is betrayed in matters of time and contents of the patient's stories.

Within the therapeutic alliance, when it's too late, the therapist is in the Super-Ego working modus, which makes everything more difficult for him, because he is obligated to follow his ethical standards, which are constantly abused by the toxic patient. This means that the therapist is the toxic patient's victim without a chance of protection or adequate defense.

Ways out of the Dilemma

The classic way out is to end the connection professionally but clearly as early as possible; with this, I am thinking of a time during the diagnostic and assessment process and before signing any therapeutical agreement.

1. A good way is the truth, i.e. the therapist tells the patient simply that he cannot trust the patient and does not see a chance of working together.
2. Another form is creating an atmosphere of intense boredom.
3. The therapist can also ignore the false emotional concomitants of the patient's messages.
4. Another method is to be persistent in questioning the contributions of the patient, like a criminal detective is investigating a suspect, a highly sophisticated matter.
5. A fifth method is the therapist's avoidance of accepting the patient's pattern of communication.

To elaborate on this last point, the therapist can disturb the course of the session, initiate or answer phone calls, leave the room for using the bathroom or for copying documents, or leaving the communication while staying present in entering the meta-level of surprising the patient with contents which erase the patient's concept. He can ask the patient about his hobby, or traveling or dreams, whenever the patient starts a new story. Like it was said to Michael Douglas in the movie "Disclosure", where the character played by Demi Moore (the toxic Meredith Johnson) puts Douglas' character Tom Sanders in trouble in a business competition fight. Douglas'

anonymous and helpful friend tells him by mail signed "A. Friend": "It's not over. She plays her game. Don't play her game. Play YOUR game". It worked in the movie.

The strategies mentioned above may sound rude, but they are not unethical. In love and war, many strategies are working and allowed. And the contact with a toxic patient is always some kind of war.

Conclusion

There are toxic patients. If we see them in the diagnostic process as what they are and recognize them as toxic personalities, we can learn a lot. However, once we have them in therapy, what should not happen, complicated changes of therapeutic technique are necessary for the therapist to save himself from a dangerous situation. The crucial point is the time factor, i.e. the earlier the patient's toxic pattern is diagnosed as toxic, the better: "The earlier" here means: before establishing a therapeutic alliance. The best timing for the detection of the patient as toxic is the first interview appointment.

However, last not least, we should not forget that there also are toxic therapists; but this is another story.

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Hysteria: From Hystera to Hystrio

Henry Zvi Lothane, MD

The story starts with a physiological allegory of sexual excitement leading to the act of procreation in Plato's *Timaeus*:

And the seed, having life and becoming endowed with respiration, produces in that part in which it respire a lively desire for emission, and thus creates in us the love of procreation. Wherefore also in men the organ of generation becoming rebellious and masterful, like an animal disobedient to reason, and maddened with the sting of lust, seeks to gain absolute sway, and the same is the case with the so-called womb or matrix in women. The animal within them is desirous of procreating children, and when remaining unfruitful long beyond its proper time, gets discontented and angry, and wandering in every direction through the body, closes up the passages of the breath, and, by obstructing respiration, drives them to extremity, causing all varieties of disease, until at length the desire and love of the man and the woman, bringing them together and as it were plucking the fruit from the tree, sow in the womb, as in a field, animals unseen by reason of their smallness and without form; these again are separated and matured within; they are then finally brought out into the light and thus the generation of animals is completed (p. 1210).

This is a poetic mythical personification of the sexual instinct in both genders driving the urge to procreate and the propulsive sexual tension of the instinct in both men and women. But it is only in women that the inhibition of this mighty instinct causes a curious disease: what it does to men had to wait for Freud's formulating two actual-neuroses, anxiety neurosis and neurasthenia. Furthermore, Plato did not cite the noun "hysteria" or disease called hysteria but only pointed to an excited male organ desiring to have an emission into womb, *hystera* in Greek, desiring to be impregnated. There is of course a legitimate and genuine procedure to the womb in medicine when a surgeon performs a hysterectomy. On the other hand, the Leipzig psychiatry professor Paul Flechsig, immortalized by Freud as the doctor of Paul Schreber, literalized the metaphorical womb-disease and prescribed surgery as a treatment for an imaginary disease hysteria.

This history clearly shows that a disease called hysteria does not exist, that there are only women and men called hysterics or hysterical. Furthermore, there was no clearly defined disease hysteria in the Hippocratic works either, but only an adjective of a condition called *hysterike pnix*, i.e., uterine suffocation (Gilman et al. 1993). According to the Oxford English Dictionary (OED) the word hysteria was first cited in 1801 as an abstract noun and has been employed ever since as a code word, label, and pathologizing label of varieties of feminine and masculine conduct; however, for many years it was anathema among doctors to speak of male hysteria because, obviously, they had no womb!

In 1965 the medical historian Ilza Veith created a stir with her book *Hysteria The History of a Disease*, "in essence an expression of awareness of the malign effect of disordered sexual activity on emotional stability" (p. 2). Veith elaborated: "the connection of the uterus (*hystera*)

resulting from its disturbances is first expressed by the term "hysteria"...in the thirty-fifth aphorism which reads "when a woman suffers from hysteria or difficult labor an attack of sneezing is beneficial" (p. 10). I checked aphorism XXXV and the word hysteria is explained in footnote 3: "Said by some commentators to refer to retention of the placenta. Galen rejects this interpretation, but Littré seems to accept it" (p. 167). Emile Littré was the famous 19th century lexicographer who also propagated the noun hysteria. Thus, a fictional disorder got adorned by Veith with a fancy Freudian interpretation.

While Plato's fable is one sort of fiction and Veith's is another, as compared to the fact of sex in procreation, both the tropes of Plato and the tricks of Veith have their usefulness: they provide an easy tag, hysteria, for visualizing the picture or image of kinds of conduct. The words hysteria and hysterical have become naturalized in common parlance as indicating a person whose conduct is wildly emotional, excited, uncontrolled and exaggerated, in a word, histrionic. Another usage is to speak of the excited behavior of a crowd, or a mass of people, as hysteria. On the other hand, the word histrionic derives from the Latin word *hystrio*, a theatre actor, thus hysterical and histrionic are synonyms as well. Hysteria was the name of a faux disease that the young doctors at the Salpêtrière hospital rehearsed and staged as a dramatic performance for the benefit of Professor Charcot, the Napoleon of the neuroses, during his legendary public lectures that were attended by the Parisian elite and the young Sigmund Freud and immortalized in the famous 1887 etching by A. Brouillet that hung in Freud's office. The etching shows a swooning Blanche Wittman falling into the arms of Dr. Joseph Babinski which Freud feared might be perceived as "theatrical by ill-disposed strangers" (Freud, 1893a, p. 18) (Lothane, 2009).

To summarize: hysteria is an abstract noun, a myth, what exists and is observed are people and conducts labeled hysterical. Like gravitation, which cannot be seen, for only falling things can be seen, so hysteria is utilized as pointing to forms of conduct along a continuum from common to clinically pathologized. In the wake of Charcot, Josef Breuer and Sigmund Freud, solved the two thousand years old conundrum of hysteria by describing disorders they called, in the wake of Charcot, traumatic neuroses: reactions to traumatic life events, in their epochal 1895 *Studies on Hysteria*. The first case of a traumatic neurosis was Breuer's Anna O, the other women were patients of Freud.

Rereading that book around 2007, when I was visiting professor at the Heidelberg Institute for the History of Medicine directed by Prof. Wolfgang Eckart, I made a discovery: Strachey did not fully understand the meaning of a word used by Breuer to describe the conduct of Anna O., aka Bertha Pappenheim, the co-discoverer of psychoanalysis. The word in question, used in the 19th century and since obsolete, was the verb *tragieren* meaning to act and to perform a role.

Breuer offered this general observation of Anna O.:

With her puritanically-minded family, this girl of overflowing mental vitality led a most monotonous existence, although she probably exaggerated it to an excessive degree for her illness. She systematically nurtured day-dreaming, which she called her "private theater" (Breuer and Freud, 1909b, italics added, p. 14).

Her illness was a syndrome of withdrawal from her family life due to the trauma of having been roped into the role of caring for a moribund father while the day-dream-dreaming was a mode of surviving under these conditions and Breuer's almost daily visits kept her from being hospitalized.

Breuer described the following event:

Unfortunately, I had to leave the city the same evening, and when I returned after many days, I found that the patient's condition was markedly aggravated. Throughout the whole time she was entirely absentminded and full of anxiety. Her hallucinatory absences were filled with terrifying images of skulls and skeletons. As she lived through these things and dramatized them partially in speech, the people around her could understand most of the content of her hallucinations. In the afternoon she remained somnolent, and at sunset in a deep hypnosis, for which she coined in English the name of "clouds" (*italics added p.18*).

Freud focused on two kinds of dramatization: (A) dreaming of scenes while asleep, (B) fantasizing in waking day-dreams and noted in the 1900 *The Interpretation of Dreams* that "phantasies or day-dreams are the immediate forerunners of hysterical symptoms" (p. 491).

A. Dramatization in dreams:

Dreams then think predominantly in visual images, but not exclusively. They use auditory images as well... The transformation of ideas into hallucinations is not the only respect in which dreams differ from waking life. Dreams construct a situation out of these images, represent something as an event happening in the present,... they 'dramatize' an idea ... [I]n dreams ... we appear not to think but to experience ... we attach complete belief to the hallucinations. Not until we wake up does the critical comment arise that ... we have merely been thinking in a particular way" (Freud, 1900, pp. 49-50; three italics by Strachey, the second in the German original and without single quotation marks) (cited in Lothane, 2009).

Freud quotes Hildebrandt on "the dramatic representation mode [Darstellungsweise] in dreams" (1900b, p. 72). In a later text Freud defines again: "the transformation of thoughts into situations ('dramatization') is the most peculiar and important characteristic of dream work" (Freud, 1900, p. 653).

B. Dramatization in act

As described in the aforementioned vignette by Breuer. But dramatization in act and in dramatic monologue or dialogue is the very essence of the art form called drama, a word derived from the Greek root dran = 'to do,' thus doing versus dreaming. Drama was invented in Greece as dramaturgy, i.e., the art of composing dramas and performing dramas in a theater, e.g., the tragedies by Aeschylus, Sophocles, and Euripides, which were analyzed by Aristotle. But life itself was the source of these invented dramas, as it is today for the dramas of theater plays, television plays, and films. There is a need for a domain to accommodate both

real life and invented dramas for which I proposed the term dramatology (Lothane, 2009), a word still not found in the dictionaries.

Moreover, the aforementioned Breuer's interaction with Anna O. pointed to the fact that the treatment situation was a drama, too, a dramatic conversation and interaction between the patient and the doctor. Breuer employed Aristotle's idea of catharsis, purging the emotions of pity and terror for the spectators, to call his treatment of trauma as cathartic purging, also called abreaction, of strangulated emotions. Freud defined psychological treatment as an interaction with "words...the essential tool of mental treatment [having] magical power" (Freud, 1905, p. 283). As I showed, this essay was written by Freud in 1892 (Lothane, 2014), which I discussed in 2007, a foreshadowing of dramatology in 2009.

In that essay Freud described "what is known as the 'expression of the emotions'":

A man's states of mind are manifested, almost without exception, in the tensions and relaxations of his facial muscles, in the adaptation of his eyes, in the amount of blood in the vessels of his skin, in the modifications in his vocal apparatus and in the movements of his limbs and in particular his hands (p. 286).

Freud's keen interest in drama was described in his 1942 essay on psychopathic characters on the stage. Drama was also an interest of the American neurologist, psychiatrist and psychoanalyst Smith Ely Jelliffe in the first chapter "The drama and psychotherapy" of his 1934 monograph:

The drama has always been an important handmaid of culture, and in every age of human history its development has kept pace with that of culture. Its direct appeal to the senses, as well as its growing intellectual and artistic value, have made it always a leader of the thought of the race and of its form of expression. It has stimulated the people, educated them, directed their religious aspirations, and has served for their amusement and recreation. So well has it done the latter that the danger has increased of forgetting that these in themselves are conventional terms for something deeper and more significant. This is something that lies in the mental life below the surface and gives to the drama in its very function of amusement and recreation a far more serious purpose for which it intrinsically stands... It also permits a constructive representation of the emotions (pp. 1-2).

In 1979 the Swedish professor of the history of literature Gunnar Brandell documented Freud's interest in drama but was unaware of Freud's 1942 essay.

Back to Breuer: he not only participated in and observed Anna O.'s dramatizations (and those belonged to dramatology), Breuer also transformed the dramatic situations into a story, a narrative (and narratives belong to a domain called narratology, a word that is found in dictionaries). What then is the domain of dramatization? Dramatology and narratology are thus the two complementary sides of the same coin: one represents a life story in action and the other in story-making and story-telling.

Trauma as drama

In the afore cited Freud's remark about dreams, that "phantasies or day-dreams are the immediate forerunners of hysterical symptoms," the word symptom is a medical coinage. But phantasies and day dreams are not really forerunners, they are the so-called hysterical symptoms themselves. Hallowed by the medical model, we speak of 'symptoms' of paranoia the way we speak of the symptoms of pneumonia. But pneumonia is monadic, it takes one to develop pneumonia but paranoia is dyadic, it takes two to develop paranoia. But it was Freud himself who redefined neurosis psychologically and so,ciologically as action, or drama, as a continuum of health and disease:

Symptoms and of course we are dealing with psychical (or psychogenic) symptoms and psychical illness—are acts detrimental, or at least useless, to the subject's life as a whole . . . 'being ill' is in its essence a practical concept... you might well say that we are all ill—that is, neurotic, since the preconditions for the formation of symptoms can also be observed in normal people" (Freud, 1916-1917, 358; my italics).

Eventually Freud emphasized the sociological dimension of interpersonal conduct: "in the individual's mental life someone else is invariably involved, as a model, as an object, as a helper, as an opponent; and so from the very first individual psychology ... is at the same time social psychology as well" (Freud, 1921, p. 69), all this having dramatological implications.

It should be helpful to show how Breuer and Freud solved the 2500 years old enigma of hysteria: having "[investigated] over a number of years [its] many forms and symptoms... with a view to discovering the precipitating cause – the event which provoked its first occurrence" (Preliminary Communication, 1893, p. 3; italics added). The precipitating causal event turned out to be "a precipitating trauma... a girl, watching beside a sick-bed in a torment of anxiety fell into a twilight state and had a terrifying hallucination" (p. 4). The event was a historical fact with time and place and person(s), it was a scene, a situation, with a monologue or a dialogue, and as such could fairly be called a drama. And they concluded: "Observations such as these seem to us to establish an analogy between the pathogenesis of common hysteria and that of traumatic neuroses and to justify the extension of the concept of traumatic hysteria" (p. 5, their italics). On an analogy with Charcot's neurological neuroses caused by train accidents, Breuer and Freud described reactions to interpersonal traumatic events and *faute de mieux*, for lack of something better, called it traumatic hysteria. Today we have a different label for a reaction to trauma: post-traumatic stress disorder. Therefore, I submit, there is good reason to cancel continuing to use the convenient cliché hysteria, one can instead speak of traumatic reactions.

Two more matters were found relevant: not only the nature of the precipitating event, sometimes quite "trifling, but the affect of fright—the psychological trauma" (p. 6), both the stimulus and the response. And it is this psychic trauma that persisted long after the event: "the psychical pain that is remembered in waking consciousness still provokes a lachrymal secretion after the event. Hysterics suffer mainly from reminiscences" (p. 7, their italics). And there are sufferers from posttraumatic stress reactions, both civilian and veterans.

Another matter not dealt with in the Preliminary Communication was the pejorative use of the label hysteria to characterize imaginary illness of the mind, as in Molière's *Malade Imaginaire*, versus the real—and respectable—organic illness of the body. In 1893 Freud made the distinction between organic paralyses and hysterical paralyses, the latter "completely independent of the anatomy of the nervous system, since in its paralyses and other manifestations hysteria behaves as though anatomy did not exist or a though he had no knowledge of it" (1893, p. 169). Note Freud's allegorically personifying hysteria as a female entity or essence, fit for Occam's razor. For in fact there is no such thing as non-organic paralysis, what exists are persons imitating, enacting and playing the part of a patients afflicted with an organic paralysis who simply will not raise their arms or use their legs to walk.

Ideas can be likened to seeds planted in mind and memory that may lie dormant for years until they sprout one day to yield the fruit of previous insights. When I was a resident in psychiatry in Rochester, NY I heard and read my teacher George Engel (1962) comparing a "conversion reaction to the game of charades. In this game one is asked to translate a verbal (cognitive) message into bodily terms, as pantomime, as gestures or other bodily movements. They are meant symbolically to represent the cognitive content the player had in mind" (p. 369). Conversion reactions, Engel taught, "are most common in and characteristic of hysteria, a condition in which there is a predilection for the use of the body for expression of feelings, wishes, and ideas, but it is not correct to equate the conversion reaction with hysteria, as has been customary in the past" (p. 369), without saying why this is so. But the inescapable conclusion back then was that hysteria is not a condition, that it is conduct and as such no different from ordinary people expressing their emotions with their bodies in gestures, tone and volume of voice, let alone pantomime, grimace, laughter, and tears, as did Freud in the aforementioned 1905 essay. Thus, conversion failed as an adequate explanation as indicated by Engel himself: "a forbidden wish is kept out of consciousness but at the same time is translated ("converted"), not into words, but into some bodily activity or sensation which suitably represents it in a symbolic form" (p. 369). Putting conversion in quotation marks and adding the synonym of translation suggested that hysteria, too, was nothing but "hysteria," a *façon de parler*, a turn of phrase. In retrospect Engel's teaching was the seed of my dramatology.

Now dramatology is not a theory to explain a disease labeled hysteria but a method to understand the person, however labeled, the person's character and conflicts, the person's outward appearance and inward thoughts, feelings, and motives of acting. Consider the example of the only male case of a traumatic reaction in the *Studies on Hysteria*:

An employee who had become a hysteric as a result of being ill-treated by his superior, suffered from attacks in which he collapsed and fell into a frenzy of rage, but without uttering a word or giving any sign of a hallucination. It was possible to provoke an attack under hypnosis and the patient then revealed that he was living through the scene in which his employer had abused him in the street and hit him with a stick. A few days later the patient came back and complained of having another attack of the same kind. On this occasion it

turned out under hypnosis that he had been re-living the scene to which the actual onset of the illness was related: the scene in the law-court when he failed to obtain satisfaction for his maltreatment (1893, p. 14, italics added).

With or without the word, hysteria would enable a writer like Chekhov or Maupassant to compose a short story built on these same scenes.

Another example is the case of Dora, aka Ida Bauer, whom Freud treated in 1900, wrote up mostly in 1901, and published in 1905. Dora's family and family drama were replete with scenes of seduction, sexual manipulation, intrigues of infidelity, love barter, and betrayals so that Freud wished he could write her story more as "a man of letters engaged in the creation of a mental state like this for a short story, instead of being a medical man engaged upon its dissection" (Freud, 1905b, p. 59). But at this point in his life Freud did not listen to Dora, as he did to his patients who were his teachers prior to 1895, but used her as a test case to prove his oedipal theory of hysteria (p. 56) and a sexual theory of hysteria, bombarding her with interpretations which resulted in dramatic verbal duels. Seeing Dora as "a girl of intelligent and engaging looks" (p. 23), "sharp-sighted" (p. 34) and firing "arguments," "rejoinders," "objections," and "contradictions," Freud, was just as sharp in his rejoinders; while not feeling justified "to attack" her thoughts, he nevertheless repeatedly confronted Dora, for "to make an omelet you have to break the eggs" (p. 49). However, the main reason for Dora's breaking off her treatment after three months, I submit, was that Freud was not loyal to her rebuffing a sexually exploitive and unscrupulous adult like Herr K. and others but was siding with them and critical of the patient. And Freud admitted himself: "Might I perhaps have kept the girl under my treatment if I myself had acted a part, if I had exaggerated the importance to me of her staying on, and had shown a warm personal interest in her—a course which, even after allowing for my position as her physician, would have been tantamount to providing her with a substitute for the affection she longed for? I do not know" (p.109).

Proceeding to rationalize the termination Freud argued: "the factor of 'transference' did not come up for discussion during the short treatment" (p. 13). Only after Dora left him did Freud realize that "the transference took [him] unawares" (p. 118) and got dramatic: "She took her revenge on me as she wanted to take her revenge on [Herr K.], and deserted me as she believed herself to have been deceived and deserted by him. Thus, she acted out [sie agierte] an essential part of her recollections and fantasies instead of reproducing it in treatment" (p.119; italic Freud's), self-pityingly "demonstrating the helplessness and incapacity of the physician" (p. 120). 'Agieren,' from the Latin *agere*, to act, does in German mean both doing and acting a role in a play, reverberating with Breuer's 'tragieren,' and thus overdetermined consciously and unconsciously. Dora's termination was not just acting out but her own decisive action to stop treatment and was blessed by Freud: "You know that you are free to stop the treatment at any time" (p. 105), showing that Freud conflated acting out with action. Moreover, Freud viewed acting out as an antonym of remembering, for acting out is an unconscious enactment of a memory of a past event. I recall a point made by Brenner in

a presentation in 1968 that not it is only dreams, enactments can also be a royal road to the unconscious.

But there was a silver lining to Freud's lament:

Dora dramatized her conflict with Freud, as other women before her; but here confrontation, contest (agon), and combat occupied center stage: she acted and—[according to Freud]—she acted out. Hence the new conception of analysis as a transference drama played out between two protagonists turned antagonists, in which "this latest creation of the disease must be combated like the earlier ones. This happens, however, to be by far the hardest part of the whole task. It is easy to learn how to interpret dreams, to extract from the patient's associations his unconscious thoughts and memories, and to practice similar explanatory arts: for these the patient will always provide the text" (1905, p. 116; my italics). Interpretation alone is no longer sufficient: "since a whole series of psychological experiences are revived not as belonging to the past but as applying to the physician at the present moment" (p. 116), since "all the patient's tendencies, including hostile ones, are aroused" (p.117), explanation needs to be amplified by confrontation. In this way, "transference, which seems ordained to be the greatest obstacle of psycho-analysis" (p. 117), became a crisis, a challenge, and an opportunity (Lothane, 2009, p.141).

Here, too, dramatology, in agreement with Freud's confrontational approach, makes a contribution to the tradition of psychoanalytically-oriented psychotherapy.

So far dramatology has been cited positively by Philip Bromberg (personal communication), James Grotstein (Brown, 2011, p xvii), Galit Atlas and the late Lewis Aron (2018, p. 47, 54, 84). New ideas tend to arouse suspicion: if it is true it, is not new is a common reaction. Dramatology is both old and new and calls for a rediscovery and a reaffirmation.

Some objections to dramatology as method might be raised in the spirit of entries in the psychoanalytic dictionary of Moore and Fine (1990). The author of the entry "Hysteria," citing four references (the Studies, the Dora case, Fenichel's *The Psychoanalytic Theory of Neurosis*, and a paper by Rangell on conversion), does not mention the word trauma and starts by claiming that "involved in psychic mechanisms in hysteria [Freud] discovered unconscious fantasy, conflict, repression, identification, and transference, marking the beginning of psycho-analysis" (p. 89). This heterogeneous list is incorrect: psychoanalysis began with the Preliminary Communication and *The Studies on Hysteria*. One statement seems to support the idea of dramatization: "The hysterical spells often pantomime complicated fantasy stories that can be analyzed in the same way as can the elements of the manifest dream, both phenomena are products of the distortion resulting from mechanisms of the primary process" (p. 90). But this correct insight is immediately vitiated by claiming that "the bodily symptoms of hysteria involve motor, sensory, or visceral phenomena—anesthesia, pain, paralysis, tremors, deafness, blindness, vomiting, hiccoughing, and so on" but also that "the symptoms therefore represent an expression in "body language" of specific unconscious fantasies" (p. 90). This is another mixture of quasi-neurological descriptions of physiological

sequelae of strong emotions and the symbolic nature of body language (see chapter 32 and 33 on compensated and uncompensated states). The term acting out is often used colloquially as a synonym for acting up, to behave in an unruly or capricious manner.

Finally, the author of the entry “action” claims that “analysts think of action as something opposing the psychoanalytic process, for example when psychopathology takes the form of disruptive, maladaptive, or inappropriate behavior” (p. 3). I disagree: action is not inimical to psychoanalysis; any action or enactment can be grist to the mill. Here Wilhelm Reich’s character analysis of identifying and confronting habitual character attitudes, both traits and states (Lothane, 2009, p. 146), and dramatology offer an approach and a method: all forms of action can benefit from applying the psychoanalytic method of analyzing enactments the way one analyzes dreams, that is with the help of free association (Lothane, 2018).

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Psychoanalytic Reflections During the Pandemic

Ahron Friedberg, MD

Introduction

This paper is based on excerpts from my forthcoming book *Through a Screen Darkly Psychoanalytic Reflections During the Pandemic* (Routledge 2021). Like the book it is structured into 4 Parts, and I’ll use them to highlight different aspects of resilience: 1) The Pandemic, 2) Venturing Out, 3) The New Normal and 4) Life Simplified (not really).

Together, they follow the arc of the pandemic from its sudden, overwhelming wallop; our tentative re-emergence from lockdown; the experience of a changed world; and development of new strategies for coping and rebuilding. But I want to emphasize that none of these parts represent discrete time periods, say, February through April or May through July. Rather, they represent a change in mood, a sort of shared sense that things had become somewhat different. Maybe it is okay to venture out, whereas before you risked your life. Maybe stores are open, but curbside pick-up is the rule. The differences are not stark, but it is possible to sense a change.

My subject throughout *A Screen*, however, and what ties this paper together, is the psychological effect produced by the pandemic, followed by how my patients learned to cope and to call on and developed resilience: our capacity to bounce back from adversity.

Definition of resilience

Firstly, I should note that while *A Screen* may provide some guidance regarding how to get through the pandemic, it is not an instructional manual. It is not systematic. It describes the world as I have seen it. However, the examples that I include reflect general principles of resilience that I would like to emphasize. In “10 Ways to Build Resilience,” The American Psychological Association suggests practices that, in some personal combination, can help us bounce back from trauma: (1) Make connections with people and build strong relationships with family and friends. (2) Avoid seeing crises as insurmountable problems. (3) Accept that change is a part of living, and there are circumstances you cannot alter. (4) Move toward your goals but make them realistic. (5) Take decisive actions, and act on adverse situations as much as you can rather than being passive. (6) Look for opportunities to discover more about yourself and gain an increased sense of self-worth. (7) Nurture a confident, positive view of yourself. (8) Keep events in perspective, and do not blow them out of proportion. (9) Maintain a hopeful

outlook, and visualize what you want. (10) Take care of yourself by paying attention to your emotional and physical needs. In examining the lives of my patients, I have touched on most of these.

Additionally, in *Resilience: The Science of Mastering Life's Greatest Challenges* (2012), Dennis Charney and Steven Southwick observed that to survive stress, cognitive and emotional flexibility are crucial because they enable you to tolerate a highly stressful situation and reassess it. As in your own body, flexibility enables you to move, and to change directions as you continue to evaluate your position. During stress, movement is more important than knowing where you will ultimately end up. They argue further that assigning meaning and purpose to life can strengthen one's resilience and may help prevent the symptoms of stress from becoming worse—and even learning to thrive.

Part I: The Pandemic

Summary: Part I begins in late February, 2020, and covers a period that lasts roughly through the end of May. It emphasizes how, amidst undeniable catastrophe, my patients develop coping strategies and even learn to cultivate hope. They write songs and poems that become cathartic; they learn languages that connect them with tradition; they recover enough self-confidence to return to work. Doctors, suffering from guilt and burnout, reconstruct a sense of mission in the face of apparent hopelessness. In effect, these people equip themselves to keep going. They step onto the narrow, shaky bridge of this pandemic (towards no one quite knows where) but they do not look down. They think they will get to the other side, but accept the idea of not knowing where they will emerge. Part I examines the uncertainty of the moment.

Vignette 1: Physician Stress

Physicians on the front lines of any public health crisis tend to open up to psychiatrists because, after all, we are physicians too, with M.D.s after our names. The assumption is that we can empathize immediately, with no lengthy explanation required. It's like when you meet someone and think, instinctively, "I've known this person all my life." When physicians come to see me, they crave this instant response – they're pressed for time, stressed-out, and looking for support from someone who gets it.

Of course, working with physicians stresses me out too. Their expectations are high and I don't want to disappoint. I also know, deep down, that my life is easier than theirs. I have to transpose my relatively sheltered existence to the chaos of a hospital ward, where patients are wheeled in for emergency intubation and monitored minute-by-minute as they cling to life. I don't exactly pretend to have been there, but I stretch myself to understand. I admire their courage, am even in awe sometimes, but it's helpful to us both if I don't show it.

Dr. J, a physician in his mid-thirties, drew on all my capacity for empathy. He presented over a year ago with anxiety and depression, stressed over his work in an ER and uncertain about his girlfriend. Then COVID hit. He had been called over a weekend to work a double shift. Hospital beds were filled to capacity and medical supplies were dwindling. He had to use the same N95 mask for the entire day, which

worried him, since a co-worker had contracted the virus and unexpectedly died. I acknowledged how vulnerable that must have made him feel, and he teared up over the loss. He recalled his brother who died of a drug overdose and wondered if he and his family might have done more to help him. I said that his present loss had brought up feelings from the past, and that we could talk more about that over time, but for the moment we had to help him deal with his current situation. I suggested that even though he was asymptomatic, he should be tested for COVID.

About a week later, he developed symptoms and tested positive. He self-quarantined for two weeks and is now doing better. But he has asked to talk about his feelings – in particular, the continuing stress – so that he can process it before diving back in.

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

For Dr. J resilience will entail dealing with acute and chronic stress, sometimes at once. We spoke about grabbing moments to relax, basically to allow himself to recover. The harder that relaxation seemed, I suggested, the more crucial it was. Of course, skyping from my home office, with none of my patients critically ill, I felt self-conscious ordering relaxation. But I hoped that if I was honest and shared my feelings, Dr. J would take my advice. I think that one of the biggest challenges posed to psychiatrists by COVID is that it exacerbates a concern with emotional detachment that we frequently have anyway: How can we give advice when we are outside the situation, looking in from a position of relative comfort? My response is that both Dr. J and I need to take a step backwards, remove ourselves from our personal psychological environment, and objectively think about how he can adjust to this crisis.

The fact is that Dr. J is starting from an enviable position, however precarious he may feel. He has a terrific education and has worked his way up to shoulder huge responsibilities. Often, it helps to recall the mountains we've climbed to bolster our resolve for the next attempt. Dr. J (who takes this M.O. literally) told me that every time he wants to give up, he pulls out his photo of crossing the finish line of the New York City Marathon. He wasn't fully trained and prepared for the event (he had done a couple half marathons and one 18 miler). So he wasn't fully confident he could go the distance. But he kept putting one foot in front of the other and made it (in under four hours!) Recalling past accomplishments can be a source of strength. It helps us maintain our self-esteem when guilt, exhaustion, or failure allow us to forget why we should be self-confident.

Dedicated self-care is not vanity. In a time of plague, it may seem vain to focus on oneself any more than is necessary to stay alive. But evidence demonstrates that dressing well and staying groomed – even if no one is around to appreciate the effort – can reassure us that we are not giving in or giving up. In a recent "Here to Help" piece, the *Times'* fashion editor, Vanessa Friedman, suggested that thinking about one's self-presentation at this awful moment

can “be a sign of faith in the future, and the idea that one day we will again be in public, dressing for the occasion, not hiding away from each other.” That’s a powerful message. So much of getting through this will depend on the belief that we will make it through.

Part of belief depends on acting “as if” we believe. Putting our money where our mind is. Belief becomes a performance, even if we are the only audience.

I have been reading lately about how mathematical models of this pandemic are in constant flux, and that no modeler is confident enough to predict the virus’ course more than two months out. In mid-April, one of them admitted: “We are reasonably certain until approximately June 15 . . . After that, God knows.” It takes an act of will to live under that paradigm, much like running a marathon or climbing the Himalayas. My physician patients, who go back on the wards every day, have been trained to practice resilience. As best we can, so must the rest of us.

Part II: Venturing Out

Summary: This Part involves reconnecting (after a period of quarantine and self-imposed isolation), albeit gingerly, with others and with oneself. I treat doctors who, for example, are still stressed to the max; they figure out how to curtail a sense of failure and inadequacy. Some patients apply for jobs remotely, perfecting a screen persona. They let go of old assumptions about what they “should” be, and think in terms of what is possible. This is not a lowering of their sights; rather, it is a cultivation of peripheral vision. Such resilience requires hope, a version of the possible. Possibility turns out to be a complicated term. If it replaces old certainties, it still allows us to consider the future from a new, unaccustomed angle of approach. There are no guarantees, but neither are doors to the future entirely shut. We simply have to adapt. Ultimately, the chapter concerns where and how to set limits, and how to enforce them. Many of my patients have never faced such questions so directly or with such psychologically potent consequences.

As I wrote these accounts, I realized that the common thread was personal creativity, the capacity of all these individuals to devise ways of problem-solving that worked for them. They appeared, instinctively, to have taken their own measure, and to understand what they could accomplish when the whole notion of possibility still seemed so constricted. They took the sort of risks, made the sort of accommodations, that suited their personalities and capabilities. In other words, they knew themselves pretty well, if only because the pandemic had thrown them back on their own resources, forcing them to think about themselves as perhaps they had never been forced to do before.

If any good thing emerges from this siege, it will be that people had closer encounters with themselves than they had ever thought necessary (in effect, venturing out precipitated an inward turn). My role was to facilitate that encounter, to ensure people that – however unaccustomed – their inward turn would be outwardly useful as the world opens up.

Vignette 2: To Commute or Not?

Since March, I’ve worked from the attic in my home – Skyping, FaceTiming, Zooming, whatever suits my patients. I call the place my “office,” in the sense that a turtle might

refer to his shell: it follows him around, so he inhabits it. It’s funny how wherever we do business becomes an office. Starbucks is some people’s office, which suggests that the whole idea of professional space has diminished in gravitas since the digital revolution. It has certainly diminished during this pandemic, where the office is likely the living room table ten feet from the kids making videos on Tik-Tok.

I spend a lot of time in my makeshift office, which is up three flights of stairs. It’s smaller than my space in Manhattan, and a little claustrophobic. But interior dimensions are not the real issue – especially when your focus is confined to a screen that is orders of magnitude smaller! It has emerged, after about a month or so, that the problem is the truncated commute between my personal and professional space. From Great Neck to Manhattan is 22.4 miles, 39 minutes on the Long Island Rail Road. I climb the stairs in 20 seconds.

Of course, nobody likes commuting qua commuting, but the transition that it provides has a certain appeal. You arrive at Grand Central, with all the other people making a transition, and voila, there is a collective sense that you’re all professionals ready for work. This notion of collective cognition is no joke – you see it in birds and fish, for example, that suddenly veer off in sharply defined new directions. We don’t know how they communicate, but they do. Yet when I’m at home, in my attic, I’m alone. I communicate (sort of) with myself. I assume the role of psychiatrist but it feels like a role – like I’m playing one until I convince myself that Yes! This is Me! I feel like a method actor applying Stanislavsky.

It’s much easier when a bunch of stockbrokers, lawyers, and Madison Avenue types reinforce each other’s commitment to the day.

So, I go upstairs maybe an hour before my first appointment with a patient so that I can ease into the role. By the time we’re talking (through whatever medium), I’m fully Dr. Friedberg. But still, I’m not quite used to this makeshift transition period, a consequence of my makeshift office, and so I’m thinking of returning to work in Manhattan.

Several of my patients are starting to commute again, though we’ve talked about why. Do they also miss the transition? One of them said, “You know how at the end of the day you want to wind down? Well, on the train to work I wind up.” He thinks about the stress that he’s in for, and accommodates to it in advance. “It’s like every day is a suicide mission, so I may as well be ready.” This isn’t exactly my rationale, but I get the point.

Yet I don’t get it entirely, since these same people report that they’ve found a certain freedom in working from home: more family time, more leisure, more time to exercise (you can lift a lot of weights in the 90 minutes that you save every day). Why give any of this up, provided that you have the choice? Many of my patients do.

On balance, I think it’s because for all the freedom that working from home confers, and all the psychic value of making perceptible transitions, we like to disappear for a while. Commuting lets us disappear. We are on our own. In charge of ourselves. It’s primitive, but it’s a thrill. Another of my patients said “When I get off the train in the morning, nobody who knows me sees me and I feel like I’m in the Foreign Legion.” Yearning to get back to that is like yearning to go back to one’s fantasy of a past. I get that.

Part III: The New Normal

Summary: This Part extends into new patterns of life that emerge as the pandemic lumbers on (it will remain with us until there is a vaccine). Thus, these essays are about getting used to change – new ways of dating; going to school; traveling. Though many such activities may not be stressful in themselves, getting used to them – that is, making the transition – can call into question our judgment, even pitch us into bouts of guilt. We may worry, for example, that our resistance (or simple ineptitude) makes it harder for others to get on with their lives. On the other hand, we may resent those who accommodate more easily. We may really resent those who have done better financially. I counsel people who have trouble with changed circumstances, and help them to develop skills for dealing with change that (deep down) they do not want to accept.

As the pandemic lumbers on, new patterns of life emerge – so unsettled that “pattern” seems like the wrong term, too optimistic, too discernible. In some cases, we hardly recognize ourselves. Thus, Part III is about getting used to change – new ways of dating; elder care; shopping; pursuing a career.

While some of these altered activities are stressful enough, our getting used to them – that is, making the transition – can call into question our judgment, even pitch us into bouts of guilt. We may worry, for example, that our resistance (or simple ineptitude) makes it harder for others to get on with their lives. On the other hand, we may resent those who accommodate more easily. We may really resent those with the wherewithal to ignore what’s troubling everyone else (as they depart the City for second homes, do business remotely, and school their kids in protected “pods”). In Part III, I counsel people struggling with change, and help them develop skills to deal with alterations that (deep down) they do not want to accept.

The New Normal is continuous uncertainty . . . except that now we’re getting used to that, and trying to figure out short-term fixes. Our horizons have become shorter. Why make plans when you’ll just have to alter them tomorrow?

Yet we still have to live, and make do with the resources and choices that we have. The one bad option is to stand still, awaiting clarity (which could be a long time coming). So, we use our judgment, and realize that we’re canner than we’ve ever known ourselves to be. We contrive what we need right now to live with reasonable degrees of dignity, self-respect, and hope. We learn how not to cut off options, even as we make provisional choices.

Vignette 3: Elderly Parents

The pandemic is reconfiguring families. Children who are back from college are now bemused (if somewhat discomfited) that their old rooms were (in their absence) turned into memorials to their long-forgotten selves. Grandparents follow, afraid to be alone but (like their grandchildren) bewildered as to where exactly they will fit in. In the middle, parents manage everyone (sort of).

I’m thinking of my patient Bob, who – like many wealthy New Yorkers – has decamped with his family to the Hamptons. His elderly father, Dan, lives alone in Boston with a caregiver, and desperately wants to spend time with his grandchildren. At 93, he fears that he hasn’t much time left.

Bob drove to see Dan a couple weeks ago, but Dan yearns for the whole family. He survived the Holocaust and WWII, and his loneliness now encompasses the next world. “I hope Mildred is waiting for me,” he told Bob. He misses his wife, whom he lost last year.

Yet while Bob and his family want to see Dan, and think that he’d like the Hamptons, they wonder whether such a visit would be safe. Would permitting it even be responsible? We spoke about finding a sensible approach, so that no one would feel guilty and no one would get hurt. My own complicated concerns about seeing my 90-year-old parents lurked in the background. For the longest time, I struggled to live up to my father’s example, and I knew how hard it was to engage with one’s father objectively.

So, I wondered how anyone (namely me) could advise anyone else concerning elderly parents in a pandemic – the situation is so personal, so bound up with one’s relationship to one’s parents. The most I could do was to help Bob think through his feelings.

In fact, and as I suspected, Bob’s feelings were not just about pandemic-based logistics. His attempt to assess his father’s visit was not – and could not be – objective, based on his complicated feelings. These went deep into his history with his father. Though Bob was not initially aware of why he was having such trouble deciding, we were finally able to discover it: his real concern was whether he could trust his own judgment (and treat his father accordingly), or whether his judgment would be colored by this history.

Bob had joined the family real estate business – a modest, if successful operation – and had built it into a fiefdom. Though Dan remained its titular head until a few years ago, Bob had made the quiet, lucrative deals that paid off as the City gentrified. But the company was still Dan’s. Until a formal reorganization transferred ownership of the business to Bob, everyone knew it was Dan’s. Bob assumed that people wondered why the transfer took so long. “Maybe they think I got here by default.” For a very long time, therefore, he felt that he had never “been the business,” as he liked to say, and that he had never been allowed to receive the recognition he deserved. “Why couldn’t my father just bow out gracefully?” he asked. “Why did he have to keep living his illusion – at my expense?”

I saw this pattern with Bob and his father. He was always a dutiful, respectful, even compliant son. But he harbored feelings of resentment about being under his father’s thumb, which especially rankled after he had exceeded his father’s accomplishments. I felt that these feelings inflected how he viewed his father’s potential visit to the Hamptons.

For sure, there were legitimate health concerns. What if his father should get infected with COVID-19 and die (COVID was especially lethal to the elderly)? Would Bob be at fault, even though his father asked to come? (Bob was in charge now, and his decisions carried greater weight). The children were beginning to socialize with other children. His wife owned a fashion store in town and came in contact with her clients. He occasionally met with clients, albeit out in the open.

Thus, the whole situation was complicated. While Bob had concerns that were reality-based, they were tied up with feelings of competition and resentment toward his father. When I told him so, he acknowledged that it was true. Such feelings had, in fact, surfaced during our years of working together, and had complicated other problems that he had

faceted. During the current crisis, people can rarely deal with health issues head-on; they are refracted through other issues that we carry around – indeed, that they have carried around for years.

In facing COVID-19, we face multiple issues simultaneously. Some seem acute – like how we care for elderly parents – while others have just never gone away, like how our relationships with parents still bother us. All of these issues now appear to gang up on us, so that we can't deal with any one of them on its own. In a perverse multi-dimensional matrix, each makes the other harder to isolate and individually solve.

The pattern is a classic example of stress, where one stressor aggravates others – sometimes it's impossible to tell which aggravates the other and, in fact, it rarely matters. For Bob, the immediate present (what to do about Dan) and the lingering past (the Oedipal remnants of their relationship) converged, leaving him uncertain. He wanted to make his father happy, but he was afraid that his judgment was unreliable – even warped – to his father's detriment. "Can I trust my own judgment?" he asked.

At the very least, Bob understood his dilemma. He was self-aware . . . but for that very reason, feeling immobilized.

He also found humor in how his fantasy- and quotidian lives merged like two images projected from opposite directions onto a screen. There was irony, he said, in how reality – the pandemic – had roused his Oedipal fantasies. "It's like science meets the Loch Ness Monster," he suggested. So how do you resolve this fix?

I found the dilemma fascinating. Often, it's hard to establish the contours of a patient's reality based solely on how they describe it. As we dug deeper, we had to disentangle objective reality – the dangers to the elderly from COVID-19 – from psychic, intersubjective reality. Once we did that, however, Bob thought he could put his Loch Ness Monster aside, and make a reasonable assessment of the risk. He plans to tell his father that the family will visit Boston very soon. It's not ideal, since it means less time with Dan, but it will be less stressful for everyone else. During this period, it's okay to act in the interest of stress reduction – especially, as in Bob's case, where the result makes everyone at least minimally happy.

Part IV: Life Simplified (not really)

Summary: These essays concern the apparent simplification of living with fewer choices – a situation that, in fact, turns out to be just another complication. How do we navigate a world in which so much appears to be closed off or, worse yet, permanently closed down? How can we cope with a new kind of isolation – not indoors, precisely, but still cut off from the exploding capitalist phantasmagoria of pre-pandemic America? The only reasonable approach, which my patients come around to, is to adjust their estimate of what actually matters. They move further towards the connections that they have; they cultivate newer, more satisfying connections; they become more introspective to compensate for the loss of easy outlets to fun and distraction. In this sense, they become more like people used to be, say, at a time when access to fun and distraction was not so easy. Part IV is about the complications of living a simpler, more focused life, after we have lived so long with a plethora of choices. Commitment entails a heightened sense of consequentiality. This worries my patients; we discuss it.

My patients feel the effects of this narrowing (they might say harrowing) diminution of choice. The lack of child-care, for example, exacerbates tensions in a relationship and ultimately causes it to fracture. Children pick up notions of a cramped, grayscale future without the bursting primary colors that, until recently, they thought would surround them forever. Single people sink into a sea of regrets, blaming themselves for mistakes that have led to unbearable loneliness. The pandemic has exposed feelings that, once hidden or repressed, are now raw and rampant.

Amidst all the resulting disorientation, I experience my own stress. More patients, more grief – it feels so unrelenting. I force myself to stay focused, I worry that my patients will start worrying about me. We're all in together, I keep thinking, psychiatrists included.

Vignette 4: Acceptance

You know that old Pete Seeger song, with the line "God bless the grass that grows through the crack"? I thought of it today when I walked down Park Avenue near my office. Throughout the pandemic, the buildings have kept up appearances. You wouldn't even know there was a pandemic – except for the scarcity of people.

But, as in the song, there are little unstoppable outcrops of nature, blades of grass where the concrete sidewalk has pulled away from the buildings' bricks. There are even weeds (weeds!) on the median running down the center of the Avenue, butting heads with the manicured flower arrangements. In other words, no obstacle (not even concrete) is impermeable. As in the song, the concrete "breaks and . . . buckles," and the grass finds its way. The metaphor, because that's what it is, drives home the message that there's some kind of eternal work-around that, after a while, just becomes inevitable. In the protest era of the '60s, that song – with its subtle, but by no means innocuous message – was the quieter counterpart of "We Shall Overcome." In the pandemic year of 2020, the song says Look Around You, people are finding their way.

It's not that anything is close to normal – not work, or schools, or sporting events. Midtown is silent. Even some Starbucks have closed. But energy, and more specifically inventiveness, are starting to come back (poking through concrete, as it were). Today, the Times ran a story with the headline "6 Months on, Transformed New York Emerges," with the lead "Signs of resilience as virus deaths in U.S. surpass 200,000." It went on to describe women who lost their jobs, and began selling street food; a nurse who planted corn and sunflowers on the median of a closed-off street; outdoor Zumba classes; artists sketching murals; stores selling dresses with phone-images, and arranging home delivery. It was terrific. There were quotes from ordinary people, citing resurgent feelings of community. Some people said that New York was showing its true, indomitable self.

Finally, I think that the key to this article is the phrase "6 Months on. . ." With no clear end to the pandemic in sight, and cases actually rising in some parts of the country, New Yorkers are tired of waiting for this to go away. But rather than just throw caution to the winds, we've started to learn to live with the virus. In other words, we've moved on to the fifth stage of grief: Acceptance. Once you finally get past the denial, anger, bargaining, and depression, you move on. You figure out what to do. You work with other people who

maybe can help. As Bertrand Russell said, “Acceptance is the beginning of wisdom.” And as Reinhold Niebuhr said, “Grant me the serenity to accept the things I cannot change.” That is, there’s no point wasting energy when you could be trying to do what you can.

For some people, acceptance is difficult. They’ve always had everything their own way (more or less), and find it hard to adjust to straitened circumstances. It’s an affront – so why even bother? In fact, those Park Avenue apartments are empty because their inhabitants couldn’t be bothered. So, they moved somewhere else. But I wonder how they’ll manage when, finally, they return. Will they feel like Rip van Winkle, bewildered by all that’s changed? Will they get with the program, or remain stuck in some stage of grief that is totally disabling? I guess we’ll find out. But they’re less interesting, for now, than the people cited by the Times. These are middle- and working-class people who always had to be elbow past concrete (!) and intangible obstacles in order to live here. They’ve always been scrappy. For them, growing through the cracks has been a way of life. Now, having accepted what’s happened, they’ve returned to doing what they’ve always done, acting out plans to make life livable. It may be that everyone, eventually, will have to follow their lead.

Of course, there are fewer options. Of course, it won’t be easy. But people have come to terms with having to exploit the options that they have. They’re figuring out ways to stretch those options.

We tend to think of Acceptance as a stage in the grieving process marked by withdrawal and calm. It’s not happiness so much as repose, a kind of benign stasis. But I don’t think that works here . . . and by “here” I mean post-pandemic New York City, and wherever else you want to apply the principle of getting on with life. Once we’ve reached the stage of accepting the virus, and the toll that it’s taken (and is still taking), we act in ways that are the opposite of withdrawal and calm. We act in some kind of subliminal concert, even showing signs of excitement when things start to turn round. No, we’re not just “bouncing back.” but we are bouncing. We’ve summoned energy from somewhere to save what’s left and, ideally, create new opportunities. We’ll have to, since so much is gone.

The effort will be long-term. One of my patients, who stayed in the City, remarked “I wonder if I’ll live to see some real kind of normal.” I suggested that what exists now is just as real as what was previously “normal.” It’s just that the emphases are different. We have to try harder. We have to be nimbler. We have to accept what we can’t change, but avoid accepting some comfortable, outmoded version of ourselves. We need to find new ways to sustain our lives when, in many ways, life feels diminished. Other people have figured out how – or, at least, they’re actively trying.

In this parlous period, when a second wave is possible, we can still hope that mere survival is too short of the goal. It’s legitimate to want something more. But the onus is on us now. We have to hustle, New York style. Think of the grass, next to the bricks, sprouting pugnaciously.

Conclusion

Hope is the underlying thread tying these stories together. They examine how to ground hope in the resources that each patient can draw on. Psychiatry works through dealing with problems based on what a patient knows or has the capacity

to learn. The pandemic is forcing us all to learn. In this posture, hope is not some leap of faith. Rather, it is a *modus operandi*, a way of getting to another place that has to be better even if it is immensely different.

In virtually every case, these stories explain how people realize the need for change and move to embrace it. For all its horror, the pandemic is motivational, even inspirational. It brings out reserves of strength that we didn’t know we had. So, while during this period no one congratulates themselves, they’re able to survive the initial shock with a modicum of self-confidence and (yes!) hope. They develop momentum and assert control (at least where they can) when everything seems totally out of control.

During this period, my caseload has increased as people try to recoup some sense of reality/their lives/fun, they need advice. Moreover, working with patients remotely is intense – the focus never lets up, even for a second (to look away might seem natural in a face-to-face meeting, but any such movement is magnified onscreen and both parties try to avoid it).

Reading poetry, writing these essays, exercise and yoga have been part of my routine for maintaining well-being as well as cultivating relationships with family and friends. I’m also encouraged by the fact that life goes on, however haltingly. The essentials are coming into clearer focus, which may be the ultimate take-away from the pandemic.

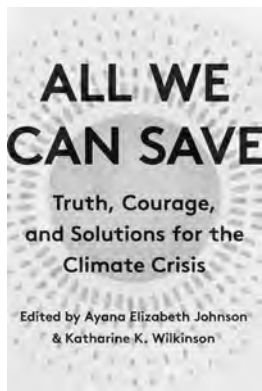
Because the pandemic will ultimately be a saga of statistics – how many infections, how many deaths, how many unemployed – I wanted to record on a personalized, human scale the way that people suffered and the way they persevered: some endured loss and loneliness; others dealt with doubt and uncertainty; doctors, mental health professionals, and clergy were on the frontlines trying to help. As a psychiatrist, my practice was a window into how people articulated their experience of the pandemic.

My clinical work during this period, and the writing that accompanied it, were often exhausting. Like many doctors, mental health professional and others, I felt “burned out” from the work. A Screen demanded that I situate myself in a future that, at times, I could hardly bear to confront. My friends and family members picked up on my sense of sometimes hitting a wall.

But I did my best and tried to be resilient, which is part of the story that I tell. Like other people in these vignettes, I had to find my way. When I felt exhausted, I had to bounce back. I hoped that this type of resilience, of putting one foot in front of another even in times of stress, would become an important dimension of the pandemic when, finally, we have time to study it.

Recovery will take time. When the COVID’s consequences are less specifically medical (maybe vaccine, maybe better treatments), we’ll need to rebuild our economy and our social norms (have handshakes disappeared forever?). Some changes in how we work and socialize will likely be permanent, and maybe for the better (more flexibility and freedom). But it will take time to get there. People will need to find a way that works for them.

BOOK REVIEWS



All We Can Save: Truth, Courage, and Solutions for the Climate Crisis. 2020, edited by Ayana Elizabeth Johnson and Katherine K. Wilkinson (Random House 2020)

Reviewed by Cassandra M. Klyman, MD

I was in the middle of medical school when *Silent Spring* was published and Rachel Carson predicted there would come a time when “robins wouldn’t sing,”

because of climate change. I thought, maybe like “Cho-Cho-San” in *Madame Butterfly*, things would get a lot worse after several of these seasons would pass without the robins. Well, it did, but I wasn’t really paying attention until Bernie Sander’s *Green Deal* spelled it out. I had read Al Gore’s book, but it seemed dry and not so persuasive. But by 2015, I had relocated from California from Michigan, and I was intent on conserving water in small ways, like shorter showers and not running the water when I brushed my teeth, and reducing emissions by consolidating shopping trips. Then the rains came and I felt rewarded for my small carefulness. But two years later, there were the campfires that destroyed Paradise, California. The skies were orange and smoke burned my throat and eyes. I would see flames in the hills and flames jumping over freeways. COVID hit and we were locked down in our homes. Then we would see fires only in our TVs, but it was relentless climate disaster despite switching from paper to metal straws and minimal use of air conditioning. Those small effects were wiped out by the perfusions of the plastics in our carry outs and the increased plastics from those cartons and cleaning supplies.

Now we do have a leader who believes in the science of climate change, pushed by wanting to attract Bernie’s supporters, suggesting slow moving carbon cutbacks by showing how they can create jobs while reducing Earth’s temperature. And here comes a book *All We Can Save: Truth, Courage, and Solutions for the Climate Crisis*. It is a collection of 62 essays and 17 poems by environmental feminists. Some are scientists, some journalists, activists. The editor Katherine K. Wilkinson is a journalist, and the other editor Ms. Johnson is a marine biologist (as was Rachel Carson). I was initially put off by the busyness of the cover and the fact that there were eight different sections like Root, Advocate, Reframe, Reshape, Persist, Feel, Nourish, and Rise with several subsections under those. While all the authors are women, they run the gambit of race, ethnicity, and there is a significant portion of Native Americans who claim a special relationship to Mother Earth. These feminists are fomenting an environmental renaissance. As I started to browse, I was fortunate to start with Stengel’s essay. She is the co-founder of Green Wave, a non-profit that trains and supports regenerative ocean farmers. Her writing was so provocative that it made me realize the gender bias in the climate change movement that I had been most aware of was men who wrote about capturing carbon emissions from our modern inventions, mainly from factories and modes of transportation: cars, airplanes, etc. Whereas these women

were primarily concerned about maintaining carbon where it is, in the soil and in the sea. They believe that courage leads to action and hope will follow. They recognize that perfection is the enemy of the good and that a world warmed by 2 degrees Celsius is far more livable than one warmed by 3 or 6 degrees.

Plants are the proverbial straws that draw down carbon dioxide through photosynthesis, so that the emphasis is on carbon sequestration. The excess that is not used in the plants seeps out to feed the microbes and stimulate the creation of soil pores holding dead microbes further enriching the soil. “Having more carbon in the soil is transformative.” (p.290). Both water filtrates and high nutrient water retention lead to crops that have less need for artificial fertilizer and are more resilient from the variegation of changing climate. Ecology equals ways to technology. We need to balance greenhouse gas with photosynthesis! Plants, fungi, and lichens are drawing carbon dioxide from the air and have been doing it for 700 million years. Microbes have been quietly doing so since the Earth’s carbon cycle. These are not razzle dazzle solutions, like hydrogen and lithium batteries to maintain cleaner air travel.

Of course my eye caught on to Ash Sander’s essay, “Under the Weather,” where she talks about the impact of ecology’s distress on the individual leading to the experience of despair. She illustrates this with Chris, a math person who leaves University of California, Davis after a period of extreme self-abnegation to go to University of Kansas to study philosophy and teach. One of his students, now the author of this essay, had walked out of his class “full of guilt and anxiety, anger and fear about a future filled with loss and death.” (p.233). She became an actor personally in her community and with the Utah Valley Farmers. She physically tried to stop construction on the tar sand mines and laid down in front of federal buildings to stop the Keystone Pipeline. She joined radical anti-civilization groups that wanted to destroy electric, gas, and internet infrastructure and bring down industrial society. Chris’s father and sister believed his desire to escape society was a projection of his feeling of responsibility for something that was not his fault, his history of childhood abuse, but he believed he was reacting to having seen on a biking trip, the sudden end of the evergreen forest to bare ground and stumps. This distinction from bounty to barrenness seemed to him to be evil and he did not want any part of it as he grew up. The writer too became obsessed with this “there are not pauses between climate changes, so why should I get a break?” (p.237). After eight years with others not being distressed by climate truths they claimed to know, she went to a therapist who looked at her quizzically. I “was sad about what? ‘The end of the world?’ They diagnosed me with depression.” (p.214) She went up to a cabin with her partner and while grieving continued reading about the Permian extinction of 25,000 years ago where volcanoes erupted with carbon, methane, and sulfur dioxide, destroying everything. Life required 8-9 million years to recover. So the author felt again she had to leave her cabin and become active. In 2012, the National Wildlife Federation wrote that climate change is creating a mental health crisis for 200 million Americans plus the disposed immigrants who come to our borders. They will suffer mental illness as a result of natural disasters: drought, heat waves, hurricanes, and floods. The diagnosis of PTSD has gotten to near epidemic levels.

Certainly, we saw this in the aftermath of Katrina. In 2017, the American Psychological Association and Eco-America name the condition as Eco-anxiety. (p. 236) In Australia and in India, more than 10,000 farmers kill themselves due to the effect of high temperature on their farms which lead to drought, starvation, and devastation, mentally and physically. Greta Thunberg, the Swedish activist, became anorexic at first when she learned about what was going on in terms of climate change. She too recovered and became Time Magazine's youngest Person of the Year. David Burke, a human rights lawyer in Brooklyn, immolated himself to call attention to the climate fight. In a major distancing from the Cartesian model, Theodore Roszak, says the solution is not to pathologize the patient but to help restore their sense of control.

The condition of losing one's home through a natural disaster was coined "solostalgia," a combination of solas from Latin which means abandonment and nostalgia, the feeling from being far from home and not being able to return as in the 17th century when globalization was occurring. Lisa Von Susturian, an MD in Washington, was influenced by Al Gore's Inconvenient Truth but saw and accepted the ability of people to consciously deny facts, which nevertheless led to stress, intrusive thinking, bad dreams, and insomnia. She felt you could breeze through reading about an insect Armageddon, the glacial ice sheets melting, world fires, climate refugee immigrants, but it registers in your psyche as a pre-traumatic stress stimulus or vicarious stress disorder and can lead to sleepless nights, obsessive thinking, and the tendency to place great importance on everyday issues so that one ends up grieving the future in the present. (p. 241) In Aeschylus Agamemnon, the princess of Troy, who is blessed with seeing the future and simultaneously cursed with not being believed, leads to the Cassandra dilemma, which Allen Atkinson connects with climate action perplexity. The more we know, the more we try to be proactive, the more others react with fear or defensiveness and resist us.

In the wake of failure of amassing facts and dealing with them with action, a key strategy is a tie to emotions. The Bureau of Linguistic Reality tried to crowdsource a term for "individuals' depression or mental illness derived or induced by living in a society that is ill or broken." (p. 242) Names considered were "distrance" or "sociopression" but it seems Eco-anxiety really fits. What is the answer? These many women suggest community mothering as the admired role to be taken towards both raising children and being responsible members of society. The pandemic has made this almost too demanding a case. In 2020, women have much more added to their already serious multitasking roles. Now both parents, mother and father, have to be factoring in climate change to their parenting skills. One of the poets represented in the book, Katherine Pierce, writes "Anthropocene Pastoral":

In the beginning, the ending was beautiful
Early Spring everywhere....
At least it's starting gentle....
even as we hold each other, warmth to warmth, and said:
sorry, I'm sorry, I'm so sorry while
Petals sifted softly to the ground all around us. (p255)

As a country, we can survey all we can save and then
by showing up again and succeed, like Mary Anne Hitt, to

inciting utility communities to close 200 coal fire plants or like Lia Stokes that showed her importance in working diligently to change institutions. (p. 338) It is exciting to read how peaceful persistence can prevail to reconstitute a part of the world. This is a characteristic mindset of women who are used to being multitaskers and nourishers. Like with COVID-19, it is important not to deny facts but plan for the worst and do all we can to save what we love. Sherry Michell's contribution, "Indigenous Prophecy and Mother Earth" represents the Penanehskek Nation in stating that it takes a "world centered view to recognize the relationship that exists among all living systems" (p18). It had been viewed and dismissed as magical thinking by the colonists. However, in 2015, the Proceedings of the National Academy of Science's first draft of the Open Tree of Life Project joined other scientific countries to covering 2-3 million species. Perhaps the humanity of the UN can save us.

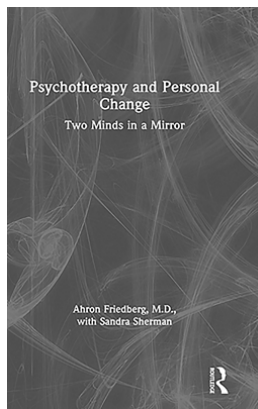
Interesting, by its omission in this book, was any emphasis on the population connection. The two leading sources which account for gigatons of CO2 is population and food waste. Plant-rich diets is the third. Population Connection states these are the best kept climate secrets. In the USA we have an estimated 1.6 million unintended births annually while globally the numbers reach 32 million. Again, it is the UN Population Fund that brings family planning and reproductive healthcare to 150 countries and real action to mitigate climate change that is the major impetus to mass migrations.

Indigenous peoples hold/claim ownership to 80% of the remaining world's bio-diversity. It will require exquisite compromising and ingenuity to raise their standard of living yet preserve the "magic elixir" of treasures that may help sustain the survival of our species on Earth. One half century ago Earth Day, EPA and bedrock environmental laws were passed and, while climate pollution went down 70% and smoking rates diminished, COPD still tripled. So much more has to be done. Strategies have been started regarding smart farming to make atmospheric carbon dioxide into sugar. That planting a tree can equalize the solar energy used by a 5-star hotel's air-conditioning system is enlightening to read about. Most of us reading this review did not learn about environmental issues in school. It is now an unexpected tsunami that this book helps us prepare for and understand.

Dr. George Pollak, Professor Emeritus at Oregon Health and Science University, recently wrote in Psychiatric News about the work that has been going on in his state and nationally since 911 in developing disaster response protocols and training events since Hurricane Katrina. In 2017, the Climate Psychiatric Alliance (CPA) was formed to educate mental health practitioners, other physicians and the public about the mental health risks of the climate crisis. CPA works with the American Psychiatric Association to lobby it to divest from fossil fuel investments as well as research and outreach via medical school curricula to deal with this greatest of existential crises. There is also an alliance with the International Psychiatric Association. APA also has a Committee on Psychiatric Dimension of Disaster to address the mental health effects upon patients who show up in emergency rooms, substance abuse facilities, and in their PCP's office for somatic symptoms of PTSD. Many opportunities exist for us to participate with our fellow physicians for the future of our grandkids and the planet.

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Psychotherapy and Personal Change: Two Minds in a Mirror
by Ahron Friedberg, MD
(Routledge 2020)

Reviewed with illustration by
David V. Forrest, MD

Shakespeare said art is a mirror of nature and Joseph Campbell (1988) added that nature is within you. Peter Steinhart (2004), in his book about life drawing, argued that artists in their interpretations

bare themselves more than their nude models do. My illustrated in-depth study of fine arts models who pose in the nude (Forrest, 2017) revealed many secrets of my subjects that could not be discerned from their nude poses as they silently practiced their ancient collaborative art. Yet every time I depicted them, my watercolor sketches also revealed me somehow, and challenged me to realize how. Perhaps tellingly, while my models were enthusiastic interviewees, my fellow artists were so reluctant to be interviewed that I gave up on including them. How much more would this bidirectionality of revelation apply to the complex webs of interpretations we make of our psychotherapy patients!

Ahron Friedberg, in a tradition of emphasis on countertransference notably practiced by Harold Searles (1979), addresses this realization. After reviewing mirrors in intellectual history, he maintains that the mirror is a metaphor of the mind, and explains the mirror metaphor of his subtitle: "Ultimately, this book is a mirror because it reflects--rather than just reflecting on--the connections that I form with patients (e.g., intimacy, empathy) and my reflections on those connections(e.g., the successes, failures, regrets, and ever-emerging self-awareness as a healer) (p. 3).

The book is not a text, though with its good index it could be used as one. It is not a book of theory, but of observations and recognitions. It is a meditation, and should be read as one. It reads like a journal, or diary of a therapist, describing what transpired with a selection of pseudonymous patients who come and go and come again, and are supplanted by new patients. Subheadings focus the attention on issues that emerge, and brief didactic paragraphs in heavier print (and tone) remind us of the received wisdom about those issues. The liveliness is in the process notes. The chapter heads sound like an manual: Talking and listening, Trust, Time and money, Empathy and relationships, The present past, Insight and understanding, Truth and doubt, Love and healing. These barely convey the immediacy of the transactions as the players on the therapeutic stage enter, strut and fret, and exit.

Many ideas emerge that could be seeds for whole articles. I'll mention a few: lying about our marital status, p. 22;

we are tutors, not teachers, p. 43; I earn a decent living but wish I were a better poet, p. 62, or Michael Crichton to describe patients, p.80; our results, unlike surgeons', are invisible, p. 64; chairs, p. 73; we set ourselves up as enemies of the parents, p. 81; quitting over fees, p. 87; Twin Tower dreams, p. 94; what my name means, p. 97; impossible treatment goals, p. 111; deeds must exceed wisdom, p.117; need for moral rectitude, p. 125; my father saved my life, p. 130; dreaming of myself admitted for observation, p. 144; worrying too much about colleagues' judgments of my value, p. 145; time to visit mother, p. 149; dom spiro spero, p. 157; forgiving myself and others, p. 159; the book is a shortened version of my career, and reflecting on this reflection, p. 160; trust but verify, p. 161; blurriness of writing about psychotherapy versus precision of my lawyer-academician co-author, p. 164; the mirror cracks, p. 165; engulfed by covid, p. 165. And trust, trust, trust and trust.

Another take, that "art is not a mirror held up to reality, but a hammer with which to shape it," has been attributed to Brecht, Trotsky and others. I hope we don't hammer too much with our patients, but change does not occur without an effort of application. The lovely cover illustration, an abstract image of a male and female head distantly evocative of Picasso's 1932 *Woman Before a Mirror*, may be a bit limp for the turmoil of treatment sampled over and over in the book. Psychodynamic psychiatry is intense with conflict, commensurate with the dedication of doctor and patient. Effortless emendation of thought and editing of behavior are figments of the cognitive behaviorists.

Janet Malcolm (1981) notoriously dubbed our profession not only impossible but difficult. I can think of no better proof of that than the candor of this book. The author dreams of healing, but sells no snake oil; he tells us of his struggles and torment, and we know they are real because they are ours.

Amazingly to some, we love our profession. Most of us think we have the best job, and few of us choose to give it up until we are dragged by disability from our therapists' chairs. I don't know anyone who regrets psychoanalytic training. But Friedberg's patients do all the things we know and love: they finesse schedules, complain of or don't pay fees, fail to trust, demand perfection, have erotic feelings, complain about note taking, resist therapeutic progress in every manner, avoid in every possible way, and so on. He struggles as we all do to see, to realize, to treat--but do we look in our mirrors and report the process as he does?

Hence my accompanying illustration, redrawn and repurposed from a classic engraving, in which I have cast Dr. Friedberg, as a representation of ourselves, in the Biblical role of Samson. Enchained, blinded, and of course shorn of his power, Sampson brings down the temple of the Philistines. We are all enchained by our ethics and our professional standards of care, we are always blind to what will next unfold, and we are shorn by ourselves of our power needs, which we subordinate to our patients' needs, welfare, and progress. By the creative destruction of the dynamic process we bring down the house of neurosis. With this revelatory book, Ahron Friedberg also brings down the house in the other sense, earning the applause he deserves for his yeoman duty and for trusting us with his mirror!

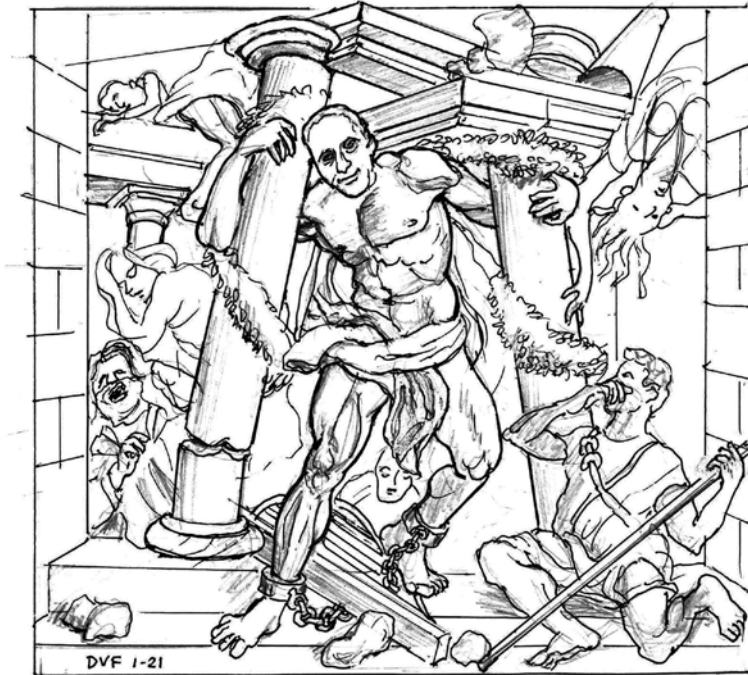
Disclosures: The author's father, Eugene Friedberg, MD, to whom this book was dedicated, was my favorite supervisor when I was in training, the most practical and

centered. And I have known Ahron, our ever-toiling and ever encouraging Book Review Editor, and Editor of our Forum, as a colleague and friend.

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