ACADEMY FORUM

Vol. 69, No. 1 - Spring 2024

The American Academy of Psychodynamic Psychiatry and Psychoanalysis

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Inside Front Cover

Cover Photo
by
César A. Alfonso, MD

Manhattan Skyline. Leica TL2; 55mm; f/5; 1/500. One needs to step away from Manhattan to fully appreciate its magnificent and imposing architecture that is constantly evolving. This view is from Edgewater, New Jersey, which could be easily accessed via a 7-minute ferry ride from Midtown NYC. Another spectacular view is that from the promenade in Long Island City in Queens. Unlike most megalopolises, air quality in New York City often allows for crisp blue skies that reflect on the mirrored surfaces of skyscrapers to intensify the experience and create an oceanic feeling that can be quite soothing, from afar.

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.

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

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MESSAGE FROM THE EDITOR

Ahron Friedberg, MD

It is a pleasure to bring you the spring 2024 issue of our Academy Forum.

First, Dr. Joe Silvio forwards his vision for the Academy as he completes his tenure as our President. We owe him a debt of gratitude for his leadership and vision for our organization. Many of the positive changes such as strengthening our membership, enhancing our programs, and the Committee on the Advancement of Psychoanalysis (CAP) have been on account of his efforts in collaboration with other Academy members. In his Message from the President, he helps to recognize and guide us through the existential angst we face as professionals and people in a post-pandemic world.

In our Letters, Announcements and Reports section, we begin with our excitement to appoint Vladan Novakovic, MD and Tyler Fleming, DO, MPH to our Editorial Board. Dr. Fleming will serve as Book Review and Film Editor. Their biostatements are featured is this section.

We're also pleased to to announce that Christopher Campbell is the recipient of the Scott Schwartz Award for 2024. His work on how technology like smartphones and other devises impacts mental health is certainly important and timely. His article on the subject will be published in an upcoming issue of *Psychodynamic Psychiatry*. We are also pleased to announce the winners of the *Psychodynamic Psychiatry* Journal Prize for 2024, namely Nina Cerfolino, MD, Ira Glick, MD, Danielle Kamis, MD, and Michael Laurence.

Our 67th Academy meeting is approaching. As you may know, "The Changing Times: Sex, Drugs and Psychotherapy" is at Mount Sinai in New York City from Thursday, May 2 to Saturday, May 4. Petros Levounis, MD, APA President, is the first Plenary speaker and Andrew Solomon, PhD, a leading author and LGBTQ advocate, the Keynote speaker. If you haven't already registered, please do. It promises to be a great meeting.

As a kind of teaser to the meeting, Dr. Doug Ingram and Dr. Myron ("Buddy") Glucksman have provided an engaging description of their roundtable discussion on practicing psychiatry in later life.

Finally, there is a beautiful piece from Dr. Nathan Szjanberg on his experience visiting the buried who were massacred at Kibbutz Be'eri in Israel on October 6, 2023. The psychological lens through which he observes and expresses the tragedy of this terrorist attack underscores its horror.

The Original Articles and Contributions section begins, rather immodestly, with an essay by Sandra Sherman and me based on our *Faces of Love: Life Studies in Psychoanalysis* (Routledge 2023). It distills the psychoanalytic process into its basics of the unconscious, free association, transference and working through and then refracts them through different aspects - faces - of love in terms of 4 clinical studies.

Then Dr. Novakovic offers us a case report of an Asian woman with an autoimmune disease and PTSD from childhood trauma. His interpersonal psychoanalytic work with the patient helped her to become better emotionally and more open to relationships with others. Dr. Janet Bachant's discussion develops on how psychoanalysis and psychodynamic work more broadly offers a unique opportunity for healing through empathy and understanding the inner world and personal history of each patient. In his discussion, Dr. Nathan Szajnberg picks up on this "magic" in the patient's experience and shows how revealing the process in terms of love and empathy can be part of what a patient carries forward from treatment in bettering her life.

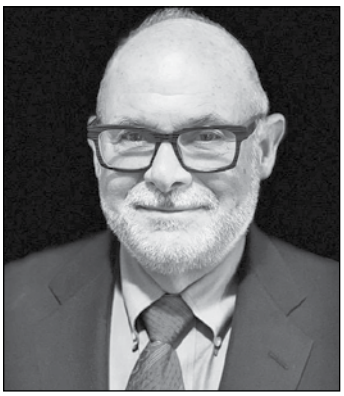
Jane Hall's piece is excerpted from her *Power of Connection* (IPBooks 2023). It underscores and develops the theme of how we connect with our patients and they with us in the psychotherapeutic process. Here too the mechanism of therapeutic action - of healing - is the relationship between therapist and patient. Mrs. Hall goes beyond the classical psychoanalytic model and sees our work as a shared journey of exploring a person's inner life. As psychodynamic clinicians we, of course, also learn a lot about ourselves in the process.

In his article Dr. Peter Olsson provides an interesting and provocative consideration of how our political attitudes and religious beliefs effect the work we do as psychodynamic clinicians. As an end note, it is certainly a timely piece.

Dr. Tyler Fleming begins his tenure as an editor with his review of Freudian Thought for the Contemporary Clinician (Routledge 2022), and a film review by Sheridan Goldstein of Crazy (Director Lise Zumwalt). Finally, in memoriam, Dr. Novakovic honors the passing of Sy Gers, MD, a respected colleague and friend.

MESSAGE FROM THE PRESIDENT

Joseph R. Silvio, MD



I have recently noticed the term "existential threat" appearing more frequently and decided to look into what it means and to what it is applied. It refers to a threat that has the potential to pose a fundamental and catastrophic risk to the very existence of a group, society, civilization, or the earth as we know it. These threats are typically characterized by their capacity to cause extreme and irreversible harm, potentially leading to the complete annihilation or collapse of the entity facing the threat. The list of current existential threats includes climate change, nuclear weapons, pandemics, biodiversity loss, technological risks, global conflict and terrorism, resource scarcity, cybersecurity, political instability.

This is a lot to worry about, and it's a wonder we're able to sleep at night. (Thank you, ego mechanisms of defense). But even if we don't worry about these threats directly, their continued presence in the background may be having a negative effect on our mental health. Take for example the impact that the threat of climate change has on young people. In a global survey published in 2021, of 10,000 people between the ages of 16 to 25, 60% reported being worried about climate change and half said their anxiety interfered with their daily functioning. In a recently released CDC report on surveillance data between 2013 and 2019, regarding the mental health of children, 20% of those between 12-17 experienced a major depressive episode, and that in 2019 alone almost 37 % of high school students reported feeling persistently sad or hopeless, and nearly 19% had considered suicide.

When faced with an existential threat, a state of existential uncertainty arises, in which one questions the meaning of one's life, one's place in the world, one's core beliefs, one's sense of self. This can lead to anxiety and depression. To counter this, one can seek out others who share similar beliefs and reject those with opposing views. Forming a strong allegiance to a powerful charismatic figure who promises to provide safety and restore a feeling of certainty about one's importance and value in the world is one frequently used solution to restoring a sense of existential certainty. To exclude any sense of doubt, those who hold views in opposition are vilified and regarded as evil.

This may help explain the vehemence that invests social movements such as removing certain books from libraries and classrooms that are judged to be inappropriate for children, despite their being classics and highly regarded for years or decades. Or blocking a woman's right to decide about having an abortion, a uniquely personal issue between her and her doctor.

For me, I have found this short message extremely difficult to write because I couldn't find a framework around which to organize it. I have to think that this has something to do with the nature of confronting existential threats. On the one hand, they seem so be clear intellectually, but emotionally they are overwhelming. It's something we need to keep in mind when our patients are feeling lost and unfocused.

LETTERS, ANNOUNCEMENTS AND REPORTS

Profile of Tyler Fleming, DO, MPH
Book and Film Review Editor

Tyler Fleming, DO, MPH, ABPN is an attending psychiatrist and faculty member at the University of Rochester Medical Center in Rochester NY. His primary roles include teaching and supervising psychotherapy education for the residency, providing outpatient and inpatient psychiatric consultations, and conducting psychodynamic and psychoanalytic psychotherapies. Dr. Fleming earned his medical degree and masters degree in public health from Touro University, California in 2018, completed his general psychiatry residency at Einstein Healthcare Network in Philadelphia in 2022, and continues his training in psychoanalysis and psychodynamic psychotherapy at the Psychoanalytic Center of Philadelphia. His interests include resident and medical student education in the areas of psychoanalytic and psychodynamic psychotherapy, within the context of contemporary graduate medical education. Dr. Fleming is also interested in how literature, theater, classical music, ballet, and opera intersect with psychoanalytic concepts.

Profile of Vladan Novakovic, MD
Associate Editor

Vladan Novakovic MD is a psychiatrist and psychoanalyst affiliated with William Alanson White Institute for Psychoanalysis, New York and Ichan school of Medicine Mount Sinai WTC Health Program in New York City.

Dr. Novakovic received his medical degree with honors and completed his psychiatric residency, at Maimonides Medical Center in Brooklyn, followed by fellowships at Columbia University Medical Center and Ichan School of Medicine at Mount Sinai. He further elevated his expertise by undergoing rigorous training in psychoanalysis, which allowed him to delve deeper into the complexities of the human psyche. In addition to his clinical practice, Dr. Novakovic has made significant contributions to the field of neuroscience. He has conducted extensive research, published several peer-reviewed papers, and presented at numerous international conferences. His work has helped advance understanding of the neurological underpinnings of mental health disorders, bridging the gap between psychiatry and neuroscience.

He has an unwavering dedication and interest in psychoanalysis and psychodynamic psychotherapy and continuing commitment to the advancement of the field. He is supervising psychoanalyst and faculty and a teacher at the William Alanson White Institute Intensive Psychoanalytic Psychotherapy Program.

He serves as a President of the New York Chapter of American Society of Psychoanalytic Physicians (ASPP) and is an active member of many professional organizations: American and International Psychoanalytic Association, American Academy of Psychodynamic Psychiatry and Psychoanalysis and American Psychiatric Association. In addition, he is an active member of the International College of Person Centered Medicine.

He is an author and co-author of many publications in peer-reviewed journals and authored a few books. He has presented his clinical and research work nationally and internationally. He lives in New York and has a private practice in the city.

Christopher Campbell
2024 Scott Schwartz Award Recipient

The 2024 Scott Schwartz Award will be given in May 2024 in New York City during the Annual Meeting of the American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP) to Christopher Campbell for his manuscript *Pseudoreality and Technology: Smartphone related Factors Impacting Mental Health*. The Scott Schwartz Award, now in its 14th cycle, is given every year by the AAPDPP for the best original unpublished paper submitted to the competition written by a medical student or psychiatric trainee. Campbell's paper has been accepted for publication in Psychodynamic Psychiatry.

Christopher Campbell is a medical student with a longstanding interest in psychology and psychiatry. He graduated from the College of Charleston with a Bachelor of Science in Psychology and Neuroscience. He subsequently chose to pursue medical school with the intention of becoming a psychiatrist. He is currently enrolled at the Medical University of South Carolina (MUSC). Mr. Campbell's commitment to mental health extends beyond academics. His clinical experiences include volunteering at Pruitthealth Hospice where he provided companionship and emotional support to end-of-life patients and serving as a Wellness Coach and subsequently as the Director of Operations for the Warrior Surf Foundation, a non-profit organization committed to enhancing mental and physical wellbeing of veterans. His research interests include investigating the efficacy of MDMA-facilitated psychotherapy, evaluating the effectiveness of the Warrior Surf Foundation program in improving mental health outcomes of participants, and exploring the mechanisms by which yogic breathing techniques provide symptom relief for autoimmune disorders. He plans to apply to psychiatry residency upon completion of medical school and is particularly interested in learning neuromodulation techniques, the integration of artificial intelligence with psychiatry, psychoanalysis, and psychodynamic psychotherapy.

Psychodynamic Psychiatry Journal Prize Announcement

Every two years, *Psychodynamic Psychiatry*, the journal of the American Academy of Psychodynamic Psychiatry and Psychoanalysis, awards a Journal prize for the best article published during the preceding two years. For the years 2022-2023 we are proud to announce that the Journal Prize has been awarded to Nina Cerfolio, M.D., Ira Glick, M.D., Danielle Kamis, M.D., and Michael Laurence for their distinguished paper, "A Retrospective Observational Study of Psychosocial Determinants and Psychiatric Diagnoses of Mass Shooters in the United States" (*Psychodynamic Psychiatry,* Volume 50, Issue 3, September 2022). The prize of $2500 will be divided by the four authors.

The editors of *Psychodynamic Psychiatry* congratulate the authors for this unique and very timely research paper which draws attention to the clinical and psychosocial aspects of the epidemic of mass shootings and links the under-recognition and under-treatment of psychiatric disorders with gun violence in the United States.

César A. Alfonso, M.D.
Jennifer I. Downey, M.D.
Editors, *Psychodynamic Psychiatry*

Nina Cerfolio, M.D., Assistant Clinical Professor of the Icahn School of Medicine at Mount Sinai, is an expert on trauma and terrorism and a board-certified psychiatrist and psychoanalyst in New York City. In practice for over 30 years, Dr. Cerfolio has published in prestigious peer-reviewed journals and presented original work on the psychological influences of spirituality, trauma and terrorism nationally and internationally, and featured on numerous TV outlets. Her thought-provoking new book, *Psychoanalytic and Spiritual Perspectives on Terrorism: Desire for Destruction* (Routledge, 2023), weaves her team's cutting-edge research with her extraordinary first-hand experiences of being a first responder and unique real-world trajectory to explore the origins of terrorism while highlighting an overlooked spiritual lens as a powerful antidote for healing from trauma.

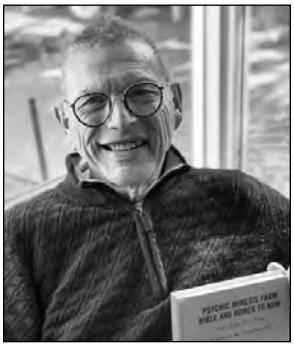
Ira D. Glick, M.D, Professor Emeritus of Psychiatry and Behavioral Sciences, previously Director of Inpatient Hospitalization Services and Chief of the Schizophrenia Clinic at Stanford University School of Medicine, has an extensive background in research, education, and academic medicine. He has been a professor at three prestigious medical schools (the University of California, San Francisco (UCSF), Weill Cornell Medical, and Stanford) as well as the Senior Science Advisor to the Director of the National Institute of Health (NIMH). He was Visiting Scholar at UC San Diego, is a Visiting Fellow at Weill Cornell Medical College, and now Adjunct Professor at the NYU School of Medicine and at Drexel University College of Medicine in Philadelphia. He is internationally recognized for his humanitarian efforts to correctly diagnosis and treat the mentally ill, decrease stigma and educate the public/media about disorders and diseases of the brain.

Danielle Kamis, M.D., is a private practice psychiatrist in Los Altos, California, as well as an Adjunct Clinical Assistant Professor at Stanford University. She has been published in multiple scientific journals working on studies of schizophrenia, women's wellness as well as sports psychiatry. Dr. Kamis co-edited the first book of its kind on a *Manual of Sports Psychiatry* after excelling in the sport of fencing at the University of Pennsylvania where she was a four-time NCAA championship qualifier, NCAA All American, Academic-All Ivy honoree, as well as captain of Penn's fencing team. In addition, she has worked extensively with Dr. David Burns and his team in his extremely effective Cognitive Behavioral Therapy model. Dr. Kamis completed academic research in psychiatric investigations in Argentina and taught mindfulness and meditation courses in other countries of South America.

Since 1987, **Michael Laurence** has represented death row inmates throughout the country and has appeared in numerous cases before the California Supreme Court, the federal courts of appeals, and the United States Supreme Court. Mr. Laurence was counsel in class actions challenging lethal gas and lethal injection as execution methods and the application of various portions of the Antiterrorism and Effective Death Penalty Act of 1996. Mr. Laurence also was a member of the California Commission on the Fair Administration of Justice, created by the California Senate to examine the causes of wrongful convictions and make recommendations to ensure the fair administration of justice. For seventeen years, he was the Executive Director of the Habeas Corpus Resource Center, a California Judicial Branch agency created in 1998 to represent death-row inmates in habeas proceedings. Since October 2015, he has been in private practice, assisting counsel nationwide on habeas corpus matters.

How Could I Not Tell You About Be'eri's Buried?

By Nathan Szjanberg, MD



Some 100 Be'eri people were slaughtered on Oct. 7; twenty kidnapped. We are still not certain of the exact number murdered because some were burned to ashes. One boy's burned corpse had to be buried in borrowed clothes; his were incinerated, his ashen corpse lie naked.

Yet, I have not been able to write about my visit to their temporary, temporary, graves in Revivim. But, aren't we all temporary until the moshiach comes, when our bones will roll to Jerusalem?

Kibbutz Be'eri celebrated its 77th birthday Oct 6th. Named after the Zionist Berl Katznelson, Be'eri was one of eleven "seed" kibbutzim dispersed from its mother kibbutz, Revivim, once a meteorological center converted into a kibbutz in the late '30's. Under Ottoman Empire rules, a community could be established by putting up a tower and wall, often done overnight.

Like a dandelion, Revivim sent off its seeds into the desert air which rooted itself stubbornly in the Negev barren soil, bordering Gaza, where Samson had his last stand. Samson's penultimate words, locks shorn by Delilah, strength depleted, were, "O God, please strengthen me once more, so that I may avenge myself from the Philistines for my two eyes" (Judges 16:28).

This I imagined some days later is my wish as I saw the Maglan boys preparing for Gaza. But, they must return. I want it all: destroy these Philistines, return our boy/heroes. The Gaza buildings, hiding places for Hamas rockets, should continue to collapse.

Nu (I slip into Yiddish at these moments, you note), enough history. What about Be'eri?

No graves in Be'eri now. The place is off-limits even for the dead, for sure for the mourning who are now, like dandelion fluff, dispersed around the land, many to the Dead Sea, lowest point on earth, beyond the reach even of the sun's ultraviolet rays. Psoriatic Scandinavians flock to this salty lake annually as they can get relief from their skin pains without fear of sunburn. Plaster the healing black mud on their bodies, their faces, blond hair sheeny, reflecting the sun's rays as they lie in chaise lounges.

Yet, in 1947, the Be'eri and other ten seeds sprouted along the oref, the "neck" along Gaza. For a time, the kibbutz grew, then aged and few joined, many of the young left. About a thousand remained.

We arrive at Revivim, at the temporary special entrance to the graveyard for Be'eri. A Revivim vatik, "veteran," perhaps in his fifties talks with the portable mike to describe Revivim and Be'eri, its offspring. I sit on the stone wall, closer to his flank to see and hear, but the words float over me. He explains that the graves are temporary, that there is a special religious ceremony to disinter them when Be'eri is safe again. But he also says that now the Revivim and other kibbutz residents know that they are on their own to protect the kibbutz. Self-sufficiency is not just for old-time Zionists; it is for today. Yes, they hope for protection from army, police. But first, they are their own protectors. Yes, they petition for water from the government, but first, they must make do for themselves. The Zionist love for the land is for today. The old song, "He'chalutz l'ma'an avodah; Avodah l'ma'an he'chalutz," is contemporary: the pioneer is for work and work is for the pioneer. Now, they are all pioneers. Now, they are welcoming families from Russia, Ukraine…and corpses from Be'eri.

Nu, let's hear about Be'eri's dead. (Listen, Sh'ma Adonai!) But, words are too weak. Recall Lincoln's felt words at Gettysburg, dashed off on the train ride from Washington: "…we can not dedicate -- we can not consecrate -- we can not hallow -- this ground. The brave men, living and dead, who struggled here, have consecrated it, far above our poor power to add or detract. The world will little note, nor long remember what we say here, but it can never forget what they did here. It is for us the living, rather, to be dedicated here to the unfinished work."

And his penultimate words:

"…we here highly resolve that these dead shall not have died in vain -- that this nation, under God…"

Listen again to Lincoln, "The world will little note, nor long remember what we say here, but it can never forget what they did here." What they did here, in Be'eri and its neighboring towns, is but be slaughtered, dismembered, incinerated, raped, beheaded. Ironically, it is Lincoln's words we recall, jot the names of the dead. Here, here, let us recall the names of the slaughtered only because they were Jews.

Bettelheim's major criticism of the word "Holocaust" is that its biblical, religious meaning is someone who has given up his life for the sake of God. But, Bettelheim continues, most of those who were slaughtered and sent up chimneys as ashes in the Shoah, did not "sacrifice" willingly. Certainly not the million and more children did not. This was murder most foul. Let's not make some "religious" frothiness to decorate this terrible slaughter—this Shoah then, this Shoah now. This was, is, purest evil.

Elahanon, our guide, explains that after we enter, the four guides will station themselves at various graves and tell of the lives of those buried there. We can wander as we wish or pause to listen.

I choose Elhanon's station for two reasons. First, because I learn so much from him. Second, yes, second but perhaps more importantly, this station is the site of four graves of one family. Two survived because the eldest son, sixteen, through his body across his two younger brothers and was riddled in machine gun fire instead. Elhanon continues in an almost whisper, a murmur, as if not to wake the dead.

Even, Stone. The Even family lie here. Aba Even, Papa Stone, was known as the fixer of things. Nothing should go to waste. Broken faucet? Fine Aba Even. Tractor not running? Even. And if the tractor after several decades was stone-cold, not fixable, Aba Even would paint it and turn it into a sculpture, perhaps for the kids to clamber upon. Ima Even, as I recall was the ugia baker, cookie maker. Also, she advocated for Palestinians in Gaza to come work on the kibbutz; drove them to Sorokoa Hospital for medical care, waited there, and drove them back to Gaza; a proponent of peace between two peoples, Abraham's children. (No Schadenfreude here, no judgment of her.) and the two boys, sixteen and fourteen, were…just two boys who deserved to live. One boy, as he lay dying, asked to be buried with his surfboard.

I recall my dear friend, the poet Eliaz Cohen once taught me about the intense meaning of the unique Hebrew phrase, mishpachat shekulah, an orphaned family. This applies to those families who have lost a son or nephew or father in the wars. Eliaz and his red-haired brother had such an uncle who fell in '48. Well, the mourning of the mishpachat shekulah, is like an India ink stain spreading on a glistening white linen tablecloth. It spreads wide with time. The center is black as hell, the edges begin to fade. But, the stains the family saying of the dead eighteen-year-old: Now, he would have graduated University, now he would have married, now his first child and now and now and now. Never-ending now's.

Why, you rightly ask (or in the French, demander), why have I taken so long to write about these one hundred slaughtered? Waited past the end of this trip. Keep forgetting to write this. Until I spoke with Gal Meiri, a physician in Soroka Hospital in the ER on October 7th. More on him later. But, his memories and feelings evoke an avalanche of feeling and memory.

On the stone matzevot, tombstones, all dated with the same death date, Jews place small stones, a ritual you may recall from Spielberg's Schindler's List, the true survivors lined up and each gently placing a stone on Schindler's tomb. I hesitate. I recall that on David Ben Gurion's tomb, overlooking the barren wilderness of Zin. You may recall Zin, where Moshe kept the Jews wandering for forty years so that the slavish Jews of Egypt would die out and a new generation of stronger Jews, Jews who never knew slavery would better be able to settle this land of milk and honey. On Ben Gurion's tomb was nothing…no stones. I looked again and saw that the stones of visitors were at the tomb's side, between David and his wife Paula, as if not to deface the tombstone.

So, I hesitate to deface the Even family's tombstones, all four. (And what of the two surviving children, will their hearts turn to stone?)

But, more difficult to write, is that I hesitate for Elhanon and others to see the silent tears flowing on my cheeks. No sobs. No histrionics. But unstoppable tears. As if, as if what? To irrigate this barren ground. As if, as if to wash away this heart's deep sadness, these losses. Tears that stream like the winter floods in the wadi Zin, carving it deeper. Carving my cheeks, carving my heart.

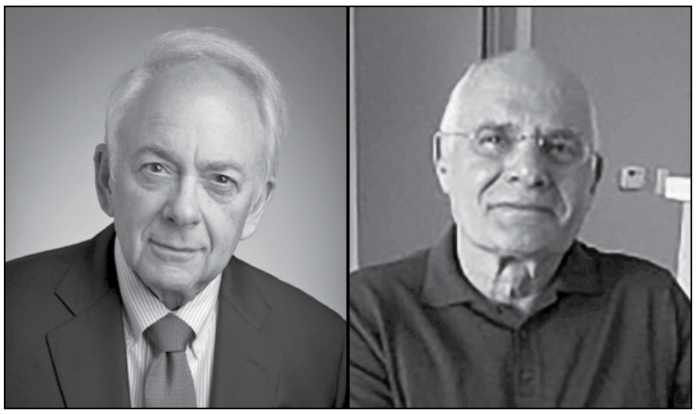
We have wandered for two millennia. new generations have sprouted in this hostile land. When can we live in our promised land without being slaughtered?

This India ink stain on linen begins to spread with the dead of Kibbutz Be'eri. Now, I am their family, their linen remnant. Those around me at the too numerous graves. The children of Israel. Jews of the world. We are stained by their deaths and the stain will spread, perhaps fade, but spread with the years.

This essay also appeared in Dr. Szajnberg's Substack column. You can visit his site at Substack.com.

Practicing Psychiatry in Later Life

By Doug Ingram, MD and Myron ("Buddy") Glucksman, MD



Douglas H. Ingram, MD Myron Glucksman, MD

We are hosting a Workshop at the May meeting of the Academy for those who are late in life and continue to practice psychodynamic psychiatry—and for those who are younger but intend to practice indefinitely.

We are of the Boomer and Silent generations. We are the ones who have become accustomed to the innocent micro-aggression still, as in, "Are you still working?"

Our contemporaries are Joe Biden, Donald Trump, Nancy Pelosi, Madeline Albright, Jesse Jackson, and Mick Jagger. We passed through the years of Eisenhower, Kennedy, and Johnson. Our music was Frank Sinatra, Elvis, Fats Domino, the Beatles and the Stones. We came of age in the starchiness of the Fifties and the exuberance of the Sixties. We enjoyed open sex, suffered kitchen table abortions, societally endorsed homophobia, assassinations of JFK, RFK and MLK, and race riots. We cheered the Voting Rights Act, marched against Vietnam, and went to Woodstock.

We belong to the generation of psychiatrists that tried Lithium for what we then called Manic Depression. Some of us were around when Thorazine first proved a wonder drug for schizophrenic patients. We worried if we were prescribing too much Tofranil for depression. We guarded against excessive use of Valium, having moved on from Miltown and bromides. For us, neurosis was legitimate. Thankfully, the term held as we switched from DSM I to DSM II, and later we frowned at its loss. Psychoanalysis was in its heyday and promised to plumb the depths of not only the individual human psyche but of history, culture, and politics. The humanities could be—and were--interpreted through the psychoanalytic prism.

For us, studying medicine was a prerequisite to becoming psychiatrists—and that was necessary to becoming psychoanalysts. Sure, some psychiatrists were content to practice psychotherapy. Not us. We were the smart medical students and psychiatric residents. And the smart ones wanted to be psychoanalysts—which we became.

And what became of us? What happened to those fractious meetings where (enlightened?) culturalists fumed against (benighted?) orthodox Freudians? What happened to the ideological battles that would determine the fate of the cosmos? What were the necessary nuances of effective interpretation? What constituted a good psychoanalytic session? Who was analyzable and who was not? And to what extent did the scientific method confirm our cherished beliefs or eviscerate them? Did psychoanalysis even lend itself to the scientific method? How and why did psychoanalysis effectively morph into psychodynamic psychiatry?

In our workshop, we want to consider the societal and professional trends of the decades since we became psychiatrists and psychoanalysts. To be frank, psychoanalysis - our vision of psychoanalysis - has mostly passed out of psychiatry. Since 1980, there are more than 40 medications for depression and a similar number of newer antipsychotics. There are many psychotherapies, all manualized. Their practitioners are mostly non-medical. And what about changes in the standards of care? Have we weathered all these developments? Have we kept up? Do we want to?

What is the kind of treatment that we find ourselves doing in our offices? Courtesy of the pandemic, telemedicine has arrived. How are we affected?

As clinicians working into the later stages of our lives, we enjoy satisfactions and encounter challenges. Yet we impacted in our work by illness and by illness in our family. What are the impairments, physical and cognitive, that we need to negotiate in ourselves and in our patients? What is the appeal of retirement and does the call of retirement stimulate conflict in us? Are there economic issues? And what about the mounting deaths of colleagues, friends, and patients? What has happened to our practices? Does mortality seem to be approaching from far away or is it at our front door? Do we have a "practice will" to help our patients in the event of our own sudden death or major illness. To what extent has moving beyond the hur-

ly-burly of earlier more active professional involvement lost for us a sense of relevance? Have we found general lifetime satisfaction from our work, or have we descended into regret, cynicism, or philosophical detachment? Have we found the much-vaunted wisdom that supposedly accompanies age? Do we retain liveliness or are we dried husks emptied of vitality?

We are realistic about what we can accomplish in our 90-minute workshop. We do not want to indulge in soupy nostalgia. Very likely, we will touch on only a few of these matters mentioned. Perhaps we will explore some in depth. Maybe we will speak in generalities. Maybe we will be enriched by each others' personal experiences. We'll see.

The American Academy of Psychodynamic Psychiatry and Psychoanalysis
67th Annual Meeting
Thursday, May 2 – Saturday, May 4, 2024

Changing Times:
Sex, Drugs and Psychotherapy

The Academy is excited to bring you our 67th AAPDPP Academy meeting titled *Sex, Drugs and Psychotherapy*. The meeting will be hosted at Mount Sinai Medical Center in New York City (5 East 98th Street, New York, NY). Petros Levounis, MD, APA President, is giving the opening Plenary Session and Andrew Solomon, leading author and LGBTQ advocate, the Keynote Address.

Preliminary Program and link to register can be found at www.AAPDPP.org or request by email (info@AAPDP.org) or phone (888-691-8281).

We look forward to seeing you all in New York in May!

ORIGINAL ARTICLES AND CONTRIBUTORS

Psychoanalysis and the Faces of Love

By Ahron Friedberg, MD

Psychoanalysis can help to heal individuals who experience conflicted love, enabling them to acquire the self-knowledge to love more efficaciously. This article provides patient stories regarding some aspects ("faces") of love which illustrate this process. It also provides supporting discussions of "libido" (from the Greeks through Freud, Lacan, and the latest neuroscience), and of terms associated with the process:

- The unconscious
- Free association
- Transference
- Working through

The stories, in context with the supporting material, demonstrate how seemingly unrelated "faces" of love (from an Oedipus Complex to obsession with a sibling) have profound commonalities in both their manifestations and their treatment.

1) Psychoanalysis and love refract through each other

The synthetic approach that I explain here took shape over years. The people (my patients) who populate the stories I relate went through long courses of analysis. I would write up my notes, reflect on them, then stand back as a picture slowly emerged. I would think about the connection between these stories – what, for example, did one patient's fixation have to do with another's? How was an Oedipus complex related, if at all, to a repressed desire of a man for his sister? Why, in other words, could I group these stories together to reflect on psychoanalysis and love together? I thought about the commonalities, and went back and forth about whether the common denominator was love (in its myriad forms) or the process of psychoanalysis (which unfolds over time and reveals the complexities of human desire). Ultimately, I realized that both phenomena refract through each other, shaping each other and providing a directionality that neither would have on their own.

Consistent with that notion, this article explores the nature of some aspects of love insofar as they can be explored psychoanalytically. I consider love – how it can obsess us, how it can distort our other relationships – but also how psychoanalysis can mediate between the subject/patient and the object of love so that neither harms the other (and, in fact, how both might enhance each other's lives). So, ultimately, I demonstrate how some of my patients, troubled by romantic, sexualized, fantasized, illicit, and/or uncontrollable desires, learn through psychoanalysis to accommodate their desires to what is possible and permissible in the lives that they otherwise inhabit. In this sense, the stories included here represent journeys from a place characterized by the epiphenomena of troubled love – grief, guilt, frustration – to one in which, through enhanced self-awareness, patients understand the sources and implications of their motivations. They begin to understand why love has seemed like a minefield, and begin to find a more fulfilling path through it.

However, once I realized the general direction of my thinking, I had to reckon with its boundaries. Clearly, it was not focused on Love in the abstract. Each patient had a profoundly unique experience that, even when set against all the others', still did not present a rounded picture of how we experience love. There was an inescapable pointillistic quality to the stories. They were about some aspects of love – intense, to be sure, but still individualized. Accordingly, I thought of love's "faces" because no two faces are the same and we can never see all the faces in the world. In my practice (and, hence, in these stories), I encounter how love is sometimes expressed, and why in those instances it leads to treatment in psychoanalysis.

Additionally, at the back of my mind, was recent work in neuroscience on facial recognition. In Origins of Human Socialization (2021), Donald Pfaff, examined how we recognize faces, in context with emphasizing the importance of that capacity to human sexuality:

> A deep neurobiological issue related to the phrase "sexual attraction" is how we are able to recognize faces. If you know nothing else about the science of facial recognition, you know from online dating that a face can be instantly attractive or an instant turn-off. If you don't like someone's face, you won't read the profile that they posted.

"Faces" is a resonant term, suggesting the range and subtlety of human sexual experience, as well as the inescapable fact that sexuality is biological, irrational, and as basic as any other urge controlled by areas of the brain that we are just coming to understand. Dealing with sexuality (as a psychotherapist, as a member of our species) is never easy.

2. The psychanalytic lens

Of course, while I am concerned with versions of love – which, like faces, can be infinite – it is still possible to see how these versions fall into alignment when approached through a psychoanalytic lens. We learn, for example, that repressed desire can continue during analysis, resulting in resistance by the patient to the analyst's attempts to help them acknowledge and confront such desire. It can result in hostility towards the analyst, who is blamed for causing still more pain. Thus, while each of the stories presented here involves unique problems concerning the nature of troubled desire and its treatment, they nonethe-

less cohere at the level of certain basic concerns regarding how that treatment is likely to proceed.

I should note that it was difficult to realistically convey these patients' stories without (to some degree) denaturing them, since the course of treatment was rarely linear and non-linearity itself became a focus of the treatment. There was no if-this-then-that quality about the treatment as there is in decision-tree medical diagnosis. In effect, a summary narrative would be misleading. Sometimes, the treatment would go round in circles, returning again and again to where it was (more or less) months before. Sometimes the treatment moved sideways in directions that had little to do with the original complaint. Often, progress was characterized by backsliding to positions that had previously receded. This was all normal, a consequence of the patient's struggle with conflicts, fixations, obsessions, and ideas about themselves that they could not or would not confront or at least accept. If they tried, they failed, or made progress that frightened them in its implications . . . causing them, once again, to retreat. To the degree possible (but only to that degree) these stories convey the difficulties inherent in treatment under these circumstances.

The complete case studies on which these stories are based appear in my Life Studies in Psychoanalysis: Faces of Love (2023).

Of course, one cannot read any psychoanalytic narrative (summary or otherwise) as a how-to prescription for how analysts should approach treatment issues incident to patients' intense, seemingly aberrant desires. I would merely observe that acknowledging the non-linearity of treatment is a necessary first step. It is a condition precedent to a realistic, honest understanding of how treatment can seem to stall – until it doesn't. It is a necessary part of helping resistant patients to remain involved in their treatment, even as they bargain, threaten, cajole, hide, and accuse in their attempts to be less than fully honest with themselves. Ultimately, if both parties hang in there, there is a break-through. It is not always complete, and not always entirely what anyone could have wished for, but it does represent a decided advance. The patient often emerges with tools to think about themselves even after therapy has concluded, so that whatever self-understanding they gained can continue to develop. Often, this is all that we can hope for, but it is significant.

3. Libido

The psychoanalytic process is so difficult, in part, because when we speak of love, we necessarily broach the unfathomable issues surrounding human libido. In psychology, "libido" refers to a person's sex drive, i.e., his or her desire for physical or emotional connection with another person. Not surprisingly, so basic an urge has etymological roots in Latin, as well as in the Greek term for a life force coursing through the world. Sigmund Freud considered libido as a kind of psychic energy, derived from the sexual instinct. But because his formulation evolved with his understanding of "instinct," it is hard to pin down. In Three Essays on the Theory of Sexuality (1905), libido is a kind of sexual desire in search of satisfaction in terms of objects. A fixation on one object can lead to psychopathology. Later in his thinking, libido was more like a force exerting pressure, tied in with narcissism and the ego. If it was not mastered, it could manifest as anxiety.

In Beyond the Pleasure Principle (1920), Freud introduced the notion of Eros, expanding libido into a kind of life force. His disciple Carl Jung virtually ran with this idea, and saw libido as embracing a "psychical energy" present in every tendency towards an object. This tied in with Freud's ideas about sublimation, a process postulated to account for human activity motivated by the force of the sexual instinct but with no apparent connection to the expression of sexuality – e.g., art, music, and all forms of creativity.

This capsule history demonstrates that starting with the Greeks, the sex drive has never been regarded as just the sex drive. Rather, in one iteration or another, it was responsible for a large share of human action. For Jacques Lacan, the famous French psychoanalyst, unconscious desire was his central professional concern, such that the aim of psychoanalysis should be to help the analysand recognize and articulate his or her desires. In his Seminar (1988), he argued that in naming such desire, "the subject creates, brings forth, a new presence in the world" (presumably, not just that of sexual being).

Lacan believed that the need for love is never fully met because no one can fully provide unconditional love. Thus, while desire has its immediate objects, the real – ultimate – object is missing and unattainable. One case study summarized here concerns a man yearning for his sister, which might have been taken directly from Lacan's teaching.

In this vein, we have all heard of the Greek notion that we are each searching for our other, missing half – and that "love" occurs when we find it. In our own contemporary mythology, the goal is to find one's soulmate. Dating sites promise to match members across dozens of dimensions (e.g., politics, religion . . . everything but the instant chemistry that anyone can recognize at once). Nonetheless, Plato deserves credit for his early, detailed anatomy of love. In the Symposium (~385 B.C.), he enumerated different kinds of love, ranging from Eros (sexual) and Agape (whose object is nature and God), to Ludus (playful and fun), Philautia (self-love) and the love between parents and children. While we would add more categories and shadings, his basic approach – that love has many facets – reminds us, once again, that everything is just a "footnote" to Plato.

But important footnotes.

As I suggested earlier, neuroscience has a lot to say about sexuality. What interests me here is its recognition that desire is always present; it cannot be confined by moral strictures or binary gender categories. As Donald Pfaff states in Origins, sex is "fundamental," a structural element of human identity:

> Men engage in polygamy, women in polyandry. But this morals-defying behavior just underlines my point: sex persists no matter what [orig. italics]. It is such a basic impulse that we do not need any cultural approval to throw it into stark relief, i.e., to demonstrate how baked into human conduct it is. That is, the prejudice against infidelity is moral – a social construction – and has nothing to do with the continuing attraction of one sex to the other (or, as I suggest below, the attraction of one differently oriented person to another, compatible person). Even when sex is available on the other side of the bed, some go looking for more . . . . . So, my point is that no matter how we slice up the social construction of sex and gender, some form of initial sexual attraction is a natural form of the fundamental human social impulse.

I quote this passage at length because it blows past all the taboos and conventions surrounding sex and, from a purely scientific perspective, argues that the sex drive – the libido – is not somehow beneath our humanity but fundamental to it.

4. Fundamentals of treatment

In this section, I describe some foundational psychoanalytic concepts that underlie the patient stories I relate, and that will help readers understand how the process operates in context with problematic desire. Of course, neither these basic ideas nor the discussions themselves are comprehensive. After more than a century of clinical practice, there is no full agreement even about what constitutes "psychoanalysis."

The Unconscious – For Freud, the Unconscious was both descriptive, connoting mental contents not present in consciousness, and topographical, encompassing a system in the mind whose contents have been denied access to consciousness because they are repressed. It operates with its own set of rules (primary process) in contrast to conscious mental life (secondary process).

Repression (of thoughts, feelings, desire) can produce an array of symptoms, including guilt, depression, anxiety, inhibition, or neurotic conflict. Certain repressed mental contents in the Unconscious become accessible to consciousness (and, hence, the symptoms can abate) only as resistance to the process is overcome. This is the primary work of psychoanalysis, which helps patients to articulate and acknowledge whatever they have repressed.

In The Interpretation of Dreams (1900), Freud called dreams the "royal road" to the unconscious. They are expressed through the patient's free associations, and interpreted by the analyst. Dreams, daydreams, and fantasies are often integral to psychoanalytic work.

Free Association – This is the basic method of psychoanalysis. A patient voices all the thoughts, feelings, fantasies, and desires that enter his or her mind as freely, fully, and spontaneously as possible. The method grew out of Freud's hypnotic approach in Studies on Hysteria (1895), and developed into the main approach for exploring a patient's unconscious mental life.

But what does "free" association mean? Ideally, voluntary selection of thoughts and other mental productions are minimized, such that patients become freer in their associative process, thereby gaining greater access to their pre- or unconscious mental life. The analyst's observations and interpretation of the patient's verbalizations provide them insight into aspects of the patient's mental life of which he or she may have been unaware or conflicted about.

Transference – A process of the mind through which unconscious wishes, fantasies, and other incidents of a past relationship are carried into and actualized in the present. Thus, in the psychoanalytic setting, early childhood relationships are experienced in a strong and immediate way in relation to the psychoanalyst. This provides the analyst the opportunity to observe and interpret the transference and, accordingly, help the patient. In fact, some psychoanalysts would argue that a patient can only be cured if he or she develops a transference neurosis, which is resolved during treatment.

Transferences characterize many of our relationships. For example, a boss, doctor, or other authority figure may represent aspects of your relationship with your father. However, the strictness and constancy of the psychoanalytic situation allows a transference to emerge more fully, and be subjected to inquiry. Understanding the transferences of a patient (and the analyst's counter-transferences), allows the analyst to both parties to grasp elements of early childhood relationships and work through them during treatment.

Working Through – An integral part of the psychoanalytic process, which constitutes much of both parties' work, and which Freud described in "Remembering, Repeating and Working Through" (1914) as a fundamental aspect of treatment. In practice, "working through" allows a patient to more fully accept repressed elements of his or her unconscious that have remained tenacious. The analyst's interpretations are key to unlocking repressed mental contents that are then worked through. Thus, in Inhibitions, Symptoms, and Anxiety (1926), Freud characterized working through as a process that frees a patient from the unconscious constraints and conflicts that have caused his or her symptoms. As a patient becomes more

conversant with his or her resistances, he or she is better able to "work through" them.

These concepts animate the studies in Faces of Love and, to the extent possible, are reflected in the summaries that I offer here.

5. The stories

A Complex Oedipus Complex

a) Definition. "Oedipus complex" defines what Freud termed the intrapsychic organization of loving and hostile desires that a child experiences towards its parents. The locus classicus of this idea is Sophocles' Oedipus Rex, where Oedipus unwittingly kills his father and marries and beds his mother. In a boy, this desire for the death of his father, whom he perceives as a rival, and sexual desire for his mother, form the basis of his phallic stage of development (ages 3 to 6, where the infant's libido centers on its genitalia and erogenous zones). During puberty, this phase is revived and mastered to varying degrees through love for another person. In this way, the Oedipus complex is fundamental in structuring personality and desire.

Psychoanalysis makes the Oedipus complex a center for psychopathology, a nucleus of neurosis, whose pull can produce multiple symptoms and conflicts. By uncovering its hidden structure in terms of personal experience from childhood – love of the mother, jealous rivalry with the father, and all the associated twists and turns – a person becomes more aware of its impact, and correspondingly freer from the conflicts it engenders.

Modern usage of the term "Oedipus complex" derives from Sigmund Freud and, in his formulation, included an element of genital obsession. But while we know what the term describes, we also know that in practice the consequences are often varied and complex. First, Oedipal conflicts like other intrapsychic conflicts are unconscious, and play out in ways that may remain unrecognizable even to those affected. Such was the case in Oedipus Rex. So, a son may just be hyper-competitive with his father on the tennis court or at chess. Or perhaps he turns on himself, with a persistent need – accompanied by guilt and nagging resentment – to live up to his father's professional accomplishments. Ideally, as the son passes through the Oedipal phase of development, he identifies with his father and the rivalry is resolved.

But what if it isn't resolved? It may play out in negatively competitive ways with teachers, bosses, and other authority figures. And what if, moreover, it escapes the confines of conventional conflict and turns nasty, even self-defeating or dangerous? This can happen, often because a person's underlying conflicts remain unresolved, causing their Oedipal tendencies to fester and turn into rage. At that point, professional help may be necessary so that the person can become aware of – and finally deal with – whatever is preventing him from resolving his Oedipal conflict.

b) The problem. Through the process of psychoanalysis, a patient learned to understand the layered, complicated conflicts that have prevented him from dealing with an Oedipal complex that – at least insofar as it threatens the men in his family – comes perilously close to its original, frightening conception. I use the term "layered" advisedly, since as the patient and I began to explore his history and motivations, his Oedipal urges emerged as deeply rooted in an intrapsychic matrix that needed to be unraveled, exposed, and analyzed. This took time, as one layer of conflict opened onto another, submerged beneath it.

The treatment became especially challenging because the patient's ostensible obsession with his father was a defense against acknowledging his intense unconscious feelings for his mother, which needed to be acknowledged as the major source of his anti-paternal obsession. It emerges that these feelings had always been highly sexualized; that his mother was more stimulating than most in this regard; and that her behavior was oriented more towards attracting her son (which, apparently, gratified her ego) than towards supporting his independence in mature relationships. To succeed with women, he first had to reframe his relationship with his mother.

Thus, while the treatment attempted to probe ever more deeply – bringing up new concerns, which the patient must assimilate – it was hardly linear. That is, we do not proceed directly in expanding our understanding of why the patient feels as he does and how he can address it. Rather, we find elements, factors, pieces of the matrix that will slowly fall into place and provide a picture of how the patient has developed – and how, therefore, he can understand himself and his obsessions, and better resolve his conflicts.

The patient veers into subjects that do not seem directly related to the basic question: how can he resolve his Oedipal conflict? But this is how the treatment unfolded over several years as we continued to pursued it. Eventually, the raw data began to cohere but, to see how it does so, the therapist must follow the process along often unpredictable byways. The therapist may experience the same impatience that the patient experiences. But at the same time, the therapist will see the treatment finally take hold – or, at least, measurably take hold.

The bottom line is that even a stubborn, deep-seated Oedipus complex is amenable to treatment, provided that the patient and analyst have the commitment and the stamina to remain engaged. Of course, below the bottom line is a further reality: the treatment reflects the same uncertainties, and even turmoil that the patient experiences.

Little Match Girl

a) The predicament. Here, a woman's quest for romantic love is continually disrupted by self-defeating behaviors

and entrenched fantasies. Our objective was to mitigate those fantasies, which kept morphing and recurring as her treatment proceeded. As in the Oedipus study, the struggle between fantasy and reality became our central focus. But in this instance, the patient was not in thrall to some mythic character but, instead, to a 19th-century fiction, Hans Christin Andersen's "Little Match Girl." To the patient, this little girl, who was orphaned and poor, and dies on the street, becomes the persistent embodiment of what she senses as her own likely failure. As she psychologically resonates with this fiction, she enacts its life-cycle repeatedly, defeating herself whenever she starts to show progress. Her deep underlying wish is that by being helpless and in need, a man who loves her will save and rescue her. The effect plays out in her romantic relationships, which she pre-emptively disrupts before the man can cause her emotional distress.

Whenever we seemed to be getting somewhere during treatment, the fantasy would emerge in some new guise, and we would suffer another set-back. Frequently, I would be blamed, since I was a male and, hence, just as likely to inflict pain as any of the men she went out with. Frequently, she viewed me as a father-figure, at once able to help but, because her father had left her, just as likely to cause harm. Her story, in large part, concerns the influence of transference – that is, when the patient treats the therapist as if they were someone significant from the past – and associated feelings ranging from love to hate. But nothing was simple with this patient. At times, she also wanted to be my mother and my lover. When she wanted to end her treatment, she was afraid of the result. Her fantasies about men were as potent as those that she derived from fiction.

Finally, the patient begins to cope with her obsessions, but the outcome is always uncertain. She wants to improve as she becomes more self-aware, but she clings to fantasies that provide her an excuse in case she should fail. I watch her toggle between these two poles. What becomes apparent (once again) is that psychotherapy it is never linear. It is frequently fraught. It deals with intangibles, like fantasies. The patient and I must find out how these fantasies originated so that we can begin to deter them, and lose their hold over her psychic life. I must help the patient examine their origin and function, so that they are not – merely by inertia – allowed to become some fallback substitute for living in the real world.

Of course, my immediate focus had to be with helping the patient cope with the realities of her life determined by her proliferating fantasies. We were necessarily drawn into the myriad ways that she experienced love – or the lack of it. The patient lacked self-esteem, that is, love of self, which was why she identified with the match girl and allowed that fantasy to supersede real-life factors that could have contributed to self-esteem. It was a vicious circle that we set out to break and turn into a virtuous one.

Additionally, we had to address the patient's difficulty with romantic love which, in turn, led to earlier problems that she had experienced with her parents. She loved her mother, but also disdained how she had lived. She longed for her absent father and loved her step-father, but the relationships were immensely complicated and continued to affect her adult relationships with men. Her experience with her step-father even precipitated a sado-masochistic desire for punishment. She would provoke men into issuing punishment – if not physical, then psychological – and, as might be expected, attempted to provoke me.

So, broadly considered, this story involves how the varieties of love are influenced by earlier relationships, and can precipitate diverse fantasies relating to sex and love. Unlike the preceding Oedipus study, which examined the influence of an unconscious fantasy, this one considers how a fantasy, even a conscious one, can undermine both romance and a patient's own self-esteem. We had to determine why the patient clings to this fantasy, even while she understands it and finds new ways to increase its potency.

We all know that love and fantasy can be delightfully intertwined. However, when their involvement becomes pernicious, we must untangle them. The study demonstrates the patient's struggle towards that end.

b) The underlying theory. This woman's story is an example of Self Psychology, a theoretical orientation conceived by Heinz Kohut (1913-1981) and now integral to psychoanalytic treatment. It focuses on developing and maintaining a solid, cohesive sense of oneself – i.e., what is commonly called self-esteem. Thus, where Freudian analysis focuses on the drives (sex and aggression), and drive derivatives in fantasy and unconscious mental life, Self Psychology considers one's inner experiences, for example, sensitivity to failure, disappointment, and slights. It recognizes empathy as essential to human development and growth and, significantly, to the psychotherapeutic process.

The patient grew up with an absent father and unavailable, narcissistic mother. Her needs for love, care, and attention were unmet. Thus, she did not have the chance to develop a reservoir of basic self-love and self-esteem that she could have drawn on later in life. During her analysis, I provided the type of empathy that had been lacking. That is, rather than simply interpreting her unconscious mental life and the transferential aspects of our relationship, I tried (within the parameters of the psychoanalytic setting) to compensate for what was missing and, thus, help her to gain a sense of her own value. I tried to mirror that value, helping her to see her positive traits and abilities.

This approach helped the patient to develop resilience, as well as a sense of herself as independent – that is, one

that did not require someone else (notably, a man) to make her feel sexually desirable or professionally competent. Towards the end of her analysis, the patient uses the metaphor of giving "birth" to a new self, different from that with which she entered treatment. The metaphor is particularly potent because, from an early age, she felt diminished by a mother who flaunted her own ability to attract men. Such narcissism literally left no room for the patient, whose sense of self (and of her own femininity) never fully developed. This inadequacy festered, expressing itself as a generalized inadequacy that the analysis had to address.

Gatsby

a) The problem. This story is named "Gatsby" after the eponymous hero of a great American novel who, like my patient, organizes his life around a false, inflated image of himself that he displays in public, while in private he lacks self-esteem.

Also as in Gatsby, my patient was obsessed with the forbidden pursuit of an unattainable woman. For my patient, the consequences of his obsession were dramatic, and contributed to the disparity between his public persona and his reality: he repressed his desire, used other women as placeholders, and constructed a persona based primarily on appearance because he cannot face his true, indeed illicit motivations. It takes years for him even to acknowledge his feelings, much less deal with them. His story exemplifies the power of desire to take hold of us, and our resistance to letting go of fantasies that support our ability to sustain such desire.

But the desire that my patient feels is complicated. It emanates from a love/hate relationship that began in childhood. It becomes the paradigm for how he conducts his life, which proceeds by on/off decision-making that constantly doubles back on itself and renders him unable to act. He loses self-esteem, which only further prevents him from functioning effectively. He becomes prone to severe panic attacks, and worries obsessively that people are watching him, measuring his inadequacy. It is only as he finally acknowledges the depth of his illicit desire that the pall it created begins to recede. But the journey is hard, and he suffers relapses – repeating, even in therapy, his on/off, ingrained modus operandi.

b) Why this problem matters. So, his story concerns the intersection of two faces of love: sexual obsession and our regard for ourselves. We have all experienced the trauma of loving someone who will not, cannot love us. We wonder whether there was something about us that brought on their lack of response. It's normal. But for my patient, the obsession remains in his psyche, buried but still potent. How does he learn to face it? How does he learn, finally, to keep it from infecting the rest of his life?

He never really learns completely. But he comes a long way. Intense, obsessive love is hard to get over – when it is illicit, it is even hard to acknowledge. But my patient, in his own best interest, at least reaches a still point where he can adjust, and feel better about himself. When love is concerned, sometimes that is all we can expect.

If we are not comfortable with ourselves, it is difficult to share our life with someone else – who, after all, are we even sharing? In this sense, there is a continuum between self-love, the stability of self-acceptance, and a romantic attachment. Of course, self-love does not have to entail narcissism, but only a healthy regard for our own worth. It involves acknowledging the complexity of our desires, and living with them despite themselves, even when they cannot be realized.

c) The underlying theory. The psychoanalyst and pediatrician, Donald Winnicott (1896-1971) proposed a distinction between a true and false self. As opposed to the true self – who we know that we are – its false counterpart refers to how we present ourselves to others so that we can get along in the world. To be successful, the individual has to find the right balance between the two. In this patient, however, the false self was dominant, so he felt more fragile and, hence vulnerable. He tended to compensate with perfectionist tendencies and outsize ambitions that would (he thought) prove his manhood.

These tendencies were traceable, in part, to another element of Winnicott's theories, the "good enough" mother. In this patient's case, his mother tended to coddle him, and shield him from embarrassment over his childhood bedwetting. Thus, while she was caring and warm, she curtailed his developing any sense of himself as a capable young man. This sense of incapacity persisted into adulthood, and we had to work on resolving it.

The patient's stunted development also raises a third theory proposed by Winnicott, involving the importance of a play space and the transitional object. The transitional object helps to mediate between play and reality (think of a child playing with a doll). Unfortunately, this patient became too playful with a forbidden object – his sibling – retreating from other objects that might have made him feel better and more confident. The patient had to work on acknowledging his feelings so that he could finally redirect them, exiting the play space into the reality of mature relationships.

None of this work came easily. His treatment, characterized by repeated attempts to withdraw from analysis, demonstrates that the process of analysis becomes an image of a patient's neuroses and conflicts. If the patient is obsessive or conflicted (as this one was), then the analysis will follow the course of their obsessions and conflicts as these emerge into consciousness. Free association bears with it sometimes sudden encounters with some conflict that may precipitate an equally sudden effort to leave therapy . . . only to be overridden, often in the same session, by a renewed commitment (however shaky) to

continue. Psychoanalysts expect this type of churn. It can impart a sense of whiplash, but any on/off incident of departure and return can engender a new insight as the patient explores the motivations behind such incident.

Finally, I should note that while the resistance demonstrated by this patient may seem extreme, patients in analysis necessarily have at least some resistance – in the beginning (when they are not sure if they are committed), in the middle (when difficult challenges arise), or towards the end (when they think they are further along than they really are). One way to understand the process of analysis, in large measure, is to see it as helping clear away patients' resistance to analysis, i.e., to facilitate a patient's unencumbered free association, so that they can open up about their neuroses and conflicts (an essential step towards insight and understanding). Here, the patient struggles with resistance until, finally, he becomes relatively capable of free association. It takes six years.

Reluctance

a) The conflict. A young man loved his father (ambivalently), but was conflicted over versions of aggressive masculinity that his father imposes. He struggles to define his own sense of maleness, complicated by what he feels are his feminizing, homoerotic tendencies. In his more "feminine" mode, he has contempt for his father, especially regarding his father's indifference to his mother's sensibilities. The family dynamic remains a source of troubling self-doubt, as well as anger at patriarchal figures whose swagger he nonetheless tries to emulate. He finally seeks my help – though I too am a "patriarch" – with how to be a male on his own terms.

The problem is that as therapy proceeds, he needs to compete with me, to prove me ineffectual and unable to help. Thus, he falls into a type of contradiction from which it is difficult to escape. The more he feels the need to compete, the less likely his therapy is to succeed. Yet he still cannot do without the competition, and fantasizes my defeat at his hands. In the fantasy world that he inhabits, he emerges as dominant, even while forcing his treatment towards abrupt reversals and failures. We make some progress, but a negative transference emerges where I become a stand-in for his father, a homosexual partner, and even the professors whose grading he resents.

I try to help him to accept his homoerotic tendencies so that he can construct a sense of his masculinity that is not subject to constant self-doubt. If he can resolve or at least manage his conflicts over aggressive masculinity, he will be less likely to compensate through fantasies of dominance. But our progress is slow. He clings to his father's notions, continuing to find new challengers whom he feels the need to vanquish.

His relationship with a woman, a major player in this story, is fraught. He has not told her about his fantasies – either the cartoonishly violent, where women are subjugated, or the homoerotic, which he regards as feminizing. He worries about their compatibility, mainly because she does not satisfy some of his sexual desires and because he feels intimidated by her intellectual success. We talk about how this relationship may or may not work out, and he remains conflicted over how firmly to commit to it.

So, this devolves into a multi-dimensional scenario in which the patient is intensely reluctant to declare himself – for or against one form of love or another, for or against his father, or me, or his girlfriend. He is even troubled for a time to commit himself to graduate school, though he has already enrolled. By the time he fully embraces the profession, he sees it as a way to compete with me. He never fully shakes his obsessions.

Yet, towards the end of his analysis – a treatment of almost four years – he experiences a significant moment of clarity when suddenly, he can diagnose the factors that, in collision, are responsible for his conflicts. Whether he will deal with them effectively remains uncertain, but he has nonetheless made progress. He has learned how to think about himself with a degree of insight and understanding. He likes himself more because he does not feel guilty over who he is – that is, he is himself, his own version of "male," and he will likely keep working on refining it. He takes significant steps towards resolving issues with his relationship based, in part, on a conviction that he will be able to see them through to success. But will he succeed?

Because all forms of love — sexual, familial, self-love — are so complex, they challenge the treatment to sort through them to some more definitive version of what is feasible, much less desirable. Moreover, the patient needs to help. In this case and not uncommonly, the patient's conflicts interfered, and so we were caught in a bind: the more the patient resisted, the less progress we made, and the more his conflicts kept asserting themselves in new, disconcerting ways. We had to settle into treatment, and wait for the conflicts to emerge in the transference, so that the patient could finally clarify how he would untangle the various strands of love that made up his complex existence. We could not out-wait his conflicts but, because of what he learned in analysis, he may go the rest of the way on his own.

b) The theoretical backdrop. As this treatment unfolded, I began to understand the patient in terms of "attachment theory," developed by John Bowlby in the 1950s. The "attachment" is the bond that an infant develops with its parents or primary care-giver, which can affect the person's relationships going forward. There are three types of attachment styles, one of which is anxious-preoccupied, in which a person seeks intimacy but needs constant reassurance and readiness from the partner. It applies to the patient in this study: he sought closeness with his fiancée,

but then needed reassurance that she cared and would be there. He'd seek to embrace her more fully, and then would pull away -- an attitude that was on display when he addressed me, and not without homoerotic implications. From Bowlby's perspective, the patient's behavior reflects a frustrated yearning for closeness with his mother who, for the most part, was passive and remote.

The patient dwells on his mother, in fact, who was so beaten down by his father that she rarely had time to provide him with a refuge. While he repeatedly sought his mother's love and attention, he was shunted off into his schoolwork. Excelling at school – and especially in sports – became his way of gaining her attention, though it left him as an anxious-avoidant participant in future relationships.

6) A few reflections

Of course, these stories can only hint at the fine-grained, complex reality of treatment. Ideally, the reader would be situated inside the conversation between the patient and myself as it unfolds over the course of analysis. They would be privy to my real-time reflections. They would share my sense of immediacy because, as a psychoanalyst, I must often reflect spontaneously on a dream or unanticipated, suddenly recovered memory or association. They would encounter both my excitement and my exasperation. In Faces of Love, I tried to make room for this sort of intimacy.

This article, however, still tries (on a more limited scale) to synthesize some complex psychoanalytic material through the lens of love. From the perspective of love, it deals with issues such as repressed homosexuality, a taboo desire for a sibling, obsession with a fantasy, a complex Oedipus complex, and transferences that become resistance, and even an obstacle to treatment until they are examined and understood. Issues that may seem to have little in common, at least regarding their treatment, emerge as having a substrate – in love – that draws them together, facilitating our comprehension of the issues and their treatment. The core take-away therefore, should be that a patient's problematic relationship to love, however expressed, can be addressed over time by enabling them to understand how love functions in their lives. This understanding develops through psychoanalytic treatment.

That is, psychoanalysis is not primarily about symptom relief. It's about reaching into the mind of human beings, and making it less likely that the causes of suffering and psychic pain (which may have deepened over decades) will persist. It recognizes that human nature is a constantly shifting constellation of conflicts and compromises. Ultimately, it aims at personal growth, increased self-understanding, and empathy towards oneself and others.

Perhaps as psychoanalysts, we help people to love themselves and others by listening and providing empathy. These are aspects of love. Some psychoanalysts have postulated that psychoanalysis is a cure through love – not, perhaps, as patients would understand it, but certainly insofar as love implies a type of attuned attentiveness where the analyst responds to the patient with insight and an empathic assurance, allowing the patient to freely associate with less fear or inhibition. In this posture, love does the work of psychotherapy. It's liberating. It enables the patient to experience a type of sharing that may, until that point, have seemed beyond reach. In this sense, love teaches. Certainly, my own work has shifted towards the interpersonal (vs. the intrapsychic) because it is through a relationship – or, rather, the paradigmatic relationship between psychoanalyst and patient – that healing happens.

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Contemporary Perspectives in Psychoanalytic Technique

Clinical Case Presentation
It Was My Body's Fault: A Tale of Trauma and Abandonment

By Vladan Novakovic MD

I began working with Lia two years ago when she came to my office in Lower Manhattan in the aftermath of her breakup with boyfriend of four years.

She offered some of the history of their relationship: "I did not feel safe with Ben as he did not stand up for me when I needed him. I resented him for spending time with friends and accused him of being uncaring. We had broken up several times over the years and I realized how I could not trust him any longer to support me so at the end he became my punching bag".

She added, "It dawned on me that I needed to work on myself first and not continue being in a relationship with my boyfriend where I felt I was not good enough and felt inferior. I need to talk things through."

On our first session, she said openly how her primary concern was how to go on about her life as normally as possible, given her anxiety and her fear about her illness, and did not speak of her boyfriend any longer but proceeded to describe herself, "I am twenty-nine, and I feel frequently that my life is over before it started because I cannot pursue certain jobs and relationships, fearing that my disease will relapse if I overwork, over-stress or overexert myself.

Lia suffered from severe vasculitis, an inflammation of blood vessels that causes changes in the walls of blood vessels, including thickening, narrowing and scarring. These changes could restrict the blood flow, resulting in organ and tissue damage often leaving visible scars on her body.

As she was unfolding her narrative, she further elaborated: "I can never have a long-term relationship because of how my parents have treated me, and I am afraid to repeat unconsciously or consciously the same patterns with anyone new. I am scared that guys would reject me because of my scars and disfigurement and also because of my low self-esteem."

She wanted I to find a way to accept her relationship with her parents and resolve the resentment towards them for sending her back to China at the age of five when she was diagnosed with vasculitis and was at her sickest. She reported frequent anxiety issues and stress causing her panic attacks. She asked if I could help her unpack some of these burdens.

As I heard these complaints, I began to feel that I was not going to be of assistance with helping her in the long run while working in my Lower Manhattan clinic and seeing patients on monthly basis and thought immediately of how she might be in need of more meaningful therapy at my institute. After our few meetings, she decided to continue working with me and applied for four-time-per-week psychoanalysis.

Prior to seeing me, she was treated by two psychotherapists which she did not feel were right for her and was turned off by them. She described her first therapist as someone who talked about herself and showed her own old photographs and the second one as being "uncaring and not understanding" of her. Needless to say, she came into my initial evaluation without any information from them.

Following my detailed interview, I gathered that Lia suffered from anxiety, low self-esteem, trauma, neglect and also in the past she relied heavily on alcohol to increase her confidence and ease tension and anxiety.

I found her a bit peculiar. She was short, fidgety, unsettling, and as she presented in a state of acute anxiety I felt as if I have a bundle of nerves to deal with. Upon meeting her for the first time, I remember her presence filled the room immediately with despair and helplessness as soon as we closed the door.

She looked petite, fragile and yet stylishly dressed. I took note of her face which was visibly distraught, fearful, and in marked distress. She would occasionally avoid my eye contact and looked away, which left me to observe the shivering of her body movements that went along with her cry for help.

As she was talking to me, I observed her continually rolling the sleeves of her shirt over her hands in an attempt to cover them up , seemingly oblivious of such gesture, that soon to became a telling sign and painful reminder of her life story.

I quickly noticed that she was missing the endings on three fingers of both hands as I caught myself avoiding to pay detailed attention to them in an effort to make her feel more comfortable in talking with me.

Lia explained how this was the actual first time that she wanted to begin with more frequent therapy and did not express skepticism or any reservations toward it, which intrigued me as I was taking into consideration her prior mentioned negative experiences in treatment.

She explained, "It was something that you said at the end of our first session that empowered me. Something simple as 'what can bring relief' that I believe you have asked me as I was panicking that I took so seriously and understood as how I actually deserve to have one and that you will be there to listen."

As she said that I recall feeling how we needed to explore this more, but despite my effort to address her premature expectations of me as a therapist and reach some understanding of what was happening at the moment, we

were unable to do so.

As this was the very beginning of her analysis, I felt surprised and yet interestingly open to our work together. I had briefly thought along the lines of her possibly rapidly developing a positive transference just to stop myself short from wondering out loud about it. I also became wary (apprehensive) of her need to idealize me early on while not knowing and experiencing me as a therapist. It challenged me to think of my own role and examine my authenticity.

At this early stage of our work, I recall musing over the idea how much this young woman must have been hurt in such a catastrophic way as to develop the willingness to connect (attachment) to me so quickly and unreservedly.

Our initial sessions would begin by her taking out a notebook and writing down notes obsessively, as if in an effort to preserve and safeguard them outside the session. I wondered to myself to what end she did it? Had I given her some way or permission to borrow from me something that she could not express and reciprocate in kind while in a session or, perhaps, was depriving her of desire to express herself freely with me?

"Whose voice was heard in the consulting room? Mine or hers?" I thought silently while imagining myself being put in the role of an explainer as she was jotting things down and creating a safe distance from me. It almost felt like I was being cheated. Still I felt some certainty that by addressing it, I might be depriving her of hope and connection with me, and that I might come across as harsh and critical of her if she did not have that distance.

Lia must have picked on (sensed) my experience at the moment when without much delay she skillfully revealed: "You know, I just have bad memories for details, and by writing them down, I can retain more of them. I have done it in the past and have many notebooks at home. This could facilitate, I thought in some way me having the advantage of therapy outside the treatment." She continued, "Are we both seeing an image of a serious student taking notes down? Sooo annoying," she said stretching the vowels - at which point we both laughed heartily.

I remember discussing this moment with my supervisor Dr. S as we both drew associations to transference and possible transitional object phenomenon and implication of it in my therapeutic work with her. I explored these moments in a timely manner, and I asked her more about their meaning, what she was experiencing here with me and what her understanding was of those moments in the session.

In the following session, we explored one of those moments more, and she produced many associations. I learned that she felt that her expected role in life had been not to take initiative and that she assumed I would take it in this relationship too. When I pointed out how this might be part of the problem, she brushed it off as insignificant upon which I felt frustrated with her failing to understand how by accepting me or anyone else in such a way meant leaving her without a choice to express herself and speak her mind.

During the following sessions as we were discussing her need to see me in a certain way, we touched upon the particular moments in which she was ascribing special powers of understanding and caring to me by viewing me as an all-powerful parent that she simply could not risk losing and with whom she could be dependent. This brought the interpersonal dynamics in which I felt a pressure and urgency to understand her experience at the moment, while she was unable to formulate and express it fully that made me feel tied up and suspended.

As I imagined how this might be confusing to both of us, I asked her whether she felt free to disagree with me and express her thoughts without needing me to affirm them. She replied, "I feel confused too. I experience you as a therapist with good intentions that have created a space for me in which I feel I can't get hurt, but I continually second guess my thoughts and desires, and worry that you will push me away and reject me just like my parents did - giving me the silent treatment."

As this motif began to emerge and was worked through in many sessions, Lia acknowledged how she became more comfortable to engage in a new experience of an analysis, while still feeling safe, secure and accepted.

She self-identified as a Chinese-American, a girl from Brooklyn in her early thirties; born and raised in the northeast of China in a city famous for fragrant flowers, rivers, and beautiful mountains. She was raised by two women since the age of one when her mother left for the US. One of them was her aunt whom she described to me as "mom-sister" and the other one was her grandmother, "a lively and sociable woman", who loved and care for her but at the same time would remind her of not having enough food, money, colored pencils. That made her feel "guilty for wanting more."

Lia would describe being raised in a "tug of war and butting-heads", an atmosphere where she was bounced back and forth between two families alternatively every week and remembered always "dreading leaving and adjusting to new households time and time again." She called this event "Sunday Blues" or "handover time" and because of that until the present she felt "inexplicably anxious and tense on Sundays."

She described feeling safe in both families and said both her aunt and grandmother were like parents. Her grandmother would mistakenly call her not by her name but by her aunt's name, and she remembered feeling comfortable hearing it. It made her feel wanted when she was a child. Her aunt took her to school where she was a teacher and taught her "filial piety"- a Confucian virtue of respect for her parents and elders. Lia found in this lively woman the

kind of loving relationship she desire - albeit elusive - and she was Lia's only beloved playmate.

Lia came to the US at the age of 5 and remained healthy and happy for only six months. She cherished these rare moments of happiness and harmony spent with family. This seemingly idyllic tranquility was abruptly discontinued by her growing bodily pains in her hands, back,and intimate areas of her body. She had difficulty walking that left her parents confused, but rather than proceeding with detailed medical workup, ultimately sent her back to China, where she was seen by many herbalists and traditional Chinese medicine practitioners but to no avail.

She recalled, "I cried and pull my mom's hair begging not to send me back, but saw no tears in her eyes." I remember feeling deeply saddened listening to her story and thought how little attention had been paid to this young woman, and imagined how much this traumatic separation from mother must have induced panic and regression in her life.

While in China, Lia was subjugated to traditional Chinese medicine treatments such as "rhino-horn shavings" and was placed on the many pain killers. Her painful episodes would come and go leaving scars and bumps on her body and extremities and subsequently leave her without distal phalanges (endings of her fingers).

She recalled, "As I was passing through the dark hospital doorway, I felt that there was no coming back for me. I saw through the dim hallway lighting the sick children their shadows on the wall, and immediately recognized myself among them. At first, I suffered excruciating pain and lost the sensations in my fingers, and soon to my horror found they fell off by themselves. I remember being scared about losing more bodily parts - my hands, my back, my elbows."

She continued, "Throughout this harrowing account, remember having conversations in my head with my mom and dad and waiting in vain for my father to walk in. I remember saying to myself, 'it was my body's fault'" as she began to cry during a session.

In hindsight, she added that she thought how their absence had created a painful space within her, in which she felt alienated but also a barrier towards the outside world in which aloneness seemed to be her only choice. Lia would find herself frequently questioning where she belonged. Was she 70% Chinese and 30% American or vice versa? Due to her illness, she received inconsistent education in China and was blamed for bringing the class average grade down. In school, teachers never missed the opportunity to mention how she had no parents in an attempt to draw sympathy for her from her peers.

As she was looking back at these moments of her life, she wondered how she had not protested against this idea of being without parents, and how strangely accepting of them she felt at the time.

Lia came back to the US in fifth grade (age 9) with no knowledge of the English language, lived in Brooklyn, and started in school where she was bullied, occasionally racially discriminated. On rare occasions, she felt at home with Russian and Eastern European immigrant kids, whom she felt accepted by. Her choice of therapist resonated transferentially with me as an Eastern European immigrant, as I became aware that she was able to foster positive relationships with this community.

Eventually, Lia was diagnosed with autoimmune vasculitis for which she is getting treatment and is currently in remission.

As she was recalling her transition to America, Lia brought more painful memories to our attention: "I felt I had arrived at a home of strangers. I had not bathed myself thinking how I could preserve the smell of my grandma with me forever. I remember putting the scotch tape over my face on numerous family photographs just to be scolded and criticized by my dad saying, 'You are ruining the family photo, you fool! No need for that. You didn't have to be there anyway!'"

As she was saying this I found myself nearly being moved to tears. It is worth mentioning how even today part of her continues to struggle with estrangement and separation from parents, whom she addresses by their personal names. So, themes of abandonment, trauma, and separation became frequent in our analysis.

Lia is the oldest of four siblings and the only one with given a Chinese name. While talking about siblings she said jokingly, "I was 'made in China' and needed to do household chores, change diapers, and serve as house maid". She continued by saying that with each new child, she felt "diluted, minuscule and humiliated." As she was talking, I thought how Lia may have been made the family scapegoat as a result of tragedy attributed to her by her family.

Lia has a younger brother and two younger sisters. She described her brother as being "a drug addict" whom she has a lot of sympathy for and her older sisters as "the most beautiful one and pride of her parents" and the youngest as being "insecure about her sexual identity."

Despite the humiliation and hurt that Lia experienced, she nevertheless held much love and tenderness when she talked about her siblings. She continues to give them constructive advice and suggestions and is protective of them. She described having friendly relationship with them and says she loves them dearly. She described them as "the American ones" and the pride of their family, without any trace of envy.

Unlike her siblings, she described parents as being emotionally distant, cold and disapproving.

"They are like the Tweedledum and Tweedledee. A toxic couple living in a Utopian bubble."

While painting the image of her father she noted, "Be-

ing in a room with him is like having a knife battle in which I am powerless and ready for the preemptive flight when he charges at me. I can't stand his voice and demeanor. He looks angry and despondent all the time. My ideas seemingly provoke him and he lashes out. And when he hits, he hits hard and hammers me down. Always with words. When I do great he feels crestfallen."

While revisiting memories of childhood, Lia fondly remembered a single instance of her clutching his arm when taken to the rollercoaster ride on rare family vacation. Much of her interaction with him he perceived by him as a protest and rebellion against him after which she felt dismissed -the feeling often accompanied with a conclusive statement of how unaccounted and missing in action she was from the get-go for them. So I figured early on that my role is to avoid him at any cost but somehow I could not come to grips with it. I had to be in an open rebellion and challenge them both."

I expressed my view how perhaps by doing so she was challenging their perception of her and by making such effort she wanted to see if she can find out her place among them which she readily acknowledged.

While exploring her childhood, I picked up on a feeling that Lia holds a sense of deep distrust towards her mother. Lia described her as being an "egocentric and prideful women, unable to deal with feelings and be a bigger person," who manipulated her emotionally growing up.

As we explore her childhood interactions further, she related the particular memory: "It was cover-my-body-up game in which she made me wear big size clothes and use sanitary napkins instead of pads. I could not conceal my pimples and wore a bra. Later, I was kicked in the crotch when I refused to date a boy. I dealt with bleeding secretly and not telling her out of fear that she might overreact."

As she brought up this memory, she became silent. I waited for her to speak. Then she continued, "Wow, it hit me now. I was convinced for years how this was my actual first period." This incident took us further into memories of physical aspect of interactions with her mother. She commented, "When I hugged her in middle school she froze." She reflected, "Now when I touch and hug her I become resentful and feel like I'm betraying myself. When I am nice to her I feel guilty."

Lia summarized her relationship with both parents stating, "Over the years I became convinced how they did not want to acknowledge my existence and almost got rid of me somewhere in China."

In our next session she related a particular moment of being confused and detached while working as a substitute public school teacher. "I was about to put my coat on a rack but felt I would make all these coats dirty. I stood there bewildered as my mind became engulfed in past memories of being tutored by my Math teacher, and heard my mom comment 'she mind simply cannot wrap it around. She is simply slow." She commented how real this experience felt in the session, and how she had to hold on to the whole of our relationship and maintain a safe distance. I felt her fragility and sensitivity.

My understanding and countertransference reactions at the time were duly discussed while working with my supervisor. For Lia and to some extent her siblings both of her parents' attributed all of their adjustment difficulties to Lia's simply being spoiled children not realizing the hardships they went through.

When I replied how I thought that from what we had learned so far, her parents seemed harsh and cruel, she concurred with me but remarked how she had not thought of them in that light while growing up but blamed herself instead.

Survival:

During one of our sessions, I sense the heaviness of the moment in my chest and uttered a sigh. "What a survival story," I observed. Lia pursed her mouth in a smirk that signaled displeasure.

Her response to this was immediate stating, "That phrase really ticks me off. No matter how you put it and how much you care about me, it labels me. It is patronizing and dismissive. They maybe wanted me to die and did not have any will to see me living. But I survived and lived. It is sort of like giving a purple heart to the vet in which everyone thinks that they have done their part. Being survivor means being fucked up and inherently flawed." She added, "I feel I just lectured you," and smiled kindly.

As she was "lecturing me", I made a comment about how I felt she was becoming freer to express her intense feelings with me, which she confirmed. I also acknowledged her point and apologized for possibly making her feel hurt, but did not further elaborate how earnest and sincere I felt about my statement.

She reported in the next session that she felt better than she had in weeks as I was not trying to "compensate by understanding her experience" with a "pep talk" but sensed how genuinely I care for her.

Lia self-diagnosed herself with low self-esteem, depression, anxiety, and being a "freak" who is ready to blow up and explode into a rage on any mention of her deformities. She felt confused and inferior.

Growing up she found herself not feeling competent and not connected and self-assured in the social situations but even less in the professional settings.

After graduating respectable university on the West Coast and majoring in English - just like both of her parents - Lia tried her "luck" working different jobs that mainly required her use of hands. She obtained bartender and hair stylist certificates, but in both places felt "out of touch and enormously anxious," and finally ended up

working as a substitute teacher at her father's school, working mainly with Asian children - a job that she deeply detested. Despite her good professional performances in school, she suffered from significant social anxiety as if a threat of shame and humiliation was looming from every school corner.

When being alone, she describes her experience as "unbearable," "tense" and "tormenting," accompanied by palpable physical discomfort from which she sought in the past an escape in drinking. Seldomly, she used other drugs (special K) that she got from her brother. When she drank, she could tolerate herself and her family better. It was a kind of self-medication.

Lia was distressed about any interaction with her immediate family and frequently panicked when faced with the prospect of seeing them. Being highly sensitive to them, Lia became anxious and distressed that mainly pertained to "reading the cues," as she called it, and sensing their internal world and deciphering their unspoken language.

Lia observed her family environment with much vigilance. She took notice of every little detail, gesture and expression. She read their body language and physical signs as clues to interpret social meaning and to anticipate any unfavorable outcome. She would operate on assumptions and would overreact in order to understand the world that cannot be taken literally. She stated, "I never knew right from wrong. I became confused about my own judgment and erred on the side of caution in expectation of a looming catastrophe. I would frequently become angry and was offended easily."

Relationships:

Lia often presumed break-ups and losses and sabotaged her personal relationships before they became meaningful and important to her. Socially, while being very loyal to friends, Lia would let them take her place and would rarely take any initiative in organizing things. She would often stay quiet and unassuming in the new circle of friends. Meeting new people was also rife with potential distress that she tried to avoid under any circumstance. The feeling of shame from being watched and criticized became an inescapable and painful reminder of her deformities and scars.

Romantically, while Lia became sexually active in College, she had only two long-standing relationships. She had one serious relationship in California that lasted five years where she became attracted to a boyfriend who was not able to have normal sexual functioning, and was eventually diagnosed with Schizophrenia. She stated, "I witnessed his decline as I felt captive of his madness and paranoia. I had compassion and feelings for him but ended up being blamed by his parents for causing his illness, so I had to leave."

After coming back to New York from California, she started her romantic relationship with a new boyfriend and spent much of her time seeking his approval, reassurance, and acceptance that brought her often into conflicts with him. Lia would use anger and aggression in order to control her relationship. She was quick to put him down and protect herself from humiliation. She described, "While I was dating him, I looked in other people's relationships. I even kept my secret talks with my ex. I resented my new boyfriend for spending time with friends and not me. I felt lonely, angry and defeated. At the end our relationship, it became a cesspool of codependence."

What has emerged from our further discussion in therapy was how frightening her experience of relying on a man and people was in general. She became defensive about her contact anyone she was close to. As a response to her mistreatment of her boyfriend, she quoted him saying, "I can see you as a mother of my children but not as my wife" and became silent.

In between the stormy breakups with him, Lia had casual sex with other men. "I slept with half of the city," she declared while describing her relationships."They were just my shield from the pain that was unbearable. At times I would come off as brash and lash out disproportionately to potential insinuation or even a sign of someone's curiosity about my scars." Being with men was not about the sexual arousal but more about what she could find out about herself afterward and whether she had feelings for them.

In the following sessions, we touched upon sexualization as a defense of loss of parents and other intimate relationships. During this time I helped Lia make the connection for herself while new and complex material was emerging. She brought up the subject of love and the notion of how incapable of being loved she felt. When discussing this topic she said, "Love is just being with someone; cooking and providing food for someone as opposed to living with someone casually" and proceeded to draw a Chinese cultural reference of love being expressed typically through giving clothes and food.

At that moment I sensed how a subject was being avoided and expressed my thought of how critical it might be for us to revisit this matter. I asked what her experience at the moment was and what she thought could happen if she spoke her mind with me. Lia acknowledged how she felt confronted and told me how over the years she internalized the idea that whatever she created was going to be fraught with doubt. Lia said she could no longer be trust people to genuinely take her in and appreciate her for who she is and take her at the face value. She doubted her experience of authenticity with others and also with me.

Witnessing and sensing her experience was difficult for both of us, I felt in the moment that proceeding further with a detailed inquiry could foreclose the analytic process.

Over time, she become more trusting and expressive in our sessions. Lia also enrolled in a respectable graduate program in the city, but she reported feeling conflicted. On one hand, she felt terrified and trapped by the idea that she needed to surpass her parents and outgrow her sense of dependent humiliation on them, and on the other, she felt a tremendous sense of guilt and shame for proving herself worthy of having such thoughts. Confusion of not knowing how to keep up on several "fronts" was her daily living experience.

Early on, Lia had developed good test taking skills as "concrete evidence of worth for my parents" and has never cheated and sought alternative ways to complete assignments in school. I pointed out how she was living the life of their expectations, and by doing so she was not allowing herself to really find out and know what she wanted and enjoyed for herself. She agreed and timidly said how she saw herself being a programmer and data analyst in the future.

Each time we met she would ask me when in doubt to affirm her thoughts. When alone and stressed out she developed the habit of keeping the internal dialogue with me as her therapist and would share this in our next session.

I noted how these various self-states made for a system of self-protection behind which she could be safe and untouched. She added, "And protect me from endless hurt."

After two years of analysis, Lia expressed feeling like a different person and described being more comfortable and content with her body than ever. She commented, "I feel I am owning my body for the first time and feel being complete in incompleteness." Lia said she was determined in perusing her academic and professional career and saw her future as an Asian woman in the highly competitive high-tech industry.

Before one session, Lia received an advertisement from China about the "Leftover Women" (single women over 27 years old). Rather than being upset by it, she reported laughing and dismissing it as funny. In Chinese society, an unmarried woman is incomplete and not getting married is the biggest sign of disrespect to your parents. "That world is no longer my world," she commented. It so corny and backward. I would fret in the past about it, but now at 30 I am ready for the new experiences and do not care."

Lia still reads me very closely and frequently tests how open and honest I am willing to be with her. She has become familiar with my hectic work schedule and concerned about my lengthy drive to the Institute and rarely misses the opportunity to comment how I seem to be always there for her sessions. She comments on my facial expressions freely and reads my feeling states adequately. She has become more open, communicative, and spontaneous in working with me in the analysis. She states how gradually she has become able to get a hold on her thoughts and feelings and disclose them to me.

I was struck by her dutifulness, commitment, perfect attendance for sessions with me that stood in stark contrast to enduring resentful and forceful relationship toward her parents. When I addressed it, Lia explained how she felt trusted, cared for and safe with me when discussing her vulnerabilities and weaknesses when dealing with her family and the world.

She frequently found herself amused by my question "What made a difference?" and "How different are you now?" while referring to particular changes in her mental states. She would notice minute change in my affect and ask me how I feel as a reflection to her responses.

After two years into the treatment, she has come to feel that her life is less filled with intense fear of her parents' hostility and reactions, and she perceives her visits as less of threatening and humiliating.

Dreams:

As her analysis was progressing Lia began to have more and more dreams about her family and her analysis with me. Despite her initial skepticism to the dream analysis, she has become more interested in what was happening in her dream life and readily expressed her associations to the dream material with me in the sessions. Her dream life was often filled with apprehension and dread towards her family: eavesdropping and spying on her father and portraying him in farcical and ridiculed manner; images of babies, sexual acts, etc. Her dreams are often accompanied by a sense of unbound anxiety of living with and witnessing her family interactions. Each time she has these dreams she wakes up terrified and in cold sweats.

Lately, I've felt she was challenging boundaries in her dreams too. In one of many of her dreams of me, she took an active participation in my own family circle and was free to associate with her role, desires, and relationship with me. She stated, "I find myself visiting your house. I see you and your wife and your brother and his wife. You warn me of danger and told me to get out of the building as the killer is on the loose who killed my brother and while producing a black and white photograph of him as evidence. I was confused.

Lia associated her dream with being inquisitive and desiring to be part of the couple, but also brought her aggressive dark side and murderous wishes and feelings by which she could possibly achieve her goals.

Getting into this material launched many associations that included sexual and erotic fantasies. She was able to express her anger and frustration over her boundary crossing in her dream and felt how she tried to achieve something unreachable. I shared my own reflection about the dream too and pointed out how she followed my directive without question, while refusing to see the truth in front of her vary eyes. After which she produced suspicion of how people can disguise their thoughts under the pretext of

kindness and use it in order not to offend her.

Moreover, she acknowledged having many dreams in the past with the theme of "attacking and dismantling the couples" frequently motivated by envious feelings of them and frequently had much trouble with falling and staying asleep while thinking of her childhood traumatic memories and emotions.

Recent sessions with me:

Lia frequently expresses her appreciation for my care towards her and her feelings of connectedness towards me and has been able to find much needed common ground in analysis while frequently crossing our cultural differences. She feels that we created a safe space like a new home in which she can express herself without being criticized and humiliated.

While I was making myself available to Lia in various ways, I became a more reliable object for her toward which she feels free to express even the most intense feelings of aggression, hostility and envy. I feel that in our sessions, I have been responding in ways that have facilitated the analytic process. As my work with her continues to unfold, Lia expressed how trusting she has become and how meaningful our sessions have been for her.

Recently, she said to me: "Therapy here is like a filter and buffer at the same time. Filter as if my old me has slowly dissipated through our work, so I am able to act more calmly, choose my words appropriately, and communicate openly with others with less fear. Simultaneously, through analysis, my new self has been becoming more protective, just like a buffer. Each session with you was like separate moments connected with each other, moments that made me feel as I have a mental friend in you that I carry elsewhere."

She added that while she understood the difference between a professional and a personal friendship that she felt she could come in any state of mind and I'd accept her and be there for. In short she felt understood. She shared that she was starting to date again. "Therapy gave me hope to have a new and different relationship outside of here. I feel, maybe for the first time, that is possible to love and I think that therapy brought me to that realm and gave me that sense of possibility and hopefulness."

Lia's words touched my heart. As began to examine my own feelings about our sessions. I realized how much I enjoyed her presence and was looking forward to talking to her with each session. I wondered how spontaneous and free I became in working with her and how I was readily open to discover new therapeutic experiences and was accepting of them. I also felt connected and close to her.

My supervisors were very helpful in framing my relationship with Lia. Our personal and authentic relationship and our interplay in therapy were thoroughly discussed as our treatment objectives.

As she reflected on our work she said, "I think that being in therapy has re-shifted my interaction with people, professionals in my graduate school and strangers. Now, I give my opinion unlike before when I never talked unless I was asked. I acted like a coy and let other people dominating my opinion. Now, being here gave me the backbone that I needed to have."

As I was listening to her I could not help but wonder how she arrived at this point in therapy and asked her for an explanation. "It's magic that made the difference… magic, your process and my motivation to change." Over the past 2 years, Lia has become better functioning and better integrated as a person. She is less negativistic about her relationships, less inclined on impressing others and more of trusting of herself overall. She gave up alcohol and stopped smoking.

In recognition of our work, she noted recently,:"I feel like our work together saved my life as I did not enjoy any part of living. As we are ending this phase of treatment, I wonder if I will I revert to my old thinking patterns and if the change is permanent. But now, unlike before, I feel I have a new potential in myself that I have not anticipated. I don't lose balance. I am in a better place."

This case study is based on Dr. Novakovic's clinical presentation at "The Talking Cure: Past, Present and Especially Future," a Symposium held at Mount Sinai in 2021.

Discussion of an Interpersonal Therapeutic Journey

By Janet Bachant, PhD

On the therapeutic journey, whether we are patients or therapists, we have an opportunity to explore the inner life. Those who choose to be in therapy, or to do therapy, embark on an adventure that has no equal. Committing oneself to understanding the inner life renders us time travelers into unseen dimensions of the mind, exploring the reality of another universe. Wishes, fears, fantasies, feelings, relatedness, actions, thoughts and motivations make up the landscape of this unknown territory. It is an exciting, at times frightening path to take, but it is an exploration that uncovers the meaning of our lives.

When we begin any treatment, we are always listening for relatedness – how patients relate to others, to us and to themselves. This relatedness is shaped by the attachments, connections, and adversities they experienced as their minds were becoming organized, as well as by the unique, biological foundation encoded in the genes. Lia's history is an expression of this relatedness. We know Lia experienced her first major loss at a year old when her mother and father left for the United States. If the grandmother was in the parental home for Lia's first year, perhaps the early loss of her parents was somewhat tempered by the sustaining presence of this parental like figure who "made

her feel wanted." Whatever happened, we are clear that by the tender age of twelve months, Lia suffered considerable adversity: first the loss of both parents in their move to the US and then the sustained, recurring losses of having to shuttle between her relatives and being described in school as not having parents. Mercifully, Lia seems to have experienced both love and safety with her relatives. We can speculate that the caring she experienced with these women provided Lia with a foundation of resilience that became vital in the face of the additional trauma she was about to endure.

At the age of five, Lia came to the United States. Within six months of her reuniting with her parents, Lia's "idyllic tranquility" was abruptly shattered by increasingly severe bodily pains -- her first symptoms of vasculitis. We do not know if Lia's move to the U.S. played a role in the expression of her disease. Whatever the case, Lia's parents sent her back to China for treatment. This time was extremely traumatic for Lia. She suffered not only isolation and the loss of her family, but also the loss of her bodily integrity as she endured excruciating pain, hospitalization, and experienced the ends of her fingers self-amputating. During this time, she had many fantasies of connecting with her parents, of them coming to her aid, but she describes waiting in vain for her father to walk in. Following the revelation of these fantasies, Lia remembered saying to herself, "It was my body's fault."

Dr. Novakovic used this phrase in the title of his presentation and it is, indeed, an important encapsulation of Lia's unconscious fantasy. Following Isaacs (1948) and Solms (1996), I speak of the process of fantasy-making as translating into narrative form the wishes, fears, defenses, ideas, and modes of relating that organize experience. Fantasy allows us to access and represent inner experience, synthesizing an infinite number of mental processes that are beyond conscious apprehension. As Solms describes it, fantasy represents these mental processes to us in a form that speaks the language of our experience. I will focus on only one dimension of this rich and complex case: Lia's relationship with herself as revealed in her fantasies about herself, others, and her analyst.

I will begin with Lia's assertion that her troubles were her body's fault. In one way this makes sense. Everything seemed fine until her bodily symptoms appeared. But when we look at this phrase more carefully, "It was my body's fault," we see that Lia is at once owning and disowning her experience. It is somebody's fault. Someone is to blame. Blame is fantasized, organized as an intrinsic part of her problem. With this idea, Lia organized one aspect of her relatedness around blame. In ascribing blame to her body, Lia sets up a divide between herself and her body. It is not she who is to blame, it is the fault of her body. Is blaming her body a way of mitigating a self-blaming impulse that haunts her mental functioning? I wonder if blaming self and other has been a part of how Lia has related to herself for a long time.

It is important to understand not only the facts of patients' lives, but also how patients relate to those facts, the meaning ascribed to them, often unconsciously. Did Lia unconsciously blame herself for her parent's initial departure? Did she wonder whether if she were somehow better that they would have stayed? Although we see evidence of Lia blaming others in addition to herself (she blames her boyfriends, the other therapists and her parents for being uncaring), I will focus primarily on how Lia relates to herself and her analyst through unconscious fantasies that are enacted in her analysis.

Dr. Novakovic has done extraordinary work in establishing a context of safety in his work with Lia. His exquisite sensitivity to Lia's need for safety enables her to open up. We must be mindful, however, as we work with patients, especially those who have experienced trauma, that early modes of relating are often replicated and enacted in the transference activity stimulated by the intensity of the analytic process. I suggest that we are seeing such an enactment in this therapeutic relationship which has at its core, unconscious fantasies around blame and redemption that have a splitting quality.

Enactments are much more prevalent than was first understood. They are all around us, appearing in little, subtle actions that often go unnoticed. Like transference, resistance and defense, enactments are representations of how our minds organize and process the world. I define enactments as automatic, unconscious modes of relating that embody our earliest emotional and defensive patterns. What becomes enacted between patient and therapist (and enacted in how the patient relates to self) are implicit emotional and relational patterns organized by unconscious fantasy.

Let us look at the case through the lens of enacted fantasies that relate to blaming, caring and rejecting. Enactments are automatic. There is no shame for getting tangled in an enactment. Rather, we use the entanglement to direct our analytic attention. Indeed, Lia's treatment begins with the enactment of her taking out her notebook and obsessively recording the sessions. As Dr. Novakovic notes, this action captures Lia's need to actively hold onto what she values as well as her need to push away more immediate connection with herself and her analyst.

Dr. Novakovic recognizes early on Lia's need to idealize him by viewing him as an all-powerful parent. Concerned about this, he muses that Lia must have been hurt in a catastrophic way to develop the willingness to connect to him so quickly and unreservedly. The fantasy stimulated in the treatment is that Lia's desire to see her analyst as a caring, protective parent results from catastrophic hurt. This is a reasonable hypothesis supported by the clinical data, but it may also be an early shift toward

enacting the very fantasy that concerns Dr. Novakovic – that Lia's traumatic history renders her in need of a good and caring parent. Lia's fantasy, a desire for an all-powerful parent, is transformed into an idea that changes the nature of the therapeutic situation.

Perhaps this fantasy of a caring parent was in his mind when Dr. Novakovic takes a more educative than explorative stance with Lia, commenting that seeing him in such a way meant leaving her without a choice to express herself and speak her mind. Dr. Novakovic is demonstrating his caring concern (needed in all therapeutic engagement) but in addition, his choice of intervention may have been read by Lia as an openness to his enacting the role of the caring parent.

A bit later Lia responded by saying, "I experience you as a therapist with good intentions who has created a space for me in which I feel I can't get hurt, but I continually second guess my thoughts and desires and worry that you would push me away." This is an interesting interaction, one that reveals fantasies in relation to herself as well as her analyst. Lia messages her analyst that she wants/expects/desires safety with him. Dr. Novakovic hears the message. Is there an unconscious agreement being enacted between them that he will not hurt her? Immediately following the comment about a space in which she can't get hurt, Lia reveals that she doubts herself (she second guesses herself, disconnecting from her initial thoughts and desires) and brings to her mind the fantasy that Dr. Novakovic will push her away. Is Lia enacting in fantasy a pattern of how she relates to herself? Does she toggle between moving toward fantasies of safety and pushing them away?

We must be aware that our realistic desire to take care of the patient can obscure ways in which these desires can become a siren call to transference activity to enact rather than explore the interaction. I believe that this exchange marks the beginning of an enactment that pits fantasies of being safely cared for against fantasies of disconnection, abandonment and emotional abuse with others and with self. Another exchange supports this understanding. To Lia's assertion that her parents attributed the children's adjustment difficulties to simply being spoiled children, Dr. Novakovic responds, "From whatever we have learned so far, your parents seem harsh and cruel." Lia concurred but added that she had not thought of them that way while growing up but had blamed herself instead. The therapist's comment implicitly draws a contrast between the cruel harshness of her parents compared with the caring concern with which he relates to her. There is a splitting, blaming quality in this formulation, one that amplifies rather than mitigates the blaming mode of relating that Lia uses in relating to herself. Addressing the unconscious blaming dynamic enacted in the therapeutic relationship, one that splits good and bad, might help Lia to accept the limitedness of all those with whom she relates, including herself. Understanding and working through her impulse to engage in blaming could help Lia to integrate the positive and negative aspects of herself as well as others.

My working hypothesis has been that the footprint of this enactment was established in the way Lia related to herself when her parents left for the United States and her primary caretakers became her grandma and her aunt. Reuniting with her parents when she was five further crystalized these fantasies of longing for love and fearing that she would instead find trauma, abandonment, neglect or emotional abuse. Fantasies of our earliest relatedness with self and others organize our mental functioning.

Questions after the Penn and Teller stage in Therapy

By Nathan Szajnberg, MD

Dr. Novakovic offers a case courageously reported case. I mean courageous in the sense of the Latin root, coeur of the heart. For it is an informed heart that can conduct and participate in such a journey.

From Dr. Novakovic and his analysand, we can hope to learn even more. He tempts as with this amuse bouche, this temptation to our appetites. I will list here briefly the questions he raised for me, both at the end of two years treatment and what I learned after five years' of treatment from a fuller version of the case study.

This woman, Chinese origin and raised there for some five years and more, developed a painful autoimmune vascular disease in childhood (after her first separation) that was eventually correctly diagnosed and treated. Further, she was symptom-free (after losing six of her digital tips before treatment) for the five years of active analysis. We learn of the recurrence of severe symptoms only after five years of treatment, a move across the country and breakup of a recent and short-lived boyfriend.

Let me begin with questions at two years treatment, which I will call the Penn and Teller phase, based on her closing comments at two years. Then she accentuated that her treatment success as due to "magic that made the difference…" Followed by, "Magic, your process and my motivation to change." For now, let us take the first phrase as truer to her mind and the addendum ("your process and my motivation") as polite addenda.

Her first reactions, twice is to "magic." You know Penn and Teller as the marvelous magicians who first perform a trick, then reveal to us how it is done. Ricky Jay once wrote that magician's at least tell the audience that they will be deceived. Magic implies deception.

But, the nature of psychoanalysis is compassionate honesty, not deception.

So, our task when a patient is at the Penn and Teller phase of treatment—that magical cure—is to move to

the next Penn and Teller phase: to show how there is not magic. Rather, we can develop a way of thinking with mind and heart about how the analysand can learn how she can perform this work outside of the office.

As we are partly archeologists—assembling fragments from the past and speculating on how they were built—we listen to her history for hints to her current architecture and how the transference may unfold. Her history suggests an insecure attachment with unresolved trauma (the somatic illnesses and various separations/reunions). But she may have a rarer form of insecure attachment with both Dismissive/defensive and enmeshed/angry components oscillating (as we gather from her boyfriend episodes, her promiscuity and as we will learn as we think further). From this, we would anticipate a severe character disorder (without venturing further into diagnoses for the moment).

A next series of questions arise from this woman. She as a one-year-old infant when her parents left her behind (taking her infant brother) in China to live with an auntie and Ja-Ja, grandmother, who fought with each other. Four years later, at age five, she is sent from her grandmother to her parents, then, within six months, develops a terrible, painful autoimmune disease that begins. Shortly thereafter, her parents sent her back to China for four more years, with this as yet undiagnosed illness, that years later we learn is particularly rare disease, but in the interim results in painful loss of fingertips and associated vasculitis in the genital and other areas. She is treated (unsuccessfully) from five until nine with Chinese medicines. She is returned to her parents at age nine. (Note, the four to five-year periods of separations were repeated at the end of her first analytic treatment.)

Her terribly painful skin lesions and autoamputations are the kind of illness that we can think of in the broad sense of psychosomatic, at least in the broad sense that the French, descendants of Marty, such as Aisenstein mean.

We might anticipate with such severe character disturbance and psychosomatic elements that in the transference and countertransference, reports as Winnicott and Flarsheim suggests, of hate in the countertransference, even as Flarsheim elaborated, a wish for the patient's death.

In the transference, we might expect more Strum and Drang: furious anger at the analyst, self-destructive threats or attempts. Or, if this patient had more as-if qualities in her character disturbance, we might see a veneer of compliance, overt agreement and chameleon-like accommodation to the analyst's unexpressed expectations and wishes with a subversive aggression.

We might also be listening for a strong erotic transference.

But, we hear little of these three characterological viscissitudes: little or no aggression with intimate relationships (including the therapist), little report of chameleon like accommodation, no report of hate in the countertransference, and only some hints of erotic transference in the house "intrusion" dream.

We learn from Shakespeare's Richard III and Edmund the possible vicissitudes of both bodily malformation and also attributing fate to the magic of astronomy.

Richard begins his winter of discontent with "I am rudely stamped… curtailed of this fair proportion, cheated of feature… unfinished sent before my time…" and he warns, "I am subtle dangerous, false and treacherous." (I i 16 ff)

And Edmund, internally deformed by his bastard state laughs at those who attribute their fates to magical astronomy: foppery of the world, that when we are sick in fortune… we make guilty of our disasters the sun, the moon and stars… an admirable evasion…" (I ii 115 ff)

But, this woman's treatment doesn't report such vicissitudes of physical ailments, although she believes in magic as a cure element.

The patient benefited from the two years of therapy with Dr. Novakovic. We can learn from him and her whether our speculation about False Self/As-Ifness/Magic existed and if so, how things changed. Space limits prevented his report of the following five years of therapy here.

We speculate here that the absence of anticipated transference Sturm und Drang is because the first phase of treatment was experienced magically per the analysand. Or in different terms, this may be an example of Winnicott's False self-analysis: the True Self is not threatened (and not treated) as there is an almost chameleon-like "As Ifness" (Wu and Szajnberg, 2020) to the initial phase of treatment. In Winnicott's case, the patient came to him after what she considered a successful analysis, but felt no better. Winnicott and she realized that this first analysis was of her False Self. Here, we may learn that the same analyst, Dr. Novakovic, may have the opportunity to provide an initial analysis of False Self, followed by the more successful analysis of True Self (with associated Sturm und Drang as then True Self is threatened with discovery and change).

Because time is short and my task is only to illuminate the manuscript (like medieval monks), I turn to the course at five (now seven) years after treatment and the patient's move across the country (after five years of treatment, a possibly unconscious reenactment of her move at five back to China).

This fuller version is a marvelous report. The patient moves across country, finds good employment and an amour. Nevertheless, she breaks up with the new amour, resumes intermittent distant treatment, but has autoimmune relapses that consisted of multifocal lesions and at times excruciating pain and swelling in intimate areas.

This challenges us with a final question that was raised

by one of Winnicott's last analysands, Alfred Flarsheim. How much treatment is enough? Flarsheim suggested for a limited group of severe character disturbed patients, analysis may be like insulin for a diabetic—a life-long sustenance.

I close with these questions and gratitude to Dr. Novakovic for his dedicated treatment and willingness to think further about the nature of our discipline.

The Power of Connection: Introduction and Philosophy

By Jane Hall, LCSW, FIPA

What follows is offered with humility during a worrisome time—a time with strains of Covid haunting the world, a time of global warming with its tragic effects, a time of fighting prejudice, of increasing gun violence, and a time of serious division in America that threatens democracy. How we react, adjust, protest, and survive depends a lot on how we use our energy effectively. Mental health must be a priority.

This collection is for anyone who is curious about how one psychoanalyst's thoughts have evolved after five decades in the field. Thanks to my own meandering journeys, my own on-going self-analysis, and thanks to my patients, to those I supervise and teach, and to my colleagues, I feel freer and more curious every day, and the design of this book reflects that. Longer essays, shorter riffs and even a poem will hopefully provide food for thought. After all these years I am increasingly interested in how the brain and the mind are related and how depth therapy figures in. I am most interested in how a dyad connects and what that connection can accomplish.

I must say up front that some of these ideas will seem old-hat to many, and to some they will sound un-psychoanalytic, so my hope is for open-minded consideration. I respect many theories of technique because we are all unique and because we are exploring unchartered territory with each patient. My slant is just that: a slant. It is a perspective that I offer based on my work with patients, many of whom have experienced degrees of childhood strain trauma that interfered with optimal development. It is a perspective that is influenced by a basic knowledge about neural pathways in the brain; how the stress hormone cortisol, and the love hormone oxytocin affect the brain's development (Doidge, 2007); and by new research findings about development (Knight, 2021).

I have always believed that the emergence of negative transference and the rage upon which it is based needs expression, but the question is: how much and for how long. How the dyad deals with it, and what they learn from its expression, is one of the most important questions in our work because an ongoing expression of primitive rage can wear both parties down and may engrave an original trauma more deeply in the brain's neural pathways. Of course, the answers depend on the unique patient's history, but when development has been derailed, and I believe this happens more often than we recognize or realize, we must find ways to get it back on track. This includes learning about our earliest days which is sometimes possible but most times not, along with our history of relationships. Think in terms of knitting a sweater. Dropped stitches in the beginning can be easily overlooked when the sweater is finished unless you look carefully. But will the sweater hold its shape over time? Unfinished or incomplete developmental tasks can be hard to spot in the adult patient, especially in the beginning stages of analytic treatment, but when impasse threatens or progress is stalled due to a patient's difficulty with reality, I have found that solid enough differentiation between self and object and incomplete separation and individuation need attention. So many things too numerous to list, including genetic disposition, how mother and baby match, illness, and early loss to name just a few, impinge upon how the child takes in and processes its surrounds. These things are what make us unique.

With this in mind, I am suggesting a level playing field with two people working together, where the analyst shares her strength with her partner until her partner feels increasingly stronger. In other words, I am considering how we redress the damage done by varieties of trauma which affect, to varying degrees, the tasks of differentiation between self and object, the separation- individuation process, and the formation of a self. I think that many patients reach impasses if this is overlooked. We are also faced with the serious dissociation that occurs in patients subjected to severe, ongoing trauma. Purcell (2019) informs us in his moving paper that with "unrepresented experience—something different is needed at the level of "technique": a technical attitude—one of doing things to our patients—must largely be replaced by a way of being with our patients, being with his analysand in non-meaning as well as in symbolic communication. In being the analyst for traumatized people, technical rules and maneuvers must give way to improvisation and creativity, integral elements of an artistry that must find its place in the analyst's attitude."

My imaginary reader shares with me the insatiable wish to understand the mysteries of why we are who we are. Having reached a certain age I realize that the more I see and the more I learn, the more I recognize how much more there is to discover. I have gained an increasing appreciation of how very complicated the human mind and brain are and I am in awe of those who dedicate their time and energy to understanding how the mind interacts with the brain, how the outside affects the inside, and how epigenetic change occurs. Psychoanalysis offers the most thorough approach to solving such mysteries, especially

when scientific research is acknowledged. Cultivating and keeping an open mind makes almost everything seem possible.

These heretofore unpublished essays and riffs were written over the past ten plus years, some quite recently, and are now the chapters of this book. My focus is on how the connection between two people, known as the dyad, encourages the growth that leads to change. Even our most challenging patients hopefully come to know on some level when someone is listening without criticism. This book is a sequel to Deepening the Treatment, and the reader will see that my philosophy has shifted from a more classical view of our work to what I consider a more contemporary one that takes into consideration research in neuroscience, affects, and child development.

How two strangers connect and the importance of that connection is the underlying theme of this book. Conversation connects us, whether in person, on Zoom-like platforms, via email or snail mail, or over the telephone. I think that all the words we use, even in one session or over the entire course of treatment, serve as the glue that bind the dyad together. And sometimes I think that if our hearts are in the right place, it matters not so much what we say to each other but how we say it. Angry words, loving words, fancy words, empty words, lack of words are important yet when all is said and done, neither party in the dyad remembers much of what was said when treatment has ended. What is remembered are the feelings beneath the words and the spontaneous moments of laughter, tears, and of feeling genuinely caring, cared about, and accepted.

About the couch: During analysis there are times when reading a person's facial expression is beneficial for both parties in the dyad. This is particularly important for the patient with an avoidant attachment style where the goal is connecting positively with a new object instead of reinforcing memories of the early, depriving and traumatic objects. When patients repeat the past in the transference instead of using it as a clue to the mystery, such repetition risks reinforcing the original trauma. As a new object relationship is formed by in depth, libidinal connection with the analyst over time, the brain's circuitry changes. The phrase 'use it or lose it' applies here so if you had a bad object relationship with a parent, and then you develop a better one with a new object, the fact that you have a trace of the old one doesn't mean you have to use it (Doidge, 2007).

Our first conversations in life take the form of the cooing and crying of infancy and the way they are responded to. These earliest connections play a major part in determining the bond we form with our mothers/caretakers and serve as a major template for future relationships. There is solid evidence that human beings are inextricably intertwined with one another from the earliest moments of infancy. At birth, the infant appears hard-wired to seek human interaction. Along with words, conversation includes how we communicate with our eyes, our posture, odor, style, our facial expressions, silences, the way we listen, and especially our unconscious vibes. In psychoanalysis the conversation goes on consistently over time in a safe place with a non-judgmental, trustworthy other.

Analysis involves a certain amount of regression, so the couch is helpful for those who have frequent enough sessions. But at times it is useful to read a person's facial expression, particularly with the deprived adult with an avoidant attachment style. I like the idea of a swivel reclining chair for the patient who can then have a choice.

One of the most important things I have learned is that those who have grown up with unavailable, narcissistic, or abusive parents or caretakers have trouble giving and receiving love as adults. We get used to our earliest diets and have great difficulty in digesting new food. We seek out the same restaurants because the food is familiar and familiarity means safety, even when painful. We choose partners who echo the past because feeling safe is a basic need. I see no harm in mentioning this tendency to a patient at an appropriate time.

This collection is meant not only for depth psychotherapists, but also for anyone interested in psychoanalytic ideas. My pronouns switch at random for the sake of brevity and out of respect for gender preferences. I use the word 'patient' out of habit. (A patient is any recipient of health care services that are performed by healthcare professionals.) I would prefer 'learner' or 'adventurer' or 'partner in solving mysteries' but I fear this would sound too futuristic. 'Co-traveler' would be good too because I see psychoanalytic work as a journey taken by two, a meandering journey (Chapter Three).

Why another book? The field is crowded with interesting, scholarly, and useful literature and I'm sure that just about everything has been said, one way or another. Many psychoanalysts are excellent writers who have even contributed fiction, memoir, and poetry. Ted Jacobs, Tom Ogden, Christopher Bollas, Arlene Heyman, Sandra Beuchler, Eugene Mahon, and Kerry Malawista come immediately to mind. Many erudite authors are sometimes more difficult to read but often well worth the effort. My style/voice is direct—no vibrato, just plain and simple. Speaking of voices, I use jazz music in Chapter Ten, On Listening, to encourage the idea of creating something new.

Hopefully, my slant, that has been developing over all these years will be of use. Also, I have been working on these essays and riffs for a long time with the hope that someone will get something from them. The song "T'ain't What You Do, It's the Way That You Do It" comes to mind because our voices make us unique. One more reason: psychoanalytic observations and theories

have gained sophistication over the years and so have psychoanalytic clinicians. Our methods are now making use of the impressive research in child development and in neuroscience. I want to encourage therapists to fight the lure of received wisdom and to allow new findings to stretch their minds:

"… you work to turn the ghosts that haunt you into ancestors who accompany you. That takes hard work and a lot of love, but it is the way we lessen the burdens our children have to carry… I work to be an ancestor" said Bruce Springsteen in Born to Run. Hans Loewald also spoke of turning ghosts into ancestors. In fact, isn't that what all we clinicians do? Ghost busting is our business.

Freud deserves our deepest respect and appreciation. He will always accompany us but psychoanalytic work has advanced and branched out to serve all kinds of people as I'm sure he would have wanted it to. By the way, Freud was far more relational than many of his followers have acknowledged. He conducted a number of walking analyses, according to Peter Gay in Freud: A Life for Our Time. Besides his four hour walk with Gustav Mahler, Freud conducted his first training analysis on Max Eitingon in 1907 through a series of evening walks. Eitingon went on to become president of the International Psychoanalytic Association and created a model of training still used today. I sometimes wonder whether some of our founding fathers and mothers analyzed their sadomasochistic tendencies with such short analyses; and how their influence affects us in today's analytic world.

Freud's phallocentric, oedipal focus has been challenged by Breger (2009), Barron (1991) Simon (1991), and Holtzman & Kulish (2000) among others. The research on attachment and the separation- individuation tasks of development featuring both the maternal and paternal influences has changed the phallocentric focus.

As I look at today's world with so many adamant believers in bizarre conspiracies, along with the rampant misogyny finally being brought to justice thanks to the "me too" movement, I believe that early childhood anxieties and the transmission of trauma play a large part. Paranoia can be seen as one result of early and on going anxiety. It has always been a part of society but social media fans its flames. With society's pressures increasing, many parents are unable to provide the safety and security that children need in order to differentiate and to individuate. Parents cannot help but pass on their own fears and anxiety to their children who often fail to develop a secure sense of self. This is not new, but the research is now available proving that children thrive under certain conditions. And even when parents are caring and available, things can go radically wrong due to certain social media platforms.

My ideas about leveling the playing field and distancing our techniques from the medical model harken back to when psychoanalysis came to America in 1911 as a medical sub-specialty. The analyst as a medical doctor, all too often took on the persona of a blank screen that was meant to help the patient develop a transference neurosis (an emotional relationship with the analyst based on childhood relationships). This has been referred to as classical or orthodox psychoanalysis. The results of a law suit claiming restraint of trade, and settled in 1989, changed the profession by allowing psychologists, social workers, and qualified others to join the ranks by studying at the American Psychoanalytic training institutes. However, their teachers were M.D.s whose model featured diagnosis, prognosis, and cure. This model heavily influenced the field in America. I join many who question seeing the analyst in the role of the physician administering a treatment based upon a judgment of psychopathology which determines analyzability. The infantilization of the patient (and of the student in training) has seriously harmed this field. Even the word 'training' instead of education illustrates a less than humanistic attitude. So-called 'lay analysts' were ignored by the medical establishment despite Freud's impassioned plea (1926). Theodore Reik, a non-M.D., began his own independent institute, the National Psychological Association for Psychoanalysis dedicated to teaching non-physicians. Others soon followed suit.

The view I take is a continuation of Leo Stone's (1954) humanistic approach. I am most impressed by Sandor Ferenczi who envisioned the analysand as a co-participant in the dyad. I appreciate and support the emphasis on empathic reciprocity during the therapeutic encounter which is an important contribution from the evolution of the intersubjective/relational school of psychoanalysis. Both parties in the dyad must be free to share experiences when appropriate, in contrast to the abstinent/blank screen approach advocated by the orthodox analysts. I see the dyad as a partnership that leaves room for the evolving transferences to be understood and adjusted thus allowing for something new. Freud's followers in Berlin led by Max Eitingon did him a disservice by bringing an authoritarian approach to both students and patients.

I learned, practiced, and appreciate many ideas espoused by the classical model but differ with its analyst as blank screen approach because it deprives patients of forming a new human connection that I find indispensable to growth. The medical model initially practiced in America could not help but affect how the analyst and patient viewed each other and this patient/doctor image, understandable as it may be in other circumstances, is what I suggest needs adjusting. I propose in these essays and riffs a basic shift in the way many (not all) psychoanalysts still work with patients. The mindset of a doctor implies a top-down, authoritarian slant and our society bows to this approach. We want a doctor to cure us and here is where I offer a different point of view. The idea of working together to get development back on track is

very different from a doctor curing a patient by interpreting her free associations. It is different because as patients resume development it is they who do what is necessary to move forward in life. I see the therapist as facilitating development. Along these lines I propose that explanation and conversation take the place of interpretation. Yes, the analyst shares what she hears but not as a pronouncement.

The shift that I envision suggests a level playing field where two people view problems together—as co-workers. This does not preclude transference explanations; we all see the present influenced by past experience. But both partners use their transference vision in the service of going beyond. This approach is especially applicable to those whose early years were unsteady and traumatic. What I am proposing is that both parties in the dyad discuss possible ways of understanding the clues presented by the patient, rather than setting up the analyst as the authoritative interpreter—the one with the answers. The attitude that includes discussion in and of itself builds the patient's ego or sense of agency. This idea will not be new to many depth therapists who have not undergone classical analytic training that focuses on analysis of defense.

I am not concerned here with talking about theories, such as Intersubjective or Self-psychology or the structural versus the topographic, and so forth, and I don't dwell on differentiating psychoanalysis and psychoanalytic psychotherapy, a topic that has plagued this field for too many years. Beneath the theories lay the therapist's stance. Does she see disease/illness/pathology, or does she think in terms of derailed development and once necessary adaptations that are no longer useful or necessary? How a clinician views a patient's difficulties is what I suggest needs serious rethinking. Instead of focusing on what's wrong exclusively, I suggest seeing what's right. We all adapt as best we can to the cards we've been dealt in childhood so why call this pathology? Early adaptations have been life saving if you think about it—but like childhood shoes, we outgrow them. The right to have new shoes is what therapists hope to instill. Benevolent curiosity (Sharpe, 1950) is the bedrock of the method I am presenting. Her words:

"The urgency to reform, correct, or make different motivates the task of a reformer or educator, the urgency to cure motivates the physician, but free to range over every field of human experience and activity, free to recognize every unconscious impulse, with only one urgency, namely, a desire to know more, and still more. When we react to something that causes us to think 'I cannot understand how a person can think or behave like that' curiosity has ceased to be benevolent."

Thanks to the research on child development (Knight, 2021; Tronick, 2001) and the discovery of the brain's plasticity, the psychoanalyst's palette is filled with more colors than our forefathers and mothers had available. I propose adding to or even replacing Freud's phallocentric, oedipal model with a developmental model, featuring the quality of the bond between the infant and its caretakers, the separation-individuation phase with it's task of differentiating self from object, as central. To put it plainly: too many have not fully realized that there are 'others' who think differently, and so are unable to respect diversity. I see the analytic goal as getting derailed development back on track. For those who find Mahler's model limited, I suggest Ed Tronick's (2001) Dyadic Expansion of Consciousness hypothesis. But both theories center on the child's early connection to the mothering figure. Thanks to Rona Knight's research we have learned that development continues throughout life and is not limited to specific ages.

My extensive experience with patients who suffered strain trauma in childhood has shaped many of the ideas in this book. Although I respect and consider the many theories available, I am committed to greeting each patient as unique. Our tendency to apply a diagnosis and then a theory to an individual limits what we see. The unique patient creates the theory (Nass, 1975).

Technique has changed gradually in that its elements, such as furniture and frequency, are no longer written in stone. But many training institutes guided by the Eitingon model still require these artifacts. Why do we cling to them? Yes, using the couch can be helpful but making its use a requirement is insensitive to the unique individual.

This book takes issue with the analyst as mostly silent interpreter of the patient's free associations. I picture two people facing the problems together as detectives solving mysteries? (See Lois in Chapter Three: Self-Murder.) This stance requires respect and benevolent curiosity. Over time the dyad develops a relationship that includes transference love, real love, hatred, and everything in between. Transferences serve as clues. When patients see the others in their lives only in terms of past relationships, their vision needs adjustment. The dyad works together to broaden their view. I must add that I respect the analyst's silence as well. Our patient's must have the opportunity to see where their minds go—so I hope for a flexible approach with the unique patient in mind. A rhythm evolves that accelerates at times and that slows at other times. No metronomes are required.

In essence, I propose that two people share the job of looking into how the past affects the present, with the resumption of development being the goal. The feelings and fantasies (conscious and unconscious) experienced by both parties are explored. One partner may hold the other's anxiety until it diminishes due to the connection that develops. Most of what goes on is unconscious and when enactments that are always happening become evident, the unconscious message is exposed. This exposure releases us from an action mode thus allowing insight.

Tronick (1998) suggests that there are dyadic states of consciousness that develop between patient and therapist that he calls 'something more'—and that change is due to these new and unique dyadic states. Purcell (2019) speaks about "a way of being."

Anxiety diminishes when criticism is not involved. In Chapter Nine: "How Long," Lisa's constant tears in the beginning phase of analysis may have been expressing her fear of criticism. Love, not often enough mentioned in our literature, grows out of respect and serves to cushion the discomfort involved in negotiating separation and individuation. Benevolent curiosity is part of love.

We need the new discoveries about the brain and mind. Norman Doidge's message in The Brain That Changes Itself, is that during analytic work we choose different neural pathways when the old ones lead to trouble—a bold idea based on the evidence of the brain's plasticity. See Chapter One of his book where he describes the stroke victim's recovery and what the brain autopsy showed after a long and productive life.

I have seen classical analysis help some people but a combination of methods can be useful depending on the unique dyad. The analyst must feel free to titrate the treatment with the unique patient in mind while still calling the treatment psychoanalysis if she so wishes. I believe many of us already feel this freedom so this is meant for those who have felt intimidated by their 'training.' What I suggest is partially based on my own personal experiences, one with an authoritarian training analyst followed by a vastly different personal analysis with a highly respected and revered analyst who refused the title on principle. These experiences helped shape the ideas in these essays.

My major focus is the therapist's slant, attitude, and manner—a manner that is based on respect, a special kind of love, and benevolent curiosity, all three allowing us to experience the patient as unique.mShort riffs and longer essays and even a poem (though by no means am I a poet) express some of what I've learned. Neither text book nor memoir—I present my personal slant on the journey including what I've learned from my experience . While doing research I was floored by the richness of our literature. The plethora of books and articles about psychoanalytic work can only mean that we are forever searching for and sharing ideas. And why not? The human mind is extremely complex, as is the brain and its outposts. Both deserve all the attention we can muster. There is no one way of thinking that captures its mysteries which relates to my feelings about the disadvantages and harm involved in measurement. The way we use the new discoveries mentioned above surely matters just as much as the evidence itself. Ed Tronick and Marjorie Beeghly (2011) speak of an instinct or drive towards making meaning that we are all born with and this makes perfect sense to me. There is so much to learn and see and experience. And sometimes, depending on how we use it, all our knowledge can actually impede us and even obscure what our partner is telling us.

Our most famous fictional detective, Sherlock Holmes, says as much in this story:

Holmes and Watson are on a camping trip. In the middle of the night Holmes wakes up and gives Dr. Watson a nudge. "Watson" he says, "look up . . . and tell me what you see." "I see millions of stars, Holmes," says Watson. "And what do you conclude from that, Watson?" Watson thinks for a moment. "Well," he says, "astronomically, it tells me that there are millions of galaxies and potentially billions of planets. Astrologically, I observe that Saturn is in Leo. Horologically, I deduce that the time is approximately a quarter past three. Meteorologically, I suspect that we will have a beautiful day tomorrow. Theologically, I see that God is all-powerful, and we are small and insignificant. Uh, what does it tell you, Holmes?" "Watson, you idiot! Someone has stolen our tent!"

A recent reading in Jaak Pankseep's (2012) work on affects, coupled with understanding more about the intersubjective/relational approach so well articulated by Phillip Bromberg, Lew Aron, Stephen Mitchell, Donnel Stern, Jim Fossage, and so many others, and recognizing the plasticity of the brain have shifted my thinking to a broader comprehension of how we relate to each other and to our patients. Heart to heart communication is what matters most, and it often takes place without words. I repeat, more goes on unconsciously than we can ever know. This is why the therapist's hope is important. Our patient's pick it up subliminally.

I have always shied away from diagnostic categories because I fear boxing people in. They provide some advantages, as Nancy McWilliams (2011) has beautifully shown us, but for many therapists these categories can stand in the way of hope. Nancy says: "Once one has learned to see clinical patterns that have been observed for decades, one can throw away the book and savor individual uniqueness."

However, my concern is that such patterns can affect what we see and experience. I worry that we are too comfortable experiencing a unique individual as being just another hysteric or borderline or obsessive compulsive described in the DSMs. This may obscure other features and patterns that make discovery of the uniqueness of each individual quite difficult if not impossible. If Copernicus had stayed with the received wisdom that the earth and not the sun was the center of our universe, science would not have advanced. Received wisdom can be wrong! My point is that the way people have seen things for decades, directs and clouds our vision. Of course, I realize that what we have learned will always influence us but my plea is to be aware of the tendency to categorize, and to replace that tendency by cultivating an open mind.

Hearing a person as a unique individual must come first. If we need a frame of reference how about this: the past determines the present and what cannot be articulated will be enacted or acted out. There is a natural course of development and when it has been compromised it is the dyad's job to clear the way for its resumption. Patients who are uncooperative have reasons!

I have not seen evidence that convinces me of the categories that DSM has devised even though they are compelling, and I have seen evidence that these categories tend to narrow our thinking, influence our perception, and leave us spinning our wheels. But most importantly, a label can obscure the uniqueness of each individual patient. So, although there is comfort in categories when used as shorthand, or for insurance companies, I fear that the patient and the therapist may get lost in the label. Boxes are like fences to me and a favorite song of mine is Don't Fence Me In. I think in terms of development, so separation-individuation and its sub-phases, along with object constancy, and differentiation, are helpful concepts. Did someone get stuck along the way, and if they did, how can they get back on track, I wonder? I use the word "wonder" a lot because it leaves the door open for new ideas and because I hope my co-traveler will wonder too. The arrogance of certainty cuts off so many options.

Phillip Bromberg's (1996) work with self-states makes great sense to me as does a favorite book by a non-analyst psychologist Stranger in the Mirror: the scientific search of the self, by Robert V. Levine (2016). Both authors write from different backgrounds but come to similar conclusions: we have many self-states that are not problematic. One is not using the same self-state when facing an emergency as when learning a subject in school or when making love. In fact, what we deem pathology was once adaptive. If we see the adaptive aspects of defensive character structure, our ability to relate to our patients is enhanced. People often forget to think "What's right with you?" Seeing the glass half full helps me. I have said to a patient something like: "Hiding from the truth (avoidance or denial) was helpful when you were a child but now it holds you back. It's like trying to walk in shoes you have outgrown. They helped then but now they pinch making it hard to move ahead."

But, you will say, what about the truly impossible patient, the patient who is hostile to the whole idea of therapy. Chapter One, Let's Fall in Love, discusses this dilemma. Bottom line, it is up to the therapist to find creative ways to respond. And sometimes treatment just doesn't get to first base. We do strike out. We are human.

Therapists, like their patients, like to feel safe, and because the familiar is safe, we often cling to it. What we learn in the psychoanalytic institute is difficult to forget. It took me many years to move beyond what I learned in the 1970s and 1980s. I question the set up of our learning institutes. Just as each patient is unique, so is each student and I hope that can be taken into account. Tailoring our knowledge to the individual is an art that must be nurtured. Each dyad creates something unique. So when I said in the beginning of this introduction that nothing is new, I also think everything is new when you expand your vision. I recently discovered David Eagleman and I highly recommend his Ted Talk.

Readers who are dissatisfied, in pain, or curious about psychoanalytic work may be inspired to take a journey inward with an experienced companion. I know of no other journey that is more fulfilling. Chapter Three describes our work as a meandering journey, which will hopefully serve as an invitation.

Not many people leap onto our couches or into our chairs, or even understand our method of work, so degrees of explanation are in order, always tailored to the unique patient. Explanations have not been part of classical work and I wonder why. Most analysts prefer interpretation, which tilts the field, putting the analyst on a higher plane. After a certain amount of time in therapy, it is the patient who will come up with ideas that contribute to growth.

People have a right to know something about what they're getting into and the explanations offered and the ways they are offered can determine the outcome of a first meeting and even of a whole analysis. Everyone has stories to tell and the very act of telling them to an attentive listener promotes growth and solves mysteries. Sherlock Holmes also said: "Nothing clears up a case so much as stating it to another person" (Doyle, 1894). This holds true in working psychoanalytically where colleagues often see our blind spots. Enjoy Chapter Eleven on storytelling.

The fact that a person makes an appointment and keeps it indicates strength and courage. If we remember that each dyad is unique, improvisation is natural and intuition guides us. Genuine spontaneity is important. Messiness is allowed when working this way, but the dyad works towards repair. Claudia Gold and Ed Tronick (2020) explore this idea in their book: The Power of Discord. This essential aspect of the dyad's work relies on the present, what we refer to as the here and now interaction, and it may even take precedence over revisiting the past. It may also include the past as reference point. "This reminds me of the time when my sister was born and I was supposed to be the big girl all of a sudden," said one patient when discussing her experience at a new job. Her memory opened a new door quite naturally, a door that illustrated the past's influence on the present. "You just sounded like my father" said another patient leading to memories of a man who died long ago and who had not been mourned.

Psychoanalytic work is filled with stories and I have found that at times the therapist's stories are a useful part of the relationship. We call this self-disclosure and it has been frowned upon by classical analysts. Some might

even call it a boundary crossing. But, when the analyst has something to share that is appropriate to what's going on, it seems only natural to do so, spontaneously and genuinely. I give an example in the Listening chapter. I think of my meeting with patients as containing both playfulness and heart-to-heart conversations along with my reflective capacity.

The therapist acts as a guide/companion on the trip of exploration. A crucial aspect of this journey is the motivation to inhabit the present, to envision the wished for or dreaded future while visiting the past when it sheds light on both. Exploring all three dimensions helps us understand ourselves without the need to master 'string theory' or 'time travel.' I think that saying "That reminds me of xyz" encourages us to use what comes to mind—what we call free association. Instead of making free association a rule, I see everything a patient says as free. And if he decides to withhold something, I assume he will figure out why as we go along. I have said to patients: "As we meet, there will be things you wish to keep to yourself. When that happens, try thinking about why. What would happen if you just said whatever pops into your head?" Usually things withheld involve shame or lack of trust and as the bond strengthens, the patient will feel more comfortable sharing what she thinks. Motivation is enhanced by the rapport established—and it is up to the guide to set a tone of benevolent curiosity. Before trusting one's travel companion, a period of assessment and testing occurs and each party uses both their conscious intelligence and their gut feelings to determine whether the trip feels safe enough to embark on together. I talk about this testing in the Chapter Three: Self-Murder.

Developing trust takes varying amounts of time but it is indispensable when traveling. Patients test us, consciously and unconsciously, so the frame is necessary because it guarantees safety. I think of the dyad's work as a long conversation, or as solving mysteries together. These analogies help me explain what I do.

Struggling to get an idea across can get messy. Ed Tronick points out that Fred Astaire and his partners surely stepped on each other's toes while practicing before their performances. We make mistakes and we recover. In the recovery lies the growth. And when we goof we apologize.

I begin this book with my first experience as a therapist, still in social work school, with Chapter One: Let's Fall In Love. I wrote these chapters with love—for the field, the patients, my colleagues, and those who I supervise and teach. Love does make the world go round, we just have to find it. I would like to see us all more comfortable with the basic love we feel.

This piece is excerpted from the Introduction to Jane Hall's The Power of Connection (International Psychoanalytic Books, 2022)

Does it Matter if a Psychoanalytic Psychotherapist is Politically Conservative or Liberal?

By Peter A. Olsson, MD

Abstract:

This essay describes contrasting features of the liberal political persuasion and that of conservatives. The author describes some impact of these issues on clinical situations and collegial communications and relationships.

Introduction:

Of course, a psychoanalyst can be conservative politically, Right? Or can he or she *really* be conservative? It is interesting to explore what conservative psychiatrists would have opined about Lyndon Johnson's conscience of a political Liberal like Barry Goldwater's *Conscience of a Conservative* was analyzed by liberal psychiatrist pundits during the Johnson vs. Goldwater presidential campaign. The majority of psychiatrists in the *Fact Magazine* article at the time thought Goldwater was dangerous. Johnson, who was thought to be safer for America by psychiatrists at that time, actually escalated America's tragic involvement in the hellish Vietnam War. Would Goldwater have been more conservative about escalation in Vietnam? I think so.

I The Liberal Political Position is at its core a utopian, idealized, exciting, romantic view of human nature that on the surface underestimates the obvious human domains of evil, cruelty, self-absorption, and greed as powerful domains in human nature. The liberal political cause is embraced or represented by liberals as ultimately noble, inspiring, morally majestic, and psychotherapeutic. Romantic liberal ideology is commonly, consciously or unconsciously, expressed by liberal Democrats as, "Our" or "The" American values.

The romantic liberal political cause, however, needs a villain against which to wage a noble struggle. That villain is conservative political ideology most often associated generically with American Republicans or Independent conservatives. Conservatives and their economic, social, religious, and legal ideas are regarded by the elitist liberal as inherently rigid, cynical, cold-hearted, uncaring… even cruel and lacking in empathy. At best conservatives are regarded as unhelpful, less intelligent, unexciting, puritanical, boring, or mundane. Labels of racist, homophobic, Islamophobic, misogynistic, and xenophobic are frequently directed at conservatives with shallow or distorted evidence for such accusations.

Underlying philosophical and social-cultural assumptions that form the basis for the Liberal position are as follows:

1) All human beings are basically the same at their

psycho-social core regardless of ethnic, tribal, national character, or lack of national character. Countries dominated by evil oligarchs and communist dictators like Russia, Venezuela, Cuba, and China are described as victims of their leaders rather than lacking the character to depose their malignant leadership. In fact, inaccurate excessive empathy for victims is a common theme for liberals. Thus, all people and groups are basically, peaceful, good, friendly, and kind if treated as such. The golden rule, not the gold rules, is a basic truth for the euphemistic *Family of Man* in the idealized global village. If treated fairly, kindly, respectfully and in good faith, they will respond in kind… eventually. Such is the ultimate benevolent course or imagined destination of human beings in the long run of history.

2) God, heaven, hell, Satan, and life after death are quaintly imaginary or necessary comforts of the superstitious, ignorant, or uneducated, or, at least really unnecessary. God, Christianity, Judaism, and Islam are really opium for the insecure and frightened masses. Karl Marx could be called one of American liberal academia liberals' spiritual leaders. As Marx said of mankind's human nature, "…by appropriating all the creative energies, they discover that 'all that is called history is nothing else than the process of creating man through human labour, the becoming of nature for man. Man has thus evident and irrefutable proof of his own creation by himself.' Understood in its universal dimension, human activity reveals that 'for man, man is the supreme being.' It is thus vain to speak of God, creation, and metaphysical problems." (Wikipedia).

3) For liberals, war is particularly abhorrent and almost unthinkable. Peace must be gained at any cost or price. All military aggression is wrong and unnecessary except for use in the last resort for noble revolutions or insurgencies against cruel dictators and oligarchs. Diplomacy alone can almost always solve world problems, even with brutal dictators and bad acting enemy groups. Globalist expressions of love conquers evil dictators in the long run.

4) Freedom, good healthcare, food, clothing, and shelter are all an inherent entitlements or 'rights' for all human beings. Freedom, dignity, and representative government are universal human rights, not social and moral advances won as the result of painful battles.

5) All anxious, fearful, insecure, abused ethnic minorities, and disabled individuals must be treated as victims to be treated with protective kindness, financial generosity, and benevolent caretaking. Financial success and attendant privilege must be abolished and require redemption and reparation. Criminals all deserve second chances, generous rehabilitation, and kind treatment - sometimes without insisting on the criminal's commitment to personal responsibility.

6) All persons and especially the poor, immigrant and down-trodden people deserve generous and free financial, social, and medical assistance from the government. Secular based scientific humanism leads to what is moral, compassionate, and good. Science-based humanism leads to gradual progress, social justice, and benevolent world-wide human societies. Humanism is often the only religion felt to be needed by liberals.

7) Morality is based on notions of social and cultural relativity. No absolute moral values, ethical standards or religious spiritual core beliefs are ultimately possible or true. Humanistic values form social justice and are superior to traditional religious beliefs which are inferior to 'scientific' logical positivism. Logical positivistic science leads to agnosticism or atheism because traditional religious beliefs cannot be observed, tested, measured, or proven.

So, the heroic, noble, and dedicated liberal political progressive is sexy, romantic, highly intelligent, well-educated, and perpetually hears and lives the words and music of John Lennon's famous song *Imagine*.

II The Conservative Political Position

1) Conservatives accept an objective moral order of immutable God-ordained standards by which human conduct should be judged, assessed, and embraced. Morality requires a battle against sin and evils such as criminality, communism, fascism, and socialism, all of which stifle individual freedom, responsibility, and dignity.

2) Conservatives emphasize human rights and freedoms strongly contingent on personal responsibility. They primarily value "the individual human person" as the center of political and social thought and political systems. Citizens all have an equal opportunity for success but are not inherently equal or so entitled.

3) Conservatives oppose liberal attempts to use the State to enforce ideological patterns on human beings allegedly to achieve social justice. Justice results from following the US constitution and the laws made by congress. Freedom for speech and individual belief and behavior is valued as long as no other person is hurt or denied freedom and legally established rights.

4) Conservatives reject the centralized power and direction of government as necessary to the "planning" of society, particularly healthcare and the establishing of excessive economic entitlements.

5) Education and social issues are best legislated when necessary at state and local communities.

6) Conservatives join in defense of the Constitution as originally conceived and recently applied by judges interpreting and not making the laws.

7) Conservatives are devoted to Western civilization and acknowledge the need to defend it against the "messianic" intentions of dictatorships, monarchies, communism, fascism, socialism, or radical Islamist governments. Freedom

and democracy are not inevitable through human education and liberal progressive applied ideas but through active defense of political freedom and individual liberty as demanded by the American Constitution.

America was founded on the rights and responsibility of the individual and limited government. Conservatives pride themselves on protecting those concepts. Left-wing radicals use conservative-bashing labels as an attempt to vilify conservatives instead of trying to debate their ideas and ideals. Attacking true conservative ideals would yield the liberal movement no ground because those principals are the basis for most Americans' traditional core beliefs based on our constitution.

Key Issues Arising in the psychoanalytic clinical situation

Whether a political liberal or conservative, a psychoanalyst is ethically committed to make every effort to not impose his or her personal religious or political beliefs on to their analysand during the work of psychoanalysis or psychoanalytic psychotherapy. In actual practice, this position is much more difficult to accomplish and likely impossible. In fact, the analyst's ethics, morality, and political philosophy often become apparent to the patient. This actually is more likely the deeper and more effective the analytic process becomes during a successful psychoanalysis or psychotherapy. After a successful graduation from psychoanalysis, the analyst/patient freely embraces and often understands his or her own political, religious, and spiritual persuasions or lack of them more deeply. Ideally, such beliefs and emotionally toned commitments in the analytic therapist are free of neurotic symptomatic conflicts, coercive agendas, and blind spots.

Clinical Considerations

1) Victim pathology: When the analysand or patient excessively and persistently portrays themself as the victim of circumstances described as beyond their control or influence, a psychoanalyst can question, interpret, or craft other interventions. Empathy for the pain of such experienced victimization while conveyed even by careful listening and responsive sounds does not imply agreement or sympathy with such a plight of victimhood. Therapeutic or clarifying interventions emphasize that the analysand is an individual to be respected and potentially empowered to transcend any form of victimhood through their freed-up and strengthened ego. An individual seeking personal freedom of action within the limits of reality can prevail. Such interventions usually occur at middle and later phases of a psychoanalysis. Traumas have been re-experienced, defenses have been explored, related conflicts resolved. Thus, healthy self-assertions undertaken to transcend experiences of victimhood are hopefully and mutually acknowledged as progress.

2) Domains of ethics, morality, religion, and politics: When in the course of treatment, a patient describes a strongly cathected and espoused moral, ethical, religious, or political commitment about behavior, it is best not avoided by the therapist. In fact, crucial progress can be made when such issues emerge in the exploration of transference and other treatment issues.

My analysand Bill, a talented physician, was raised a strict Baptist. Bill commented at an evaluation session that his father who did paid work as a baseball umpire was as strict in his morals as he was calling balls and strikes. Bill was not currently as completely involved in the church as his father had demanded he and his brother be during their childhoods. Bill spoke of himself as "straight arrow" in his ethics. He spoke negatively about "wheeler-dealer" investment practices in which his medical colleagues participated.

At a session months later, Bill described his efforts to accumulate more money so he could take his new wife on nicer vacation trips. Bill declared from the couch, "Dr. Olsson, you really should invest in the new hotel for patients' families being built near the medical center. It will be a great write-off and money-maker." When he pressed me directly, I said to Bill directly that it would be unethical for me to act on such information obtained from a patient session. Bill grew silent for the rest of the treatment session. I thought Bill seemed miffed. My self-inquiry led me to wonder if I should have neutrally explored the generous offer rather than being direct.

Several weeks later at a session, Bill described a dream in which his father was hitting fly balls to Bill and his younger brother. The balls kept landing off to the sides of the baseball field in the bushes. Bill and his brother felt angry and frustrated. Bill associated to his aging father's hints that he needed money. Bill then said that he had checked the list of investors in the patient hotel project about which he had told me recently. He noticed that I had not invested. When we explored Bill's feelings and associations, he revealed tearfully that his father had proven not to be a fair baseball or life umpire. Bill's father had always told Bill and his brother that he had an insurance policy that would mature and pay for their college educations. It turned out that the ill-fated insurance policy did not mature until years after Bill and his brother graduated from college. Their father did not offer financial help to them, claiming he could not afford it. Bill earned a full scholarship to college and his brother worked his way through college and seminary. Bill said, "You were straight with me, my father was not." After a silence, Bill said that he had been angry at me when I wouldn't join the investment project about which he had informed me. He reflected further that he had assumed as a psychoanalyst I needed income. I said, "Then I could be the good father/umpire who did have money?" Bill agreed and further ex-

plored his passivity about financial matters in his practice and his marriage. The Christmas after his graduation from his psychoanalysis, Bill sent me a baseball with a handwritten note on the baseball. It said, "Thanks for keeping the balls in play."

Several years ago, after a round of golf with three surgeons, our foursome was sitting in the locker room having drinks. The younger surgeon partner was sharing with us how much he and his wife enjoyed a relaxing and romantic week in Bermuda. His older surgeon partner interrupted him saying, "Bermuda sounds great, but why go with your wife and not your girlfriend?" The interrupter continued to playfully pester the Bermuda advocate about this idea. The young surgeon finally forcefully said to his senior partner, "My wife *is* my girlfriend!"

The sadness and pain in the philanderer surgeon's marriage and family was clear to me a year after the episode I described above. He sought help from me for his analysis and referral for marital and family therapy. The emotional impact of the young colleague's moral boundary stand acted as an impetus to his senior partner's important self-inquiries into the fabric of his character defects related to his marital, religious, and moral commitments.

A *New Yorker* magazine cartoon portrayed a psychoanalyst hitting his patient over the head with his shoe saying, "It might have been true even if your mother said so" or a priest/pastor said so. Many busy and successful men I have known from clinical work and from social acquaintances drift into a pattern of infidelity. I call it the 'Bill Clinton split'. They partition their life into several compartments. In one domain they act as a worker/wage-earner, in another they behave as a proud father to their children and perform as a dutiful husband. And in still another compartment, they have a secret erotic life with a mistress. These splits arise in inner domains of their defensive structures protecting them against intimacy anxiety. Therapeutic confrontations about such specific contents of moral, spiritual, and marital commitments touch on how clear the analyst is in his own mind about such matters.

3) Current events: The emergence of current political events in the associations, dreams and fantasies reported in treatment sessions as well as collegial communications between psychoanalysts about political issues, challenge the analyst's self-awareness of his or her own political philosophy and commitments. Patients in psychoanalysis often associate to the lies, obfuscations, hyperbole, broken promises, and moral, ethical, or sexual/marital boundary violations of celebrities and especially politicians who have become by definition celebrities in modern life.

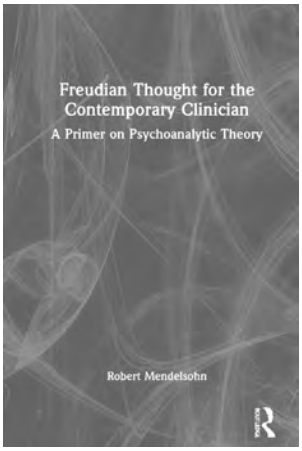
Recently, a previously trusted, admired, and respected psychoanalytic colleague reacted with anger and scorn as he denounced me for writing an article defending former President Donald Trump against condemnations by many psychiatrist and psychoanalyst colleagues. Those colleagues advertisement described Trump as delusional, mentally ill, and dangerous to America. This irate colleague attacked me, saying, "I cannot be more appalled or disappointed if you were sending me a justification of Adolf Hitler… and, like some of his enablers, you are an otherwise sensible and intelligent person. I do not mind receiving other communications for you, but *nothing* about this despicable character [Donald Trump]." This colleague is a talented teacher and supervisor of future psychiatrists!

The old adage about the impact of discussing religion and politics upon family harmony and friendships has validity.

Summary:

This essay describes contrasting features of the liberal political persuasion and that of conservatives. Some impact on clinical situations and collegial communications and relationships is discussed. It is important for us as clinicians and colleagues to be aware of our biases, both conscious and unconscious of possible, and to be considerate and appropriate professionally.

BOOK AND FILM REVIEWS



Freudian Thought for the Contemporary Clinician: A Primer on Psychoanalytic Theory

by Robert Mendelsohn (Routledge, Taylor & Francis Group. 2022, pp. 194)

Book Review by: Tyler Fleming, DO, MPH

"So this is the scene at my sister's wedding, right. There she is getting drunk regretting she ever got married, for the third time, mind you. My mother is so jealous she's sprouting snakes from her hair, and I'm thinking this is perfect. We've got three feminine archetypes: the divine whore, Medusa - and me. Who am I? What archetype?" Hands shoot up from the tiers of students in the horseshoe-shaped lecture hall, so full some are standing along the walls, others sit in the aisle, and others cram the door spilling into the hallway beyond.

This is a scene from the 1996 romantic comedy *The Mirror Has Two Faces* directed by and starring Barbra Streisand in the lead role of Rose Morgan, an English literature professor at Columbia. As the lecture unfolds Professor Morgan walks up and down the gallery. Students crane and twist in their chairs to follow her, some lean over the rails of the upper tiers, and shout out answers as the psychology of love is explored. The classroom is alive, interactive, and buzzing. They are completely enraptured by the personality, ease, and humor of their professor, her grip on the material, and her involvement with them.

Reading *Freudian Thought for the Contemporary Clinician: A Primer on Psychoanalytic Theory* by Robert Mendelsohn left me feeling like one of those fictional Columbia students. This text is derived from a series of lectures that were transcribed and edited from a required introductory course for doctoral clinical psychology students of Freudian psychology that Dr. Mendelsohn delivers at Adelphia University. The preface is clear about his goals – how to get what can be the arcane and era-bound language and theories of Freud in the minds, work, language, and wider acceptance of the current generation of clinicians?

By reading these lectures you feel that you are in Dr. Mendelsohn's class – on the edge of your seat and looking forward to the next lecture. The questions posed by his students and his answers in the lectures, interrupt the didactic material without breaking the flow and are some of the richest moments in this text. Some of these questions are hard-hitting such as how Freud's theories apply to those of non-Caucasian background and why the hysteria Freud describes is less prevalent today than when he was writing. Without tossing the theoretical baby with era-bound anachronistic or culturally bound limitations in science or political thought, Dr. Mendelsohn maintains his pose and flexibility while delivering the theoretical point and maintaining his ties with the student.

The text also shows another important point about one way to teach Freud – by concept first with chronology as a secondary priority. His lectures are structured around key essays such as *Studies on Hysteria* (1895), *Interpretations of Dreams* (1900), etc. which largely keep to chronology but when needed for consolidation of learning the concept takes priority over the theoretical stream of consciousness and revision that can be reading *The Standard Edition* cover to cover. Along these lines, Freud's case studies are retained at the end across two lectures.

Given the rise of neurobiological psychiatry, cognitive-behavioral therapies, financial pressures upon healthcare and training systems, and debate about the wider humanities in education in this country this text comes at a critical time. This text demonstrates one method to teach Freudian thought while navigating reasonable questions about its limitations, history, contradictions, gaps, and immense contemporary value. After all, these are changing times where the emphasis and quality of psychotherapy training in residency is variable, and traditional analytic training can have limited geographic reach and added expense to what can already be expensive professional debt-ridden training, what Dr. Mendelsohn shows us is revivifying for both the clinician, student, supervisor and teacher.

References:

Streisand, B. (Director). (1996). *A Mirror Has Two Faces* [Film]. TriStar Pictures

Film review of *Crazy* (Lise Zumwalt, director, 2017)

By Sheridan Goldstein

Schizophrenia is one of the most severe and debilitating psychiatric disorders characterized by a range of cognitive and emotional dysfunctions. With schizophrenia, individuals exhibit symptoms of hallucinations, delusions, and disorganized and erratic behavior. Each person diagnosed with schizophrenia has a unique journey that is characterized by their own set of experiences, challenges, and approaches to treatment. It is a complex condition that necessitates a nuanced understanding, considering the diverse ways it manifests in individuals. The conventional response to psychotic disorders like schizophrenia involves prescribing anti-psychotics, rooted in the prevail-

ing perspective that views the condition solely as a chemical imbalance. Yet, the documentary, *Crazy*, directed by Lise Zumwalt, provides an alternative narrative. Following the lives of Eric, a young adult diagnosed with schizophrenia, and his father Rick, shed light on the struggles they face as they grapple with the complexities of effective treatment. *Crazy* embraces a pro-choice narrative, recognizing that people with mental illness, specifically schizophrenia, should have autonomy over their treatment while also collaborating with healthcare professionals.

In 2006, Eric had his first encounter with the mental health system where he left home barefoot to go on a walk in the cold without a coat. This seemingly innocent act, triggered concern, prompting his mother to involve the police, leading to Eric's subsequent hospitalization at Mendota Mental Health Institute. During his time there, Eric was subjected to high doses of psychotropic medication. Eric had been given a myriad of diagnoses, including paranoid schizophrenia, bipolar disorder, schizophreniform disorder, and psychosis. Following his hospitalization, Eric's treatment involved a diverse medication regimen with which he was prescribed risperidone, lorazepam, clonazepam, quetiapine, olanzapine, and haldol. This medication cocktail was an attempt to address the multifaceted nature of his schizophrenia. An interesting aspect of Eric's diagnosis is that the voices he hears are not pervasive; they manifest primarily in times of stress, and he doesn't experience them on a daily basis. This notable distinction, where the voices neither occur regularly nor significantly distress him, should have prompted a more nuanced evaluation by his healthcare providers, suggesting that Eric's condition might not align with an extreme form of schizophrenia. Despite Eric's relatively moderate experience with the symptoms, he found himself drowning in a high dose of antipsychotics for an extended period. This highlights a critical aspect of the mental health system – the tendency to administer potent medications without tailoring treatment plans to the individual's unique manifestations of the disorder.

Ever since the beginning of his diagnosis, Eric was not keen on the idea of taking medications or being forced to do something he did not feel was right for him. However, he was always told by his doctors that medication was the only way to treat this and manage his symptoms. In February of 2011, Eric encountered a new complication as he began experiencing uncontrollable tremors in his face and extremities. He believed that this was tardive dyskinesia due to the risperdal he was taking. The gravity of tardive dyskinesia, being an incurable condition, fueled Eric's determination to stop taking the medications responsible for these adverse effects. Eric said that he was extremely sad and was thinking about jumping off of a balcony. Dane County, where Eric is from, deemed that Eric was a danger to himself. This led to his involuntary commitment to Mendota for six months with a mandated treatment plan, even though this went against Eric's wishes of no medication. The decision made by the county encroached upon Eric's constitutional rights by depriving him of the agency to make decisions about his own treatment.

Eric spent 87 days in Mendota on high doses of medication. Instead of getting better, Eric's symptoms worsened. In an attempt to justify the approach taken, Janet Leno, a social worker for Dane County, framed coercion as a necessary means to restore Eric to stability, emphasizing the decision for the immediate need to control his symptoms. Following his stay, Eric was released on an outpatient commitment where he had a list of behaviors and requirements the hospital provided that he had to follow. Central to this regimen was the strict adherence to medication, a mandate monitored diligently by representatives from Dane County who made daily visits to Eric's home. If Eric did not comply, he would be sent back to the hospital. The arrangement, while motivated by a desire to safeguard Eric's well-being, raises ethical questions regarding the balance between individual autonomy and the perceived necessity of intervention.

Rick, Eric's father, who is also a medical doctor, noticed that Eric is always at his worst when he is on medications, which was proven in Eric's records. At this point in Eric's life, he had been on medication for about 5 years and was still adamant that medication was doing more harm than good for him. Rick had always agreed with Eric that these antipsychotic medications failed in their primary objective of alleviating Eric's symptoms and instead only exacerbated his symptoms. Their shared perspective finds resonance in the research of Robert Whitaker, a renowned medical journalist, who has delved into the long-term effects of antipsychotic drugs. Whitaker's findings suggest that these medications might be rendering individuals more biologically vulnerable to psychosis over time. This implies a potential erosion of the long-term benefits of antipsychotic drugs, questioning the sustainability and efficacy of a treatment paradigm that relies heavily on pharmacological solutions.

During this time, there was a perpetuating stereotype that individuals with mental illness were inherently violent. This prevailing sentiment gained unfortunate reinforcement from the tragic Sandy Hook shooting, where a mentally ill man claimed the lives of 26 people. The aftermath of this heartbreaking incident fueled a broader perception that anyone with a mental illness posed inherent dangers and should be consistently medicated. Mendota Mental Health Institute had a very conservative approach that did not take into account the needs of a patient who severely struggled to cope with the effects of antipsychotic drugs. Recognizing the inadequacies of this approach, Rick and Eric devised a collaborative treatment

plan where Rick would assume responsibility for Eric's care. The judge denied this arrangement, aligning with Mendota's perspective on Eric's case. It is evident that the hospital did not want Eric to suffer from his symptoms of hearing voices or hallucinating. However, Eric had made it clear that the voices had never bothered him. Eric said that if the voices were bothering him, he would've said during an episode "help me make the voices go away," but he has never said that. At one point in October of 2011, Eric went off of his medications for 10 days, and Eric said that his thoughts were finally clear but this ended up violating his commitment. Mendota said that a patient cannot dictate what is best for them and that if Eric did not take his medication it could turn into a crisis. By dismissing Eric's ability to dictate what is best for him, Mendota's stance diminishes the importance of informed consent, leading to decisions made without Eric's agreement. Eric felt like he was being treated like a criminal. No patient should ever feel like that no matter the circumstance. Furthermore, the idea that not adhering to medication could lead to a crisis implies a lack of flexibility in treatment approaches. It suggests a narrow view that medication is the only pathway to stability, disregarding the potential efficacy of alternative interventions or personalized treatment plans.

Throughout December of 2011, Eric was in and out of Mendota being forced to take his medication. During this time, Eric's father proposed an alternative plan. This innovative approach involved assembling a private team of doctors who would collaborate with Eric to determine the necessity of medication, respecting his autonomy in the decision-making process. The acceptance of this plan by the court marked a significant shift in Eric's treatment trajectory. However, even upon release from Mendota, Eric grappled with persistent paranoia, fearing the prospect of a return to the hospital at any moment. In a drastic decision, he opted to stop taking his medications abruptly rather than adopting a gradual tapering-off strategy. Throughout February and March of 2012, Eric kept imagining there were fires in buildings and would pull fire alarms, which resulted in him being arrested multiple times. The turning point in Eric's journey emerged in March, a moment marked by a pivotal agreement between him and his father. Recognizing the need for a more measured approach, they decided that Eric should slowly taper off the medication, a decision that brought Eric a sense of peace. This strategic and patient-centered approach to psychosocial treatment proved to be a critical component of Eric's recovery. Subsequently, Eric experienced a positive transformation, allowing him to lead a more normal life. The significance of this recovery is emphasized by his academic achievement, as Eric successfully graduated from college with a degree in genetics. Currently maintaining a dosage of 1.5 mg of risperdal, Eric's story is a testament to the importance of personalized, flexible treatment plans in mental health care. His ability to overcome challenges and achieve academic success demonstrates the potential for recovery when individuals are empowered to actively participate in decisions.

After watching the documentary, *Crazy,* I was deeply surprised about the profound injustices endured by individuals with mental illness within mental institutions. As the documentary unfolded, it revealed a stark reality that resonated with me particularly when Rick said, " You will never be able to find a more powerless group of people than the severely mentally ill." This powerlessness is not an inherent trait of the individuals themselves but a consequence of a system that may sometimes prioritize control over collaboration and intervention over empowerment. Watching the documentary, made me realize that schizophrenia is not a one-size-fits-all condition; each person's journey is uniquely complex. Eric's experience with mental health professionals, individuals entrusted with the crucial task of providing support and fostering a sense of comfort, unfolded as a disheartening testament to the flaws within the mental health care system. Instead of finding solace and understanding, Eric encountered a series of challenges that highlighted the inadequacies and complexities inherent in the relationship between individuals seeking help and the professionals meant to guide them. The conventional approach, which was centered around medication as the primary solution, appeared to overshadow a more holistic understanding of Eric's unique journey with schizophrenia. I realized that Eric likely faced more emotional turmoil from disagreeing with his doctors, which could have exacerbated his symptoms and contributed even more stress to his life than necessary. The documentary allowed me to understand that people with schizophrenia all exhibit different symptoms and it is necessary for mental health professionals to understand this and develop personalized and effective treatment strategies.

IN MEMORIUM

In Memoriam of Sy Gers, MD

By Vladan Novakovic, MD

In a world where the human mind is a labyrinth of thoughts, emotions, and perceptions, two men, both psychiatrists, find themselves entwined in the delicate dance of friendship. This dance is not the simple waltz of ordinary companionship, but rather a ballet of intellectual discourse, mutual respect, and shared experiences. It is a dance choreographed by none other than the great master of human mind, Sigmund Freud.

The young man, full of vigor and the unbridled optimism of youth was a psychiatrist just beginning his journey, some 20 years ago, into the vast and complex world of the human psyche. He finds on his path a likeminded soul full of kindness, guidance and wisdom. His mind teems with theories and ideas, a kaleidoscope of knowledge gleaned from textbooks and lectures. Yet, for all his learning, he is aware of the vast ocean of understanding that lies unexplored before him.

His older colleague, seasoned by years of experience, is a man who has delved deep into the human mind's abysses. His eyes, though softened by age, still held the spark of curiosity and the unwavering gaze of one who has stared into the soul's darkest corners. He is a psychiatrist of the old school, a man who has earned his wisdom through years of patient listening, careful observation, and thoughtful reflection.

This was my first glimpse into Dr. Sy Gers, whose passing I report with sadness and utmost respect.

Our friendship, much like our profession, started as a study in contrasts and similarities and grew into a friendship of virtue. I was frequently drawn to Sy's wisdom and experience, but also his lack of patience and tolerance for nonsense, his quiet confidence, and his unwavering commitment to our shared craft. It felt at times in turn, that Sy found in me a mirror of his own youthful enthusiasm, a fresh perspective that challenges his own, and a reminder of why he first embarked on this journey into the human mind.

Our conversations were often a symphony of ideas and insights, accompanied by his sincere and genuine listening, his eyes twinkling with amusement and admiration, before responding with thoughtful counterpoints and anecdotes from his years of practice.

In the grand tapestry of our friendship, we weaved a tale of shared passion and the timeless beauty of intellectual companionship. For me it was a friendship that transcended age and experience, a testament to the power of a common pursuit and mutual respect. It was a friendship, much like the profession we shared, that delved into the depths of the human psyche, always seeking, always questioning, always striving for a deeper understanding.

Sy, your kind voice, rapt attention, wisdom and guidance will be missed.

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