# ACADEMY FORUM

**Vol. 70, No. 1 - Spring 2025**

The American Academy of Psychodynamic Psychiatry and Psychoanalysis

# Inside Front Cover

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**Volume 70, Number 1 – Spring 2025**



**Cover Photo**
**by**
**Eugenio M. Rothe, MD**

Sundown on New Years Day 2025, off Key Biscayne, Florida.

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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:

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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.
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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.
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   a. Never use the space bar more than once in succession. This includes at the end of a sentence after the period.
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   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

We're very appreciative to Dr. Rothe for his message of realism and hope for our Academy during these challenging times when psychodynamic clinical work by psychiatrists tends to be undervalued. We do need to work together to support our professional activities and commitments to continue to grow as practitioners and an organization.

In our Letters, Announcements and Reports section, we excited for our Annual Meeting, which will bring us together virtually as a group (our 68th year!) and also help us join as a community of likeminded practitioners. Such considerations include encouraging new members to attend the meeting as well as publicizing the event to colleagues. In her letter, Merle Molofsky reminds us that various forms of prejudice have pernicious roots often based in unconscious fantasy. By unearthing those societal beliefs, we can live more respectfully together.

Perhaps we can learn from Dr. Norman Straker's work that begins our Original Articles section. His piece on treating patients with cancer at Memorial Sloan Kettering, involved building a team of mental health clinicians, educating cancer doctors and other specialists, and establishing a base of evidence to demonstrate the efficacy and usefulness of psychiatrists in that setting. Now we take it for granted, but 50 years ago it was not a given. In his article about the philosophy of Paul Ricoeur, Jeffrey Sacks demonstrates how progress in psychodynamic theory and practice has origins that come from philosophy and other disciplines. This is a helpful reminder as we seek to deepen the basis of our work and also to broaden its influence. In my piece about everyday leadership, I frame how each of us can contribute in our own modest ways to being leaders in our chosen profession and in our lives more broadly: developing a vision, being determined yet adaptable and flexible, organizing and planning, communicating and collaborating with others, and taking ownership and responsibility for our work while mentoring the next generation.

One example of such leadership is found in Dr. Eugenio Rothe, our Academy President, who writes about the importance of stepfathers. His article is an excellent contribution to the literature on family dynamics and how they present in our patients. It's interesting that there's a whole genre on wicked stepmothers and the like but a relative paucity on stepfathers. Dr. William Butler helps us to rebalance the scale of psychodynamic considerations in consultation-liaison psychiatry and integrative care by reminding us of the field's psychodynamic origins, which also point toward its future in fields like neuropsychoanalysis and affective neuroscience.

Finally, with our book and film reviews, we're treated by Dr. Gerald Perman to an insightful book review of "Hidden Valley Road" by Robert Kolker that considers a unique family of 12 children with 6 psychotics sons. It tells a complex and at times tragic story of both the contributions and limitations of our work. Merle Molofsky rounds out the issue with her review of Roberta Satow's "Our Time Is Up", a unique novel by an accomplished psychoanalyst, that fuses memoir and fiction.

We hope you learn from and, of course, enjoy this issue and consider submitting a piece of your own.

# MESSAGE FROM THE PRESIDENT

Eugenio M. Rothe, MD

Our Academy will face significant challenges in the next two years. Firstly, we will be experiencing very important structural changes from within the management of the Academy that will be explained in a later communication. Secondly, we will soon be having our second Zoom (virtual) Annual Meeting, which will take place outside of the American Psychiatric Association (APA) Annual Meeting. We encourage all of you to support and make the best efforts to attend this meeting, so that we can overcome this obstacle and push ahead to future in-person meetings. As had been mentioned before, the decision to have a Zoom meeting in the year 2025 was due to the lack of anticipated attendance at the upcoming Los Angeles APA meeting in May and the calculation that having an in-person meeting would generate a significant loss of income for the Academy.

In the next few weeks you will be hearing more about important re-structuring plans for the Academy that will strengthen the association, bring us up-to-date with the rapidly changing current times, and help to successfully propel us forward into the future.

I wish to express our deepest thanks to the Academy staff for being aware of the needs of our members and for their concern about the future of our group, and with their help, we will continue to have a strong, growing and vibrant Academy.

Eugenio Rothe, MD

# LETTERS, ANNOUNCEMENTS AND REPORTS

## The American Academy of Psychodynamic Psychiatry and Psychoanalysis 68th Annual Meeting *Virtual Meeting*

**Saturday, May 3 – Sunday, May 4, 2025**
***"Connecting Through Adversity"***

**Annual Meeting Program Co-Chairs**
**Autumn Ning MD, Sergio Badel MD, Lucas Lopes MD, Mariana Pereira MD, and Jeffrey Tuttle MD**

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**Kimberly R. Best MD and Joseph J. Rasimas MD**

**Continuing Medical Education Committee Chair**
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**MEETING HIGHLIGHTS**

**Saturday May 3, 2025**
*The Psychodynamic Journey of Exile*
**Eugenio Rothe, MD**

*Relationships Between Fathers and Sons From the Threat of Murder to Loving Reconnection: The Transformation of my Relationship with My Son*
**John Tamerin MD**

*Insights: Charlie Chaplin and His Father*
**Stephen M. Weissman, MD**

*Psychodynamic Perspectives on Father-Son Relationships*
**Eugenio M. Rothe, MD**

*Training Innovations: A Psychodynamic Alliance for a Psychotherapy Track*
**Mikaela Mintz MD, Sergio Badel MD, Radu Saveanu MD**

**KEYNOTE ADDRESS**
*Trump Redux, Covid-19, and the Murder of George Floyd:*
*Psychodynamic Reflections from a Brown Analyst*
**Aisha Abassi MD**

*Trainee Education: Inpatient/Hospital Psychodynamics*
*Clinical Tips and Tools*
**Kimberly R. Best MD**

**Sunday May 4, 2025**
*Fagioli's Human Birth Theory and Group Psychotherapy*
**Daniella Polese, MD**

*Older Psychodynamic Psychiatrists: Practice Metrics and Subjective Observations*
**Douglas H. Ingram MD, Myron Glucksman MD**

*"A Little Match Girl" - A Case Study of Therapeutic Connection*
**Ahron Friedberg MD, Vladdan Novakovic MD, Nate Szajnberg MD**

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**Annual Business Meeting**

**PLENARY**
*Clinical Perspectives: Nelson Mandela*
*"I Have Crossed Famous Rivers"*
**Cheryl al-Mateen MD**

*Psychodynamic Theory vs Technique in Outpatient Work*
**Autumn Ning MD**

*What do Residents Want and Need of Psychodynamics Ongoing*
**Discussion with Trainees**

The American Academy of Psychoanalysis and Dynamic Psychiatry is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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# Blood Libel: Rooted in Fantasy

Merle Molofsky, NCPsyA

Anti-Jewish sentiments have been rampant in European folklore for centuries, for millennia. One focus of these sentiments has been the notorious blood libel, exemplified in the belief that Jews murder Christian children to collect the children's blood to bake matzoh used in the Jewish holiday of Passover.

Perhaps most, or even all, of blood libel fantasies are rooted in the first pernicious blood libel, that the Jews killed Jesus Christ, whom Christians worship as an aspect of God, the Son of the sacred Trinity of Father, Son, and Holy Spirit.

Crucifixion was not practiced by Jews. It was practiced by the rulers of the Roman Empire. In the Christian Bible, Pontius Pilate tells the Jews that they could make a choice to free someone among the men condemned to die by crucifixion, and the Jews cry out, "Give us Barabbas", who was thought to have been dedicated to rebellion against the ruling Romans. And thus, Barabbas was freed, and Jesus was crucified. From this episode arose the belief that the Jews killed Jesus.

In the 1960's, Pope Paul VI said the Jews were not collectively responsible for the death of Jesus. I am Jewish. My then-husband, from a Roman Catholic family, had taken our baby son to visit relatives. He mentioned what Pope Paul VI had said, and added, and thus our son was not responsible for the death of Jesus. A relative answered, "I don't care what the Pope said. The Jews killed Jesus, and they all deserve the blame". The contemporary 21th century CE Pope, Benedict XVI, has explicitly said that the Jews did not kill Jesus, but many Catholics, many Christians, still believe the Jews indeed did so.

Indeed, when I was 18 years old, and was going to marry the man who now has long been my ex-husband, my parents were invited by that man's father to meet his parents. He escorted my father into the home of these two elderly people, who had never learned English, and said in Italian, "This is Sam. He is a Mazza-Christo, but he's still a very nice man". Mazza-Christo is a dialect form of the phrase "Christ-killer". It was the only word for Jew this family used. My father knew a little Italian, since his own father, who was a plasterer, worked in construction when he first came to the United States, learned Italian, thinking he was learning English.

The Last Supper, the last meal Jesus shared with his disciples, so often depicted in Christian art throughout the centuries, was the Seder held in celebration of the Jewish holiday, Passover, which is celebrated for a full week. Western culture has used the solar Gregorian calendar since the late 16th century CE, replacing the solar Julian calendar, and most of the world uses it today. Jewish holidays are celebrated based on a lunar calendar. During Holy Week, Easter week, Christians observe sacred days, beginning with Palm Sunday, when Jesus and his disciples entered Jerusalem, leading to Good Friday, when Jesus was crucified and died, and then to Easter Sunday, when Jesus was resurrected.

Passover celebrates the liberation of the ancient Jews from slavery in Egypt. The story of the liberation includes telling of the Pharaoh, the ruler of Egypt, being warned that if he did not free the enslaved people, his land would be visited by 10 plagues, the last of which would be the slaying of the first born, both animal and human first born. He did not heed the warning. The Jews were told to sacrifice a lamb, and smear the blood of the lamb over their doorways, to indicate to the Angel of Death to pass over those dwellings, thus exempting the Jews from that last, terrible plague. "Pass over": hence the English term for the holiday, "Passover". The Jewish seder entailed a feast, singing, and joy.

Very often, the two holidays occurred close together. Thus, while the Christians were mourning the ordeal Jesus was undergoing, his torture, crucifixion, and death, Jews were laughing and celebrating. Some Christians took this to mean that the Jews were celebrating the death of Jesus.

Who is Agnus Dei? Agnus Dei is the Lamb of God, Jesus. If Jesus is the Lamb of God, and Jews sacrificed lambs to avoid the plague of the deaths of the first-born in ancient Egypt, then it is understandable that many Christians may have believed that the Jews indeed killed Jesus, using the blood of the Lamb of God for their own purposes, indeed celebrate the death of Jesus, the Lamb of God, on Passover, and indeed use the blood of other Christian children to make matzoh to eat on the holiday of Passover.

There are other pernicious instances of folklore speaking of Jews seeking the blood of Christian children.

In the British Isles, there was a well-known blood libel horror story, recounted in a folk song, Child Ballad 155, under a variety of song titles, "The Jew's Daughter", "The Jew's Garden", "Little Sir Hugh". A Christian child, little Sir Hugh, was playing ball with friends, and the ball bounced over a fence into the garden of a Jewish family. The beautiful daughter of the Jewish family invites little Sir Hugh to come into the garden to retrieve his ball. He is reluctant, but she offers him succulent fruit, and he enters her garden. She takes him into her house, and stabs him in the heart, "like a sheep". Nota bene: a sheep, a lamb, just like Agnus Dei, the Lamb of God.

This story, recounted in song, was thought to be true. Little Saint Hugh, a Christian child who was sainted, was found dead in Lincoln, a city in Lancashire, during the 13th century CE. It was widely believed that he had been sacrificed by Jews, who had collected his blood for their rituals. An uprising resulted in the murder of many Jews.

Even earlier, in the 12th century CE, another child, William of Norwich, was found murdered, and the Jews of Norwich were accused of crucifying the child.

In "The Prioress's Tale" in Geoffrey Chaucer's The Canturbury Tales, Jews are described as being compelled by their evil impulses to want to murder Christian children.

Ironically, the Jewish religion, as practiced by devout Orthodox Jews, forbids the consumption of blood. Animals are killed in ways that guarantee that no blood remains in the meat, which must be certified as kosher. Perhaps the fact that the blood is drained before the meat can be used was interpreted by others as a desire for using the blood, rather than the actual forbidding of the use of blood.

Alas, today, variations of the blood libel keep surfacing. In 2003, stories were recounted in a TV series shown in Syria and Lebanon based on The Protocols of the Elders of Zion, resurrecting old blood libel charges, that Jews want to rule the world, and continue to use the blood of Christian children they murder to make matzoh.

We must wonder, why do these pernicious lies continue to be circulated? Why are some people fascinated with the idea that Jews are hungry for blood? Might this be a projection by people who hate Jews of their desire for Jewish blood to be shed?

# ORIGINAL ARTICLES AND CONTRIBUTIONS

## A Playbook for Therapists Treating Patients with a Cancer Diagnosis: What I've Learned in 48 Years as a Cancer Therapist

By Norman Straker, MD

*This article is based on a presentation that Dr. Straker gave at the 67th annual meeting of AAPDPP at Mount Sinai in New York City.*

I am very pleased to be invited to participate in this year's AAPDPP program. As John Tamerin mentioned, the theme is innovation and its relevance to clinical practice. As an octogenarian, I have had the opportunity to be creative, based on my longstanding clinical work. My presentation today will highlight how I learned to be a psychotherapist that treats cancer patients. My playbook evolved over decades as I relied less on my early training and more on what I learned as a clinician and supervisor.

In 1976 Jimmie Holland and her four Montefiore colleagues were recruited to begin a psychiatric service at Memorial Sloan Kettering. I joined them, and we embarked on a journey that would eventually lead to the development of the first clinical fellowship in psycho-oncology and eventually the establishment of the medical subspecialty of psycho-oncology.

At first, our small faculty chaired case conferences on the wards to generate referrals. Nurses and social workers attended what we called "mental health rounds", but oncologists never came. Our failure to involve oncologists in the emotional turmoil of their patients needed a remedy. Opportunistically, I met the spouse of a cancer patient who was a movie producer. Together we made a film to try get oncologists to identify more closely with their patients, entitled When Doctors Confront Cancer. (Straker & Draven, 1990) The doctors with cancer in the film spoke about how crucial it was for them to feel cared about by their doctors. This movie was widely acclaimed, and the film became a requirement for board certification in internal medicine and palliative care.

As the only psychoanalyst at Sloan, I was in a unique position to lead the initial attempts to develop a modified psychoanalytic psychotherapy for cancer patients. When our first fellows arrived, I led a twice a week seminar on psychotherapy. I also took my interest to the American Psychoanalytic Association and chaired a discussion group on Psychoanalysis and Psychotherapy with cancer patients, which has continued for more than 35 years. The combination of my own clinical work and my supervision informs my presentation today.

I suggest that the core concepts in psychotherapy of cancer patients include recognizing that the patient's history, character, defenses, ability to manage adversity, and level of attachment will all influence how he or she will cope with their illness, therapy, and dying, Transferences and countertransference are heightened in contrast to psychotherapy with non-cancer patients. (Straker, N 2019)

A modification of the therapist's role is required and includes the need to be very flexible according medical and psychological situation, be an advocate for the patient's quality of life, promote the best adaptation to the illness, and finally to learn how to manage death anxiety.

Hearing the words "you have cancer" is traumatic. After hearing these words, the patient is in shock, often dissociated. This existential crisis conjures up the prospect of an early death, disability and toxic treatments. Many patients

even fear imminent death and others cannot imagine how their life will go on. Psychiatric syndromes are a common outcome immediately after diagnosis including panic disorder, anxiety disorders, depressive disorder and adjustment disorders. Referrals for therapy are common at this point.

Psychological Interventions to manage this crisis should include exploring the patient's anxiety about their association of cancer with imminent death. I recommend reassuring them that death is not imminent. If they are given a five-year survival of 20 per cent, I recommend that they try to think of themselves in the 20 percent group that will survive. In general, because so much about the disease and treatment is unpredictable, I strongly recommend trying to live with "accepting uncertainty". As the first meeting ends, I acknowledge that we have a difficult journey ahead, and we will work together to manage the illness, treatments and side effects while focusing on achieving the best quality of life possible.

The medical treatment is determined by the type of tumor, the patient's dynamics. and preferences. Two examples are offered.

**1) Managing a lack of basic trust.**

A mid 70-year-old man with early prostate cancer refused standard surgical treatment because he feared being asleep and not in control. His early history included being raised by an alcoholic negligent mother who enjoyed partying and a father who left the family. I recognized his need to be in control and agreed with his decision. I also gave him access to my cell phone to help him gain the trust that I would always be available. After a two-years of radiation and female hormones he was in remission. Two years after his remission a tumor mass was discovered on his kidney. The psychotherapeutic gains we made together allowed for an uneventful surgical removal of the tumor mass.

**2) Managing overwhelming fears of dying.**

A mid-40-ish year-old woman with an early diagnosis of early breast cancer, demanded a bilateral mastectomy despite her surgeon's view that it was unnecessary. The patient was referred to me the day before surgery. Post op we began a twice-a-week psychotherapy. Her fears of dying were difficult to manage. Medication, multiple reassuring texts, and my connecting her multiple visits to the ER as a child, because of her mother's fear that she was dying, had little impact. In desperation, I suggested that she write a note on her cell phone that said, "My oncologist said I am cured". Whenever she felt anxious, I suggested she read that note. This was very helpful and became a part of my interventions for very anxious cancer patients.

My analytic training during the 1960's did not exactly equip me to help patients faced with the realities of dying. Freud treated death anxiety, as a secondary anxiety, a derivative of the repressed anxieties of childhood. His focus and model were based upon intra-psychic conflict, not the reality of actual and imminent death. As a result, the "elephant in the room." anxiety about dying was most often dealt with by denial and avoidance.

This impasse was best resolved by consulting sources beyond Freudian psychoanalysis. Contrary to Freud, Becker believed that all human activity is largely driven by unconscious efforts to deny and transcend death. He hypothesized that we build character and culture to shield ourselves from the devastating awareness of our underlying helplessness and terror of our inevitable death. (Becker, 1973)

Sheldon Solomon undertook the task of validating Becker's hypothesis. He designed research studies that demonstrated the existence of unconscious death anxiety and its defenses, previously unknown to psychoanalysts, known as "terror management theory". (Solomon, 2015) The main tenets of terror management are: If we feel we are a valuable member of our culture that creates high self-esteem. So we create a path to symbolic immortality and lessen our fear of death. Mobilizing these defenses by validating the patient's life achievements, and contributions to their community is an essential intervention for lessening death anxiety. Avoidance and denial are no longer necessary, so end of life care can be discussed and worries about dying can be explored.

When the patient is terminally ill the therapist can focus on helping the patient establish their legacy by inquiring as follows: How do they want to be remembered? Do they want their estate to support some future undertaking that offers them a kind of symbolic immortality, such as contributing to cancer research? Do they want to address old conflicts with family or friends? Do they want to make attempts to say good-bye to friends? If they are breast cancer patients and have young children, would they want to go on mothering after they die? If so, would they consider writing letters or making videos that address their children's milestones such as a message when they graduate high school, go off to college, etc. (Straker, N 2020)

**Case 1**

Mr. X, a semi–retired, senior partner, and law professor emeritus, was referred to me after an asymptomatic aggressive tumor was diagnosed with a 6-month prognosis. He had had a prior analysis. I immediately picked up on the themes from his earlier analysis, too stoic, private, overachieving, self-deprecating, masochistic. Soon after we began our work, he became quite ill, and characteristically continued to work, told no one, and was reluctant to spend money to make his life easier.

I intervened, picking up on the need for us to work hard on resolving old conflicts to ensure a better QOL. I suggested he consider limiting his work schedule, revealing his illness to partners, and possibly plan a winter vacation with family in the Caribbean. He agreed and after returning from his Caribbean trip, he uncharacteristically revealed his prognosis to colleagues, invited them and friends to visit his home when he was bedridden. Colleagues, old students, and friends visited daily.

I visited him three times a week at his home. He spoke about the pleasures he experienced from the intimacy he used to deny himself. He was surprised and joyful that he was liked and had made important contributions to his students and colleagues. Most importantly he was able to talk to his wife and family in a more loving manner. Despite his declining health, he said the last six months had been the most meaningful and enjoyable of his whole life. As he became weaker, I inquired as to whether he had any concerns about the future which we had not discussed. He wanted to continue the analysis, and was fully invested in the meaningful present and not panicky about the future. He passed away in his sleep.

**Case 2**

Phil was a very energetic 80-year-old married man who was referred to me with a diagnosis of pancreatic cancer with a 3- to 6-month prognosis. His chief complaints were panic attacks and a deep depression. He was counting down the days until he was expected to die and preparing for his death. He was arranging a goodbye party for himself. He had visited the chapel where his memorial service would be held and had also compiled a list of speakers for his memorial service.

Phil did not give the appearance of a dying person. His good color and his robust presentation were impressive. He was anxious and spoke about his imminent death with sadness. He was receiving chemotherapy and opiates for pain.

Phil had lived the American Dream. His parents were from Eastern Europe. He worked his way through college, became a successful money manager on Wall Street, married a woman whom he described as "a beauty" and lived in a large fashionable apartment. Phil considered himself an intellectual and was very vocal about current affairs. He wrote many letters to the editor of the New York Times and had a blog with many followers. He spoke about his life, his acquaintances, and his writings with great pride. He and his wife had been a dashing couple and socialized with the rich and famous.

My initial comments were that I was most impressed with how well he looked. I mentioned that I had seen many patients before with terminal pancreatic cancer, and his appearance did not fit his prognosis. I recommended he try to drop the 3- to 6-month prognosis and try to "live with uncertainty". I further suggested that rather than a planning a good-bye party, it might be more appropriate to consider a party to celebrate his remarkable life. I said we would both know when he was weak and near the end, but it was not now.

We agreed on a once-weekly psychotherapy. I prescribed fluoxetine up to 40 mg for his depressive disorder and clonazepam 0.5 mg twice a day for anxiety and clonazepam 0.125 mg wafers for panic attacks.

I began each session remarking on his healthy physical appearance, which lasted up until two weeks before he died. This was a very important intervention, as it was reassuring to a man who had been told he was going to die imminently. His panic attacks decreased. We spent most of the time talking about the testimonials he was receiving from emails. Clearly, these activities fueled his unconscious defenses against death anxiety. I routinely reinforced these defenses by validating his contributions to his community and noting the important people who were eager to seek his counsel. It was important for him to know that he would not be forgotten. He was also very proud of his daughters and grandchildren.

As I mentioned earlier, Phil had been well until two weeks before he died. He cancelled his last two appointments because he wasn't feeling up to coming to my office. I was informed by one of his daughters that he died exactly one year after our first visit. I was very saddened but took some comfort from the fact that he had really "lived" the last eleven months.

This brief case summary illustrates the importance of not accepting imminent death, living with uncertainty, focusing on celebrating a life well lived, reconnecting with old friends and acquaintances, accepting testimonials, and saying goodbye. After his panic had dissipated and he had stopped thinking about how little time he had, the sessions for the most part were joyful, and he took great pride in recounting his life's journey. I believe my validation of his life was helpful in diminishing his death anxiety and panic. The relationship was real and meaningful. I did not function like a blank screen. It was somewhat puzzling that he did not say good-bye to me.

**Case 3**

While there are many more clinical situations, I could cite, I chose one to illustrate how terror management was effective in a single session. A 70-year-old radiologist was referred to me with terminal glioblastoma. He was very depressed and anxious about dying according to his wife. He was extremely compromised physically, barely able to sit comfortably, and used a walker. His speech was slurred. He said he was very depressed and worried about dying.

I asked him if I could inquire about his life as a radiologist. After he agreed, I asked the following questions: Did

you pick up early breast cancers, did you find preclinical lung cancer? His answer was yes and yes. I said, "Can you imagine all the patients you have saved by your early diagnosis? Can you imagine how important saving those patients was to their families? You did a great deal of good in your profession". We arranged for a second visit, but he died three days later.

His wife came to see me shortly after the funeral. She reported he was a changed person after the one visit, less anxious and much less depressed. He said the visit was very helpful. This is an example of terror management. I validated his life as a healer. His patients and their families gave him a sense of immortality, a feeling that he contributed to the larger good and my admiration most likely increased his self-esteem.

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## Intersubjective Vulnerability: Contemporary Psychoanalytic Attitude and the Praxis of Paul Ricoeur


By Jeffrey H Sacks, DO


**Introduction**

In this paper I will introduce Paul Ricoeur's concept of intersubjective vulnerability and share how I applied his work to a challenging clinical case with references to a late short story of Herman Melville. Ricoeur, a major thinker of the twentieth century, blends literature, philosophy and psychoanalysis, which offers an enhanced interpersonal multidisciplinary platform and transformative ideas of the clinical process.

Ricoeur's concept of intersubjective vulnerability evolves from his studies of the two person interactive nature of language, which suggests an "alien other" dependency of recognition. This dependence on the other for recognition, when applied to the analytic process, anticipates the analytic attitude towards co-construction and mutual recognition. Embedded within this complex process are concepts of vulnerability, dependency and mutuality which will be highlighted and introduced as significant elements within the contemporary therapeutic process.

I suggest that the clinical community has independently reconfigured the analytic attitude from an active knowing helper to collaborator within the relational field.

These reconfigurations of the helping process offer opportunities for enhanced engagement of human suffering within the widening scope of psychoanalysis. For Ricoeur, transforming the act of knowing from an active one party process to an active/passive vulnerable two party process of intersubjectivity alters the foundation of the therapeutic process. In this transformation, the capable person/clinician now is embedded in a complex world of intersubjective vulnerability.

Vulnerable clinician's interdependence with a suffering alien other's unique, hidden multiply determined meaning alters the analytic work and the analytic attitude. This posture change from a "knowing hermeneutics of suspicion" (Ricoeur 1970, p. 32) to an interpersonal hermeneutics of both suspicion and affirmation, implicitly creates a new capability as vulnerability.

Paul Ricoeur, developed his Philosophical Anthropology, in which man's vulnerable intersubjectivity is the core process of knowing himself as well as another. This interactive process driven model parallels the clinical community's evolution from a one-person to a two-person field and transforms the analytic process. For Ricoeur, we are alive as one but need another to be truly human. "…selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other"(Ricoeur 1992, p. 3)

In "Freud and Philosophy" (1970) based on lectures Ricoeur gave in 1965, he introduces concepts of semantics of desire, surplus meaning, hermeneutics of suspicion and affirmation, and an interpersonal intersubjectivity to the analytic community. Semantics of desire offers his interactive linguistic model. Hermeneutics of suspicion is Ricoeur's pioneering interpretation of Freud's one-person model of understanding. Alternatively, hermeneutics of affirmation is Ricoeur's interpersonal and intersubjective two-party dialectical conversational searching for multiple meaning. For Ricoeur, symbols and people both reveal and invite multiple meaning interpretation as well as conceal.

Meaning in this sense is surplus and never ending, moving the listening interpreting clinician from capable and responsible for meaning towards interpersonal and intersubjective collaboration and vulnerability. For the next 50 years his work humanizes linguistics, literature and knowing hermeneutics itself.

In his last two major works he further develops intersubjectivity in "Oneself As Another" (Ricoeur 1992) and enters the consultation room in "The Course of Recognition" (Ricoeur 2005) where he more fully humanizes interpersonal relating, development and healing.

In this paper I will summarize Ricoeur's concepts of intersubjective vulnerability, healing mutual recogni-

tion, the hermeneutics of affirmation, and gratitude and explore their implicit impact on the practice or praxis of contemporary psychoanalysis.

Intersubjectivity is a two-party process in which the self needs another to develop, heal and more fully know itself. For Ricouer, absolute knowledge is utopian and unattainable for both the patient and the clinician. We need another to make more sense of our lives, an alien other to help us continue to learn about our multiply determined selves. This interpersonal dependency moves agency for both the clinician and the patient from a one-party to a two-party process and clarifies a profound vulnerability in all of us.

**Clinical Praxis**

Vulnerability implies a dependency on another and a dimension of helplessness towards bewildering complex forces embedded in language, culture and the interpersonal field. These elements of human entrapment, suffering and helplessness capture a dependency that defines the horizons and limits of the human interpersonal venture which Ricoeur calls Philosophical Anthropology.

Tolerating complex vulnerability in the search for healing mutual recognition in a sea of dissonance and a field of surplus meaning demands a challenging state of mind and analytic attitude called gratitude. As we all know, interpersonal and intersubjective healing is a complex multi-determined process with bewildering states of enactment and unknowing co-constructions. Gratitude is a new concept of tolerance and acceptance of the complexity and vulnerability of the clinical undertaking.

The hermeneutics of affirmation with its inherent multiple meaning and its subsequent vulnerability and gratitude evolved gradually from Ricoeur's opus as both a critic of classical Freudian psychoanalysis, as well as an innovator in his broader project, his philosophical anthropology of man. In this project he synthesizes literature, philosophy and psychoanalysis into a hopeful, liberating, intersubjective, future-oriented course of man's need for another. He humanizes language, narrative, and time and animates these abstractions through a two-party dialectical process.

His lifelong project included an attempt to modify Freudian psychoanalysis by incorporating domains of linguistics, sociology, critical theory as well as philosophical works. He blends Aristotle's intuition-based practical wisdom and the narrative, the future orientation and intersubjectivity of Hegel, Gadamer's notions of prejudice and belonging, and Levinas's focus and responsibility for the other into a unique vision of man as a hopeful future oriented being.

This philosophically influenced progression towards the future, the "passion for the possible" and intersubjectivity, parallel the evolution of contemporary psychoanalysis's from a one-party to a two-party process-from only backwards looking to hopeful futuricity and change.

His two-party intersubjective philosophical anthropology culminates in the pursuit of an "ethical intention", "aiming at the good-life" with and for others, (Ricoeur 1992, p. 172) in just institutions. Thus, humanizing hermeneutics, man's search for meaning.

No longer is knowledge a one-party process but a two-party other dependent dialectic. The two-party hermeneutics of affirmation is the humanizing and healing attitude he called mutual recognition.

**Mutual Recognition**

In one of his last major works "The Course of Recognition" (Ricoeur 1992), he examines linguistically and philosophically the concept of recognition over time. He discovers the evolution of the definition of "recognition" from one-party active knowing through a middle phase of self/other knowing to a passive state of being known or recognized. This "course of recognition" parallels both his intersubjective philosophical anthropology and the contemporary two-party psychoanalytic arena's evolution from an active knowing or recognizing to a passive being known or recognized.

The history of the definition of the word reveals the history of the changing concepts of the word. Recognition like analysis moved from knowing (to recognize) to being known (being recognized). For Ricoeur being human is more than being alive and is now a mutual dyadic process.

The alien other is now essential for self-development and healing. In this work on mutual recognition and as well as misrecognition, he offers an animated cautiously hopeful healing attitude of human interaction and its implicit companion misrecognition and vulnerability. For Ricoeur, every moment of recognition is embedded in a sea of misrecognition, and ironically, every clarification creates a series of new questions.

Building on his work on linguistics, "Recognition" like metaphor bridges a gap between two dissimilar states. The bridge building is a creative act, a complex combination of intuition (imagination) and information. This is what Aristotle called practical wisdom.

This creative process between two people in a complex passive and active dyad depends upon a familiarity and tolerance of the vulnerability towards multiplicity of meaning and an alien other. We find more of ourselves when we encounter an alien other, which begins the ongoing dialectic. We find and define more of ourselves through encounters with the unfamiliar and experience vulnerability. This vulnerability is ironically an essential aspect of the new capable man. Tolerating and welcom-

ing vulnerability demands a new state of acceptance called Gratitude.

**Gratitude**

This state of mind called gratitude incorporates and contains his revolutionary concept that a capable person is vulnerable. In a world of hermeneutics of affirmation and surplus meaning, vulnerable embrace of the alien other as an essential partner is the new capable posture.

Tolerating and embracing this vulnerability as one faces an alien other both demands and enhances gratitude. This attitude reflects a familiarity with the two-party intersubjective alternatives to the one-party hermeneutics of suspicion and knowing capable man of the enlightenment.

Although clinicians differ on the nature of the intersubjective process and the struggle for mutual recognition, Ricoeur suggests mutual recognition and the inevitable misrecognition, vulnerability and gratitude are the essential elements in his two-party dialectical healing process. For Ricoeur we are alive as one, but to be truly human we need another. Struggle, for Ricoeur, is a preliminary type of relating better understood as negation and the hermeneutics of affirmation. Domination does not encompass recognition.

Gratitude is a state of mind that evolves from as well as enhances the experiences of the search for mutual recognition and it's inevitable misrecognition. Ultimately active and practical, I suggest gratitude captures the challenges of contemporary psychoanalytic arenas and offers a new clinical praxis or orienting state of mind.

This state of mind is an acceptance of tolerating, enduring and ultimately embracing the paradoxical human condition. This paradoxical embrace of vulnerability and multiplicity of meaning has been the implicit message in the pioneering psychoanalytic work of Levenson (1972) , Bromberg (1998), Stern (2010) etc.

These contemporary analysts embrace the fallacy of understanding, unknowing enactment and the third. Each concept removes the analyst from the knowing hermeneutic of suspicion into the two party hermeneutics of affirmation and vulnerability. Each concept introduces and educates the clinician's vulnerability in a therapeutic field too complex to single handedly understand and interpret. Whether this process is highlighted as "a force of the third" or inevitable unknowing enactments, the implicit messages are a new vulnerability in the intersubjective clinical arena.

Each clinician differs somewhat in the precise nature and path of vulnerability within the mutual recognition/misrecognition intersubjectivity domain but all implicitly embrace the movement inside the mind of the clinician (analytic attitude) from knowing hermeneutics of suspicion to unknowing vulnerability. Each embrace vulnerability yet each struggle with Ricoeur's concept of vulnerability.

Each concept of intersubjectivity clarifies an aspect of vulnerability and an implicit paradox that the capable man is now the vulnerable. These conceptualizations are clinical technics that alert the clinician to their implicit state of vulnerability.

I further suggest that gratitude is one Ricoeur's culminating concepts both theoretical and practical, which captures the evolution of his sixty-year opus, his philosophy of man.

Gratitude is a concept not developed fully by Ricoeur, but I suggest his work on recognition and misrecognition alert us to the challenges of being human. No longer are life's mysteries easily translated into Freudian hermeneutics of suspicion.

How are we then to go on without knowing? Gratitude offers a tolerance for the opportunity to participate in the paradoxical experience of being alive.

The clinical embrace of the paradoxical and dialectical opens the door towards sharing with our patients. One way to understand our patients' predicament is their personal inability to make sense of what has occurred in their life experience.

Our constantly changing narrative identity is a two-party process, which offers some sense making but always with a cautious not knowing and toleration of the implicit bewilderment of all of our experiences. To know is to mock the complexity and richness of our lives.

Contemporary psychoanalytic theorists have courageously explored and developed concepts of not knowing and uncertainty in a clinical community that was embedded in a tradition that claimed to bring insight and comprehension to the human condition.

Ricoeur's work offers a transition zone of exploration and respect for the Freudian knowing of the unknown and offering a new type of knowing, the hermeneutics of affirmation and its subsequent vulnerability and gratitude.

Ricoeur's formulations predict and parallel contemporary psychoanalysis's development, from knowing suspicion to vulnerable listening. Gratitude offers both the theoretical as well as practical implications for the new more ambiguous clinical world and remains an unexplored and undeveloped state of mind or praxis for the contemporary clinician.

We need one another to heal; we need one another to develop. We need one another in the ethical or relational therapeutic process. Lifting impediments to mutual recognition becomes the therapeutic process, and mutual recognizing moments become analytic moments of the healing. Knowing becomes integrated through the alien other and the experience of being known articulates a

new hermeneutics of affirmation. The hermeneutics of affirmation both challenge and enhance this new uncertain but steady state of the analytic process.

**Hermeneutics of Affirmation**

The hermeneutic point of view suggests that knowing is both a two party as well as a subjective and objective process. This process contains a multiplicity of factors between two unique selves during discourse. The one-party knowing and scientific method is no longer segregated from human perception, subjectivity and creativity. The observing is embedded in the subjective as well as objective human experience. A paradoxical combination of distance and involvement is created and a revolutionary demand to tolerate the paradoxical was born.

Ricoeur (1970) clarified that a knowing hermeneutics of suspicion and a one-party scientific model was a limited model. Ricoeur embraced a portion of Hegel's two-party intersubjectivty and added surplus multiple meaning; thus formulating the hermeneutics of affirmation.

His humanization of hermeneutics of knowing and suspicion was a key transformation into a new hermeneutics of affirmation. He built upon and enhanced one-party objective knowing and hermeneutics of suspicion, Freud's model of psychoanalysis.

Ricoeur's attempt to save Freudian theory paralleled the clinical world's transformation from a one-party to a two-party process of interrelating. Ricoeur called this new process the hermeneutics of affirmation and hope, a world where symbols reveal and invite interaction.

He opened a human world of the future as well as the past. He humanized language and symbols from a "word bound" semiotics to a "sentence bound" semantics (Ricoeur 1977, p. 78). This humanization of symbols as revealing as well as concealing offers a creative metaphoric space for interpersonal translation. This linguistic human space is the space of paradox and surplus meaning. The tolerating of the complex knowing and not knowing space opens room for translation and dialectical conversation.

This space offers opportunity for mutual recognition and healing. Gratitude is the state of mind that both results from and facilitates mutual recognition. What is to be known is truly beyond knowing. Capable man is now vulnerable man, and gratitude is the humbling and facilitating attitude.

Ricoeur's work on the hermeneutics of affirmation prior to mutual recognition and gratitude articulated the core conflict between explanation (one-person knowing and science) and experience or understanding (phenomenology) as well as the hermeneutic blending of both. Calling upon Aristotle's practical wisdom, he formulated a challenging paradoxical necessity for simultaneous blending of explanation and understanding within the human two-party dialectical discourse. Imagination and creative poetic metaphor are now essential aspects of the making sense process (Taylor 2006).

Making sense becomes a two-party process as well an encounter between explanation and understanding, the hermeneutic arc. Making sense becomes an embrace of the rational and the irrational, surplus meaning, the public and the private.

Making human sense, the narrative, is now a two-party embrace of vulnerability, the hermeneutics of affirmation and the paradoxical. Making human sense now embraces sense as well as a type of nonsense, the paradoxical. Healing is now a translation from one unique self to another searching for mutual recognition in a sea of dissonance.

Within the search for our narrative via mutual recognition, we are engaged in a process of synthesis and making sense with hope, relatedness, attachment and connection. But, vulnerability and gratitude are essential to tolerate the complexity and the challenges.

In a major conceptualization shift from Freud, Ricoeur clarified that symbols reveal, invite interpretation and surplus meaning as well as conceal. This complexity contributed to the two-person paradoxical process of being human and making sense.

When we move away from one-person to a two-person process we invite intersubjectivity, language and translation. These processes bring along additional two person processes of surplus meaning, metaphor, semantic innovation, imagination and their inherent complexities. These complexities bring human vulnerabilities. The capacity to contain or tolerate and perhaps enjoy complex processes both demands as well as facilitates gratitude. This gratitude is a remarkable state of peace in the face of a new world of paradox and bewilderment.

Vulnerability and the struggle for mutual recognition contain an implicit dependency towards the other. This process was further complicated when Ricoeur argues that negativity is a privileged affirmation, an alternative other in the multiple meaning subjective paradoxical world of the hermeneutic of affirmation. The hermeneutics of affirmation now includes negation (irrational affirmation) and now both affirmation and negation are potential engines or creators of hope and agency.

The challenge of the paradoxical negative as a human positive embraces the clinical paradox. (Freud 1925, Green 1999). Now capable man becomes vulnerable man and Gratitude is a new ideal state of mind. Gratitude is a practical human solution to the human challenges of intersubjectivity, surplus meaning and the

struggle between solitude and solicitude, rationality and irrationality, explanation and understanding. Ricoeur's gratitude offers the clinical world a new praxis, practice or state of mind even if the mind is in turmoil.

**The New Analytic Attitude**

Gratitude is the unashamed state of mind or opportunity to endure the human paradoxical without absolute knowledge. Wisdom now is tolerating limits in a world of imagination, a two-party world of explanation and understanding where the alien other is essential for making sense and well-being. This attitude I suggest facilitates the challenges of contemporary psychoanalysis. The clinical world of expanding application of psychoanalysis to challenging patient populations of severe disorders of relating and being demands a new therapeutic attitude.

This is a new evolving process in which two parties come together to make sense of a particular and somewhat unique experience of the human paradox. No longer a knower and a bewildered subject, but a partnership in a search for a narrative and an experience of peaceful gratitude. I argue that gratitude is both the new goal and the model for the contemporary analytic patient and clinician, "a special state of peace" (Ricoeur 2005, p. 259).

This peace is a utopian model of the endurance of what it means to live a life of never ending search for recognition in a world of dissymmetry and multiple meaning. A world in which the dialectic between self and other is never ending and leaves the search for knowing certainty unsatisfied.

Tolerating and enjoying the process is gratitude, an opportunity to experience life and all of its complexities in the presence of another. The contemporary analytic clinician's search for and development of gratitude is also a never-ending process and challenged by many factors.

We are burdened by many factors: our patients' suffering, related and unrelated experiences, our disciplines history of a knowing hermeneutics of suspicion, our tradition of a healing power and responsibility, a culture of commerce that measures success in oversimplified metrics and a theory of healing that offers a new orientation towards affirmation and capability as vulnerability. We are burdened by negation as a privileged affirmation and burdened by a theory of paradox.

Finding states of peace in that challenging mix, finding gratitude for the opportunity to represent this new healing model is the orienting principle in our therapeutic experiences with our patients as well as ourselves and our students.

Ricoeur's intersubjectivity offers clinicians a model of relating and healing that is applicable to the widening scope of psychoanalysis and an opportunity to engage a more diverse patient population.

**Gratitude: The practical**

When the hermeneutics of affirmation is embraced several core constructs in classical analysis are implicitly transformed:

1. Ricoeur's interdisciplinary intersubjectivity offers interventions to wider scope of human suffering
2. Two-party knowing replaces one-party knowing
3. Unknowing replaces responsible knowing
4. Ambiguity and the poetic enhance the scientific
5. Suffering and vulnerability replace safety for both parties
6. Tolerating these transformations demands and consolidates gratitude

**Case Presentation**

I offer this case as an example of my own struggle to tolerate and engage in an altered analytic model of intersubjective vulnerability.

A former patient returns to treatment after a 20-year hiatus. Nora had transformed her life during her treatment, divorced, returned to the work place became very successful, remarried, lost her husband and now retired.

Currently, all her talents and abilities were now suspended. She was on permanent vacation and could say "no" or "I'll do it tomorrow" joyfully voiced. Nora had accumulated a library of films documentaries and books and was enjoying her submersion in the aesthetic and the poetic until she realized that she had begun to retreat into an elite world where only she was welcome.

I was the only one she was willing to venture out of her home to meet, and I was appreciative for the opportunity to help. We had worked together for an extended period of time and helped her discover and work through a history of sexual abuse, depression, and isolation from her childhood family as well as her own nuclear family.

Nora had slept through many days of her children's childhood and had felt ashamed of her abandonment and neglect. Our previous work helped her make sense of her paralysis as a parent and her childhood traumas that set these overwhelming processes in motion. We came upon these early experiences through an erotic transference and determination to seduce her analyst.

The success of the treatment and her transformation of her life from hopeless paralyzed victim to a Wall Street executive were impressive. We knew and we understood and now a few months after retirement she was retreating and reenacting the isolation of 30 years ago. She was "on vacation" and could "enjoy herself". Her children and their children were now neglected. Holi-

days and birthday celebrations were rejected. Gradually, she rejected her own beloved garden, seasonal wardrobe changes, home maintenance and even food preparation. Each day she awoke with "not today" and ended each day with "tomorrow, I will start tomorrow".

She came for help but was deeply embedded in her joy of "no" and spent her time in her sessions sharing the joys of her private life of exploration and study of a world she was rejecting. Award winning biographies, lengthy novels, selected classic movies, and TV shows. Nora created a life of knowing, learning and bliss. A one-party life of knowing, a life of security and safety, a blissful life yet no life at all.

I wondered why this bliss did not empower her to maintain her public life. Why a yes to private and the no to public? I thought of Melville's Bartleby, a short story in which a scribe doing well at work and liked by his new employer suddenly and mysteriously says "No, I'd rather not" to every request leading to food refusal and death. This challenging imaginative fiction alerted me to the potential danger she was in.

The "no" had become "yes" and her insights were now supporting her rejection of the world. The world of paradox was too dangerous and too demanding of vulnerability.

In our sessions she explored her feelings of me and was convinced that I was hiding from my life in the therapy room. I was safe in a world I controlled, a world I had studied and knew the rules. We were the same, two avoiders and two traumatized souls. I listened and struggled with her challenge.

Of course, Nora only knew my clinical self and I was visible to her in that limited way, for her she was (one-person ) correct. My attempts at interpreting or examining her projections were rejected. I struggled at her intense scrutiny of me but "vulnerability and gratitude" helped me and I accepted her invitation of mutual recognition.

My rejection of vulnerability was her truth and was true enough for me to learn about myself. I had spent my life in offices with suffering people and had enjoyed in part the isolation, and intense one on one experience. I surrendered to her distorted and partially informed perception of me as avoider of a more public life and vulnerably partially accepted her interpretation. I felt clarifying her false overgeneralizations of my life would disrupt the mutual recognition process necessary for healing.

Nora talked about the paintings in my office, the books on the shelves, the rugs, furniture all confirming her assumptions; I too was an abused child hiding from the unstructured world. I too had hidden from my parental responsibilities, my working late, avoiding home life. I too had said "No" to life. Nora's intense challenges of my character provoked memories of my experience of Bartleby.

My first reading was recommended by a frustrated supervisor 40 years ago. We were arguing over the treatability of the case I was presenting for supervision. The patient was the brother of a Nobel Prize winner but had rejected everything and embraced "No". He was often mute in session and this challenged the supervision.

The story then left me confused: who was Bartleby, the patient, me, the supervisor? He demanded I abandon the patient and I refused. I felt committed to treating the so-called untreatable. I intuitively embraced the negative in an affirming hermeneutic. This concept was unfamiliar to the classically trained supervisor. The patient gradually made great strides, and I selected my analytic training at The White Institute. But Bartleby remained a mystery to me.

Years later I took a literature course and studied Melville's late novels. Bartleby was back and here Melville was the one who had said No. His 20 years silence after a disappointing review and sales of Moby Dick was broken with Bartleby. How could the story help the reader make sense of life, which was a rejection of life and a seemingly pleased one.

Ricoeur's work of the negative as a privileged affirmation made some sense, but still the suicidal solution concerned me. Now my patient returned, suicidal and enjoying the "no" convinced that I was her partner in rejection. Her healing demanded I recognize her and recognize myself as partially Bartleby 40 years later. I could embrace the vulnerable in the treatment but gratitude seemed far away.

During this phase of our work in the mutual recognition mode, I marveled at the progress the patient was making, she began to long for her children and grandchildren and found their anger at her for rejecting them, as moments of love not hate. She was embracing the paradoxical and was grateful. I realized that Bartleby was a gift for the reader to experience the horror of the "No" and its both seductive and obliterating dimensions.

Bartleby now seemed to explore the experience of his rejection of life for the reader. The text informed in a sharing modeling horrifying way. My patient informed herself as well as me in a horrifying way, we were Bartleby to some degree. We are all Bartleby and not.

Of course neither of us was Bartleby for he was a fictional character with metaphoric powers. As Ricoeur helpfully clarifies a metaphor is a connecting bridge to two dissimilar states or persons. The metaphor enhances the similarity but does not eliminate the dissimilarity.

As I gradually shared our dissimilarities, she became despairing. I had recovered she claimed and again she was alone. As we explored my life she gradually became disappointed in her blissful "No". Her flowers

were dying, her food was wasted, and her home was soiled. I had ruined her sanctuary and she was forced back into the world. These visits seemed different now.

Her world of affirmation from her children, neighbors and admirers of her photography posted on line were both affirming and despairing. How could she have neglected her children, her home, and her talents? When would she long to engage actual life? I had taken her safety, her security and knowing away. How could I have pushed her into the world of vulnerability? I could tolerate that state and have gratitude but where did that leave her?

Her anger at me gradually shifted to curiosity. What was gratitude like? How could I tolerate the vulnerability? Didn't my clinical training protect me? Didn't I know what was going on, her history, her process?

I began to share the shift in the clinical world and my world from hermeneutics of suspicion to the hermeneutics of affirmation and essential vulnerability. Her imagined knowing security of mine was her partial fiction.

We were together in a world of paradox where her children's anger at her abandonment was also love. When she could see and feel that, then they could begin to laugh at their own successes with their children, her grandchildren. Perhaps things were not as bleak. Perhaps the negation was a privileged affirmation. Her time with her children when not asleep had been rich and driven to repair her absence. Not ideal but for her real. Finding this space of complexity, multiplicity of meaning and reconciliation is part of her healing.

She continues to expand her life and after calling her daughter and singing happy birthday she joyfully realizes that her daughters enjoyed the call, the attention and even the singing, she was not being humored, she was being enjoyed.

She reports a dream of her abusive ex-husband demanding sex. She refuses, she says "No" to him and "Yes" to herself, her safety her security. Suddenly her confusion between "No" and "Yes" become clearer. We laugh at the power and clarity of the dream. A week later the dream reoccurs but now the demand for the sex is frightening. She is no longer invincible with a "No". She is present and vulnerable; she is human, dependent and at times helpless.

She continues to expand her activities and enjoys lives complexities and reports a dream she had early on in our treatment 20 years ago. A wall of water needed to be moved or repaired but she could not get any help from her husband. Although she had divorced her husband and built a new life of competence and success her vulnerability had been present and unbearable throughout her successful life. The retirement and new freedom had opened up the space to joyfully say "No" and retreat into a world of false invincible of the "No".

Our mutual recognition as suffering souls set the groundwork for hope. Tolerating her conviction that we were similar "no Sayers" to life was informative, interesting, threatening and helpful in its partial truth. Perhaps I was too distant 20 years ago, too knowing and saying "No" to involvement. Perhaps she was correct to recognize our mutuality and joy of distance, isolation and knowing. Her healing was dependent upon my recognizing my "Bartleby". Gratitude modeled the attitude of vulnerability and opportunity to participate in the healing two party processes. Tolerating the process facilitates the process.

**Conclusion**

This clinical experience offers an altered analytic attitude that evolved through my work with this patient through the orienting and disorienting ideas of Ricouer.

My patients "No" for life was a yes, at least for her. Her No interfered in her assuming a position as a vulnerable person in her life and patient. Ricoeur's notion of negation as a privileged affirmation enhanced my desire to relate and help. His notions of the paradoxical supported me in my awareness of my own struggles with vulnerability and gratitude.

This permitted me to surrender to her exploration of me and my own "No" with a type of peace. I was grateful for what I learned about myself as well as what I learned about the patient. Gradually she entered the world of her family and ordinary responsibilities with joy.

She realized the "No" in the dream was a yes for herself and how muddled her life had become when she retired and had the freedom to say no. She thought of Bartleby as a teacher about the dangers of "No".

She appreciated the import of her "No" but was beginning to appreciate that life demand a yes, surrender of a sort, an acceptance of her own vulnerability. She was grateful for a chance to say yes. She was grateful for the opportunity to reconfigure her life and move towards the future with hope and liberation.

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# EVERYDAY LEADERSHIP

By Ahron Friedberg, MD

**What is an Everyday Leader?**

At some point, any of us may be called upon to become a leader. Maybe the family business is suddenly rudderless, or our kids' school needs a fundraiser. Or perhaps we just want to fast-track a start-up and test a new idea. None of this will make the headlines. But to us it's still a challenge and, at least initially, an uneasy mix of risk and responsibility. As we settle in, we toggle between anxiety and elation. We do not want to disappoint anyone, including ourselves. This is the situation of an "everyday" leader. What they do will resonate within a circumscribed community, though they are still intensely involved. The question is, how do such leaders take on these responsibilities and carry them out successfully?

Though everyday leaders take charge beyond the glare that surrounds their more prominent counterparts (e.g., crypto moguls, tech billionaires), the problems they face are just as perplexing: What compromises should I make? How can I encourage people to join my team?

But despite their commensurate challenges, everyday leaders have fewer resources – they must do more with less. They must imagine new ways to finance their projects, for example, since they may lack the credit history to reassure banks. They may need to create a persona inconsistent with who they think they really are. Is it possible to sustain the energy – the focus – for all this? Everyday leaders have no choice.

From this perspective, everyday leaders travel through unknown territory, while making the best of the accommodations. Yet while many of the resources they call on may be internal, other people can provide essential support. Perhaps the leading, most highly-distilled idea I have drawn from my years of counseling leaders is that leadership is collaborative: It need not be lonely at the top. Many people are potentially a source of support. We need to learn how to tap it, assess it, and apply it without unduly compromising our work.

"Compromise" is a crucial term in everyday leadership since it denotes both cooperation with others – necessary if we are to survive – and dilution, since too much can undermine what we set out to do. So, making the best of things entails a balancing act, where we draw on other people's help without giving away the store as a *quid pro quo*. It's a skill that everyday leaders employ every day.

In view of its unique challenges, everyday leadership is not just a subcategory of Leadership (just as children are not simply little adults). It's similar – to a degree – but on a smaller scale. Many of my clients' issues involve relationships that, while not primarily emotional, have a higher emotional/psychological content than we conventionally associate with managerial challenges. I am sensitive to these issues because I am a psychiatrist. My work counseling leaders, while distinct from my psychiatric practice, is still necessarily psychologically informed. Thus, my approach to everyday leadership is so informed.

Becoming a leader calls on a type of psychological readiness, which is part of stepping up and taking charge. Actually, at every step along the way, the Everyday Leader must learn how to measure and evaluate themselves, and be psychologically prepared to find themselves falling short. It's okay to fall short. What matters is knowing how to acquire the mettle to keep going – and, ultimately, to improve. Part of what I do is help people develop the psychological wherewithal to stay the course and keep improving.

Leaders need to believe in themselves. They are never effective if they are grudging or half-hearted. Anyone can sense a reluctant leader, and they will find someone else. So, part of being psychologically ready to lead is being convinced that the task is worthwhile. As a general matter, it *is* worthwhile. Leaders are change agents. They alter the course of history. By their example, they give people confidence to go out and perform themselves. They provide direction and energy – like Roger Bannister, who broke the four-minute mile in 1954. After that, people knew the so-called barrier *could* be broken, and then it was, agin and again. What was extraordinary became, in effect, everyday. Bannister was inspiring. The movie about him – *Chariots of Fire* (1981) – is contagiously inspiring.

Of course, it is possible to multiply examples endlessly. How about Gandhi, who helped found a nation, or Henry Ford? Even Jeff Bezos, though you might not like his methods. Leadership is important. Think of the world before and after these people, and you get the point. Though Everyday Leaders operate on a smaller scale, their work is a version of the leaders we all know. The question is how to fully invest in your own leadership potential, and then pursue it effectively. How do you energize people, and impart your energy to them? How do you help them see that the road ahead, as you envision it, is worth the trek? Leadership, even in relatively scaled-down contexts, is a combination of the practical and the visionary.

If leadership were not this complex mix of present tense and (ideally) future perfect – i.e., if it weren't so central to how people organize their lives – we wouldn't recognize and celebrate it as we do. Our culture features holidays

named after leaders. Take, for example, Martin Luther King Day or Presidents Day . . . or Christmas, named after the founder of Christianity. We take time every year to think about how these people altered our collective experience. It makes us feel good that these people existed.

This is no fluke. Neuronal research has shown that leadership is a fact of human organizational strategy. In "Understanding social hierarchies: The neural and psychological foundations of status perception," Jessica Koski et al. (2017) observes that "We undoubtedly vary in the skills and traits we possess, and when choosing the appropriate person to listen to, follow, or emulate, we want someone with the skills and traits we consider the most desirable or important." It is possible to identify this principle throughout history and even in lab experiments with animals. The point is that leadership is woven into social organization and, in most cases, we are glad that it is.

**Leaders learn by leading**

The leadership issues faced by "everyday" leaders are personal, and bound up with their specific situations. Thus, it's impossible to lay down "infallible" rules (either for becoming a leader or for managing in that position). That would miss the subtlety and spontaneity of how each of us may be required to respond. It would miss the jerry-built nature of leadership on a small scale, where we accomplish what we can and then think up new, possibly more productive strategies that utilize the resources at hand. So, I favor broad, individually adaptable principles for coping with challenges as they arise – that is, as we evolve into a leadership role and adapt as we go.

From this perspective, everyday leadership is situational, a way of managing challenges so that they do not prevent us from reaching a goal that has not been unduly compromised. Apart from conforming to some basic principles ("I will always treat my colleagues fairly," "I will always be honest"), we may be required to change course too often for one overarching approach to govern how we proceed.

I've been down this unmarked road before. When I wrote a book on happiness, I argued that no one can tell anyone how to be happy. That is, each of us finds our own way, based on the circumstances of our lives. A similar principle applies to everyday leadership, since it's futile to lay down managerial rules for the unique challenges that everyday leaders face. What does help, however, is to learn from how others, in similar circumstances, navigated their own challenges. We can study how ordinary people (at least in terms of their status) managed to step up and lead. Their approaches can be adapted as need be, recognizing that every approach to leadership must change in response to the demands of their situation.

However, I think that certain general, adaptable principles can inform our understanding of effective leadership. Perhaps the most important is that leaders are in constant negotiation with the led (and with those whom they seek to lead). A leader cannot be effective absent loyalty from the people they lead, and – to earn it and keep it – they must reassure such people that there are benefits from the relationship, and that the project is worthwhile. This may require compromise, so that everyone tangibly experiences the benefit. Viewed in this light, leadership is an exercise in building relationships. Most challenges are too big (even on the reduced scale of everyday leadership) for one person to manage single-handedly. They will need a team, and teams need to feel that they have the leader's support. So, even as circumstances evolve, no leader can stand apart, either from the troops or from the network of people on whom they rely for advice, expertise, and material support.

Another principle I want to cite is the need for empathy. A leader must never forget that they lead real people, with their own needs, interests (and, yes, challenges). It is crucial – if one is to gain and keep such people's trust – to respond to their concerns. Strategically, a leader must *understand* such concerns so they can respond in ways that allow people to feel like more than just cogs in a machine. Again, compromise may be necessary. But people will likely require less if they feel that you care about them, that you take them into account as you move ahead.

Compromise is the result of flexibility. So, while leaders should be determined, they should never be rigid. They should listen and weigh options. Sometimes they must listen to themselves, as they debate internally their various possible courses of action. I pair flexibility with determination, since plowing ahead with a leadership initiative can fail without accepting some likely redirection. In the un-lonely world of the leader, flexibility may become the defining M.O. It is the foundation of communication and collaboration.

In the discussion so far, character traits have segued into ways of responding to practical challenges. This is because they are hardly separable. An everyday leader must empathize to appreciate constituents' needs, and compromise accordingly. They should be flexible in order to work with teams they rely on. A leader develops useful character traits so that their actions do not seem forced – a matter of expedience rather than genuine concern. While some leaders "play a good game" (it's all they're capable of), most literally work on themselves, learning to think like a leader as if that were their natural inclination.

In this vein, another principle I want to cite is that leaders always learn as they go, never discarding useful insights – even where these result from failure. They become more sensitive, literally more conscious of themselves as leaders. Being a leader is never static, even with

your title on the door. Learning how to lead (in context with the demands of one's own situation) is part of leading. Picking up the pieces and starting over is never a waste of time, but just an aspect of learning. We can learn as much from failure as from success, sometimes more.

Of course, I could cite other leadership principles, like the need for self-discipline and a willingness to acknowledge responsibility (even when things don't turn out well). I could mention that leaders must know how to communicate and collaborate. But these skills are straight-forward, and I wanted to highlight those that are more nuanced. They are foundational to an everyday leader's success.

So, my larger point is that leaders do not merely bring to the task the skills that they have. They enhance these skills, and develop new ones. The process – and it is a process – calls for a high degree of continued self-awareness, an ability to take stock of oneself in a situation as the situation changes. Leaders should look at yourself honestly, and register people's responses. They should take account of those responses. When a client asks me "How do I become a leader?" I say that you must live in a world of two-way mirrors. You look out at people looking in, and when you see how they react you either keep-on-keeping-on or change accordingly. Leadership is a dynamic process, where leading and *becoming* a leader are inseparable.

**What it takes to be a leader**

In my work with leaders – and their would-be counterparts – I have identified certain key qualities. The first is "Vision," i.e., the need to define what you want to accomplish in view of the constraints of time, money, and your own competing needs. Do you want to build a trucking company, run a family business, strike out on your own in real estate? Well, there may be compromises you will need to make, and false starts that you'll have to double back on. So, what degree of compromise and disappointment can you accept and still maintain your initiative? How do you put together a support network, and recalibrate your vision as you experience its implications in your life and the lives of people around you?

*My client Lee was faced with these dilemmas. She had two competing visions – one to be a mother, as was expected of traditional Chinese-American women, and the other to lead her family's business when her father no longer could. She questioned her motivations ("how can I still feel comfortable while 'bending' tradition," "whom can I rely on?") and, finally, made compromises that allowed her to be a leader while (she hoped) becoming a mother in not too long. She prepared herself for criticism but realized that she had support. She decided to pursue a complex vision that was traditional but not so traditional that she'd have to forego a place in the larger world.*

The second pair of qualities is "Determination and Flexibility." That is, once you understand your vision, you must find the *will* and *external resources* to pursue it. The emotional/psychological and mundane practical considerations of leadership are inseparable. Accordingly, flexibility (and its necessary component, empathy) is necessary for a determined pursuit of a vision. You must cultivate trust among the widening penumbra of people affected by your initiatives. In this sense, determination-and-flexibility (paired) are about maintaining balance among the competing considerations you will encounter along the way, always recognizing that "balance" is not the same as stasis – the strategies that you use to remain determined are always likely to change.

*My client Elana dealt with these concerns. Her vision was to develop a unique style of music, combining classical Persian melodies with their modern American counterparts. Initially, she hoped to perform these "renovated" classics in the conservative Persian community where she lived and attended synagogue. What a challenge! The older members of the community were skeptical, and could hardly imagine extending their comfort zone to accommodate any such changes. But Elana was determined. She got the younger members of the community to support her. She was also flexible, seeking advice from the older members and featuring some of their recommendations. Soon enough, she was performing her work.*

The third consideration, "Planning and Organization," is largely about logistics. If we like to think grand thoughts, how do we develop an interest in the nitty-gritty? How (conversely) do we conceptualize the big picture? Can we discern what's coming next, and when to emphasize what? Planning and organization are as much a source of anxiety as pursuing a vision, though in fact they're just down-to-earth versions of that pursuit. Moreover, as in every stage of leadership, how can we rely on others without surrendering our initial vision? This becomes a particular challenge as our enterprise grows and matures.

*Here I am thinking of my client, George. He was determined to crack the outdoor-display market with a type of "smart" billboard that adjusted its message throughout the day. The problem was that he faced environmental opposition which, in turn, discouraged potential financing. To meet these challenges, he developed contingency plans – if one obstacle became insurmountable, he'd have routes around them. When his progress remained slow, he kept adjusting his plans. He brought on new people with specialized expertise. But he kept on top of his plans, and allowed them to remain fluid. Also, he never lost sight of details that could ramify if they were ignored. When he was ultimately cleared to erect his billboards, it was as a*

*"demonstration project" in a suburb with fewer restrictions. But he figured, "I'm on my way. My plan is that the cities see how my billboards drive traffic – then they'll come to me!"*

The fourth concern, "Communication and Collaboration," is based on the idea that leadership is never lonely. An everyday leader – who seeks help where they can find it – must connect with other people. They should make themselves understood and, ideally, appreciated. To move their plans forward, they must inspire. Such connection is ongoing, even though whom they connect with and how they connect may change. The point is that leaders are networkers. I use the term "connection" here because it is general – it applies to both communication and collaboration. But effective communication is a prerequisite of collaboration. They're joined at the hip, like determination and flexibility. Thus, collaboration is impossible unless the leader makes their case.

*My client, Dr. R, was a medical center departmental chair who is ambitious for his department. Through a series of staged questions, responses, and offers to the right people, he learned how to draw people into his department and help them to become productive. He became a more effective, prominent leader – and his department increases in stature. But none of this would have been possible without a studied effort to communicate, which estaboished the conditions for effective collaboration. He told me that "I had to get past the usual professional jargon, and all the associated protocols, and get to know people. They were surprised but, for that reason, all the more forthcoming – and willing to trust me enough to finally join my team." In effect, Dr. R understood that communication facilitates a mutual interest, and is crucial to building a durable collaboration.*

The fifth quality, "Responsibility," concerns a character trait necessary to leaders who must step up and take ownership of disappointing situations without deflecting blame or offering excuses. Assuming responsibility tests a leader's mettle, and can determine what people think of them over the long haul. Is this leader honest? Is he or she strong, and strategic enough to get out in front of situations before the fallout overtakes a whole enterprise? These are major questions, if only because trust is crucial to a leader's continuing success. However, responsibility also refers to looking after a project or an enterprise so that its wheels stay well-oiled and everyone involved with it stays employed, satisfied, and high-functioning. It requires clearing away obstacles, as well as mentoring the next generation of leaders and vital employees. So, responsibility is almost about cultivating what might be considered old-fashioned virtues, in the face of more prominent leaders who think of themselves as hired problem-solvers and never commit themselves long-term. Responsibility, therefore, comes back around to having and pursuing a vision in the right way. In the long-term, a vision falters unless the one pursuing it displays responsibility.

*My client Christina was a financial advisor whose son had autism. Based on her professional skills and personal experience, she assumed a leadership role in advising families faced with the challenge of caring long-term for autistic children. She assumed responsibility by recognizing an unmet need and figuring out – step by step – how meet it. Thus while Chritina could have hired someone to care for her son, or even put him in an institution, she instead became the public face of a new, much-needed service: helping similarly situated people manage the finances and practical demands of raising an autistic child. She formed a nonprofit that guided them through the maze of state, federal, and private assistance. In a few years, the organizaton was the go-to source for such guidance. Christina was acknowledged as having brought autism out of the shadows and made help with its challenges accessible to everyone. As she told me, "If I see a need I can meet, I feel responsible." That's the essence of principled leadership.*

Obviously, all the qualities that I have cited intersect. A leader cannot, for example, devise a good plan unless he or she flexible. So, the implication is that leaders need to be well-rounded, and develop an array of qualities needed to confront the various challenges that they will face. Of course, this takes time, and some leaders are born on third base. Nonetheless, most people find the means when the pressure is on. They survive.

It is encouraging that modern neuroscience is on the side of approaching leadership as a social activity. Donald Pfaff's *Origins of Human Socialization* (2021) observes that "It is crucial to understand the compelling evidence for our natural sociable affinities. . . By 'affinity' I mean a spontaneous natural liking or sympathy for another person, an interest in forming a bond or relationship." Prof. Pfaff traces the development of hearing and sight, for example, and examines how they contributed to humans' becoming "naturally" social. He examines the brain mechanisms involved in socialization, and our related genetics. My view is situated alongside this discourse, i.e., ordinary people have the *natural* capacity to assume leadership roles. Leaders must work with this capacity. They must work *on* it if they have never ventured outside their comfort zones.

Of course, if you embark on a leadership project, no matter how challenging, it's still only part of your life. You are still You. That is, leaders need to know when to

wind down, stop obsessing, and live a life outside of taking charge. Thus, even if a leader is laser-focused on the job, they can kick back when they're back home. Leaders should remember to relax. They should learn to separate themselves from work.

By the same token, they should not let purely personal aspirations infiltrate their work. You might think, "Oh, I want to be liked." But catch yourself, and recognize that that's your everyday-self talking – not your Everyday Leader. You should maintain a discrete distance between the two, adjusted as appropriate to the situation. In time, you should learn that Who you are and What you are will not always be the same.

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If there is a bottom line to the idea of everyday leadership, it's that it's based on experience – we learn to lead as challenges arise, and we develop skills to address them. Thus, *in the process of leading*, we learn to communicate, to compromise, and to collaborate so that others can help further our objectives. Basically, we experience our way to becoming a leader. In this sense, we don't need what might be called the "leadership gene," that rare combination of family background, elite schooling, and early involvement in an environment where the exercise of power is second nature (think of the Kennedys, the Roosevelts, or Winston Churchill). Everyday leaders pick up the skills they need, often through trial and error, and through a willingness to change course (and sometimes features of their personality) as circumstances change. They *focus* on being a leader, and integrate what they learn into their own, evolving path through the world.

To experience leadership as a type of constant learning and assimilation, is the opposite of linearity. Just like any other type of ongoing experience, this type is full of zigs and zags. The aspiring leader – and even one of long standing – must be open to it. Thus, so much of successful leadership depends on how we think about leadership, i.e., on how we approach and continually redefine our tasks, our objectives, and even ourselves. So, while leadership is not necessarily an "adventure" (with all the thrills that adventurists seek), it still may be full of surprise, tough going, and some hair-raising near-misses. That's okay. The best leaders find a way to fight uphill battles and rearguard actions (even simultaneously!) because they must. Of course, they may panic and break a sweat. But they keep going, assimilating experience, refining their goals and their strategies.

The everyday leader does not stand back in awe of a challenge but, rather, takes its measure appropriately. Reluctance, and sometimes even fear, can be debilitating, while self-confidence (you know your stuff!) can be energizing. So much depends on how you assess yourself in relation to a challenge. Right-sizing a challenge (I *can* learn a new technology, a new set of rules) will help overcome the sense that a challenge is beyond you. In Irving Feldman's *All of Us Here*, an apt passage suggests that we are just as large as our burdens allow, and no smaller than the task at hand requires. In other words, we're up-to-it, provided our perspective (on ourselves) is adjusted accordingly.

In my practice, I examine what leaders see when they look inside themselves – what still needs improvement, how to compensate for mistakes, whether to share more responsibility. This is because a) I am a psychiatrist, so I study how self-estimation affects how one acts, and b) effective leaders project self-assurance, and a firm sense of understanding a challenge. They want to get to a place where they are credible as leaders. An uncertain leader, who displays uncertainty, rarely inspires confidence in his or her leadership. So, my objective has been to help leaders find the self-confidence – and to develop the skills – to believe in themselves as leaders.

Of course, it's natural to measure oneself against world-class leaders ("Well, I run a tight ship, but I'll never be [Bill Gates, Julia Child, Coco Chanel"). But we can't even imagine ourselves in their situations. We're down on the ground in the real world, struggling with everyday problems that can still drive us nuts. Probably, we operate in obscurity. It's best, therefore, to have a workable vision that we can pursue with energy and a willingness to change course as the need arises. It's best to assume responsibility and take the high road since, in the end, we need to live with ourselves. Everyday leadership is hard. But if we work at it, we'll be effective. We may even leverage our successes into greater success. The point is to stay focused, and be ready to deal with what's next.

In this regard, it helps to think of an old technology. Before GPS became standard equipment, compasses indicated the "true north," so that we could determine the direction to follow. We could calculate any redirection based on the degree of deviation from true north. My sense of a leader's vision is very much like how sailors, pioneers, and everyday travelers used to determine their way forward. They knew where they wanted to go, and understood that they might have to alter direction if a storm – or other challenge – arose. Unlike GPS, compasses can't provide advance notice of some looming challenge. They demand a kind of canny independence on the art of the journeyer, who switches gears and adjusts his or her course as some obstacle comes into view. (The movie *Titanic* is a case in point). This need for quick, nimble response distinguishes the best leaders.

In a way, leaders are thus like firemen. Through constant practice, they develop skills that finally become instinctive. They make the right moves, so that where everyone sees risk, they see a way through. It's hard work. But if you undertake the task at all, there is no other choice.

This article is based on Dr. Friedberg's recent book *Everyday Leadership: Taking Charge in the Real World* (Routledge 2024). He is founding Director of the Park Avenue Center.

# Stepfathers: Psychodynamic Issues and Treatment Considerations

Eugenio M. Rothe, MD

The importance of the role of the stepfather in the American family has only recently been acknowledged. Historically, fairy tales and other works of fiction are replete with characters of evil stepmothers, yet stepfathers are rarely mentioned. Only two decades ago, with very few exceptions (Lamb, 1976), there was a sparsity in the psychiatric literature with respect to the positive contributions of stepfathers to their new families and stepchildren. In contrast, an exhaustive review of the literature conducted by this author in 1999 revealed a number of papers addressing sexual abuse perpetrated by stepfathers towards stepdaughters, but not one reference explaining the positive contributions of the stepfather to the psychological development of their stepchildren.

This strikingly negative portrayal of the stepfather has long historical roots. The dictionary defines the word "stepfather" as "a man who occupies one's father's place by marriage to one's mother" and "step" as "a prefix indicating a connection between members of a family by remarriage of a parent but not by blood". It adds that the prefix "step" derives from the German root "steif" meaning: "to bereave" as well as the old English verb "bestepen" signifying "to deprive (as in children)". (Random House 1966) Highlighted in the origins of the word "stepfather" are: (1) the absence of a filial blood bond; (2) the bereavement over the loss or absence of the biological father; and, (3) the potential for child neglect. This strikingly negative portrayal of the image of the stepfather, if taken literally, presents a serious concern to our society given the recent family statistics in the U.S. (Rothe-a, 2001)

**The New Demographics of the American Stepfamily**

The most recent statistics reveal that 43% of all marriages in the U.S. will end in divorce and that the average duration of the marriage before the first, as well as the second divorce, is 8 years. The average time between first divorce and remarriage is about 3.5 years, and of those who get divorced, 75% will remarry and 65% will bring children from a previous union. After 5 years of divorce Whites are most likely to remarry (58%), followed by Latinos (44%) and African Americans (32%), and 60% of those who get remarried re-divorce. Having low income and living in poor neighborhoods are associated with a lower chance of divorce. In the U.S., 40% of married couples with children are step-couples. Also, 42% of adults have a step-relationship, either a stepparent, a step or half sibling, or a stepchild, adding to a total of 95.5 million adults and 13% of adults are stepparents (29-30 million); 15% of men are stepfathers (16.5 million) and 12% of women are stepmothers (14 million). So, in America today, when spouses remarry and bring along children of previous unions they create "blended families" where both the husband and the wife assume new roles as stepparents remarriage (Pew Research Center, 2011).

**Risk Factors and Protective Factors of Stepchildren:**

Compared to families with both biological parents, stepchildren tend to have more struggles with behavior problems, emotional well-being, and academic achievement. Stepchildren show more signs of depression and are at greater risk for developing emotional problems and risky behaviors. Changes accompanying remarriage, such as moving to a new home and attending a new school, tend to make it harder for children to adjust to remarriage. Teens tend to have a harder time adjusting to their parents' remarriages than do younger children. However, overall these differences are small, and may disappear when factors such as family income and length of time since the remarriage occurred are considered. The increased financial resources, parental monitoring, support, and attention can also help correct these differences (Wallerstein, 1991 and Wallerstein and Lewis, 2004) have been accurately mapping the risks factors of divorce, which antecede the entry of children into a stepfamily. They report that after divorce, only 45 percent of children "do well" after divorce and 41% are doing poorly, worried, underachieving, self-deprecating, and often angry. Fifty percent of the women and 30 percent of the men were still intensely angry with their former spouses. Divorced parents provide less time, less discipline, and are less sensitive to the children as they are caught up in their own divorce and its aftermath. The majority of parents of divorce are chronically disorganized and unable to parent effectively.

In contrast, the children of divorce tended to do well if mothers and father, regardless of remarriage, resumed parenting roles, putting differences aside, and allowing the children continuing relationships with both parents. However, children often suffer emotional scars that last a lifetime and have trouble with their own intimate relationships as adults.

Given these risks factors, upon his arrival in the new family, the stepfather must assume a pivotal role in re-negotiating and re-designing the hierarchy of attachments in the "reconstituted family". He must first gain the acceptance and support of the mother of the child who

will serve as a "gatekeeper" in his relationship to the stepchildren. The stepfather and his spouse will become responsible for restructuring the nurturing and disciplining roles of the adults and for setting boundaries on the children and on each other (Rothe-a 2001).

**A ghost in the new family: the present or absent biological father**

The relationship between the stepchild and the stepfather is defined by the absence of a biological father. Rothe (2001-a p. 28), addressing this issue from a psychodynamic perspective, explains that, "the loss of the biological father may exist as an 'actual reality', such as in the case of death or abandonment by the father, or even when there may not be an actual physical loss, the child may experience this loss as a 'psychic reality'. In either case, there is an aspect of bereavement and mourning involved". In the child psychiatry literature there has been controversy with regards to a child's capacity to mourn. Furman (1992) has argued that young children can complete a successful mourning process with the help of a surviving parent. In contrast, Wolfenstein (1992) has argued the contrary. She believes that the completion of adolescence represents the first developmental experience of mourning and that prior to adolescence the child is developmentally unready to mourn. In her view, adolescence is a necessary pre-condition for the capacity to mourn and that if a child loses a parent before the completion of adolescence, this event may cause developmental interferences and later narcissistic vulnerabilities in the child. Wolfenstein (1992) also adds that if a young child, who is not yet developmentally ready to mourn loses a parent, this produces a split in which at one level the child accepts the loss, while at a more unconscious level the child denies, in fantasy, the existence of the loss and develops a "hyper-cathexis" with the lost parent, always expecting the absent parent to return. Sometimes, the mother and stepfather may become the target of severe aggressive attacks by the bereaved child, making the acceptance of the stepparent in the family more difficult. In such cases, the survival of the step-fathering relationship will depend on the readiness to parent, the maturity and moral integrity of the stepfather, as well as of the biological mother.

The relationship with the new stepson or stepdaughter may re-awaken inner conflicts in the stepfather, such as unconscious and sometimes conscious oedipal rivalries over the mother. Stepfathers and stepsons may find themselves engaged in an oedipal battle which is "too real and to frightening" for both participants, since the stepson stands as a living reminder and the continuation of the man who once possessed the mother sexually. In terms of the girl, the stepfathers relationship may become excessively eroticized, also proving to be "too real and too frightening" for both participants. In both cases, the boy and the girl may perceive that the stepfather as a person does not love them unconditionally, but also someone who could regard them as "mother's extra baggage", seemingly capable of abandoning them. (Rothe, 2001-b)

If the stepfather experienced loss or deprivation in his own life, his arrival in the new family may elicit feelings of envy and rivalry toward whom he may perceive to be his more fortunate stepchildren. The stepfather may also carry loyalties to his previous family and the attitude of his former spouse and his biological children may play an important role in the quality of attachments that he will be allowed to have with his new stepfamily. In turn, the presence or interference of the stepchildren's biological father may exert similar influences, and strong loyalty battles are likely to occur. In all of these dynamics, the mother holds a key position in acting as a "gatekeeper" for the arrival of the stepfather into the family. The mother will need to be active in setting limits between the family members and promoting or impeding the bonding between the children and the stepfather. Temperament will also play an important role in determining the "goodness of fit" between the stepfather and all the members of the new stepfamily. (Winnicott, 1965) Many other factors will play a role in the acceptance of the stepfather by the new stepfamily. Among them are the attitude of the key extended family members of the mother and the stepfather, such as grandparents, who may be playing an important role in the children's lives and filling emotional and parenting vacuums that are often left by the biological parents during and after the periods of divorce. Finally, if the biological father is physically absent, he may exist in the family history as an admired figure, for example, if he was killed heroically at war. Or as denigrated figure, if he abandoned the family or was the perpetrator of abuse and his memory is associated with anger and shame. (Rothe, 2001-b) These scenarios will also have an important influence in the arrival and reception of the stepfather into the new family and may generate complex conscious and unconscious family dynamics.

**Stepfathers: What the new research shows**

New empirical research on stepfathers is still in its infancy, however, the available literature differentiates between three types of stepfathers: 1) adoptive stepfathers, who have married into the new family and have legally adopted the children, 2) non-adoptive stepfathers, who have married into the new family but have not adopted the stepchildren and 3) adoptive fathers, who have adopted children that have no biological ties to the adoptive father or adoptive mother.

In some cases, adoptive fathers have even been found to be closer and more emotionally nurturing than biological fathers. In contrast, non-adoptive stepfathers are not

legally committed to their stepchildren and their roles in the child's life are often unclear. The ambiguity of the role and the lack of legal rights may prompt the child to question the stepfather's legitimacy as a father. In addition, the non-adoptive stepfather's involvement with their stepchildren may be transitory given the failure rate for second-marriages, which is calculated at around 70%. These transitions and emotional losses may cause serious emotional hardship to the children and the stepfather and are aggravated by the fact that after the non-adoptive stepfather leaves the family, he has no legal rights to the children.

In summary, the research findings suggest that 1) adoptive fathers were more nurturing and involved than non-adoptive fathers, even when they entered later into the child's life, 2) that the stepfather's legal and financial commitment to the child increased the emotional commitment and nurturance, 3) that non-adoptive stepfathers remained less involved and were less nurturing to their stepchildren and the variables responsible for this require further clarification, 4) that the early entry into the child's life and longterm relationship of the stepfather was positively significant only in adoptive fathers and stepfathers and, 5) that when both parents adopt non-biological children their level of commitment and nurturance is higher than the other two categories. (Rothe, 2024)

Sometimes if the identity of the stepfather has not been disclosed to the child, this presents a delicate challenge to the parents and the therapist that needs to be handled with much care, such as in the following example:

**Ramiro**

*The Bertucci family were referred to the psychiatrist for a consultation in order to decide how to tell their son, 10 year old Ramiro, that his stepfather was not his biological father. Ramiro's mother and biological father were born in a country located in the Andean High Plains of South America and were of Native-South American ethnicity, but lived in the U.S. The parents separated and later divorced when Ramiro was 2 years old, because the father became involved in the illegal drug trade and was serving a long prison sentence. The mother moved to another city in the U.S. and re-married when Ramiro was 4 years old. His stepfather was of Italian-American descent and had no other children and had never been married before. He developed a deep connection to Ramiro and stated clearly that, "I love him like a son, he is my one and only son and I don't want anymore children". Both parents had been apprehensive about telling Ramiro about his paternity issue and worried about how this would affect him, especially given the fact that his biological father was in prison. They also worried that on several occasions the other children in Ramiro's elite private school had made racist comments to him calling him, "the little Indian boy". The parents asked the psychiatrist to prepare things so that Ramiro could learn about his paternity, "before someone else with bad intentions says something hurtful to him". Upon meeting alone with Ramiro on the second session, the psychiatrist brought up the issue of verbal bullying that had taken place in the school and asked the child to elaborate about what had happened and he responded: "Well, the other boys make fun of me because I look more like my mother, and by the way Doctor, I am so glad you brought this up, because I have been wanting to ask my parents a question for a very long time, but I'm afraid they may get angry." When the psychiatrist inquired what question it was, Ramiro responded: "Well, maybe you can tell me why is it that we have a picture in the living room of my house and I am the ring-boy in my parents wedding?"*

In the cases where the child is not aware of the stepfather's identity as a stepfather, the disclosure of the stepfather's identity needs to be handled with care and the parents need to be attuned to the child's readiness to ask the question and invite the child to express his or her curiosity about the family's history. This brings about a series of complicated family dynamics which will acquire different configurations according to the variables involved. For example, (1) the age of the boy when the loss occurred, (2) the hiatus of time between the loss and the arrival of the stepfather, (3) the climate in the house before, during and after the arrival of the stepfather; as well as innumerable other possible variables. So the adolescent must negotiate the difficulties of the particular developmental stage, in addition to the recapitulation of the mourning process that occurred when the biological father separated from the family, perhaps at an earlier developmental stage when he or she were "unready" to mourn. This places the adolescent boy or girl at risk of developing developmental fixations unless an appropriate substitute can be found. (Rothe, 2001-a). Recent, empirically-based research indicates that stepfather-stepdaughter relationships tend to be the most conflicted during adolescence. This may be related to the budding sexuality of young –adolescent stepdaugthers and the tension and defensive distancing that occurs with stepfathers (Bray & Berger, 1993).

**Conclusion:**

The psychodynamic psychiatrist must become familiarized with with the conflicts and dynamics of stepfathering, since the mission of becoming a stepfather is a difficult one, because it begins with the encounter of a child who has already experienced the loss of another paternal figure. The stepfather's role will then not only involve the usual paternal functions that allow

his stepchildren to successfully negotiate the different developmental stages, but it will also involve a reparative and restorative element. This intense emotional process will, in addition, allow the stepfather to rework his own unresolved issues, characteristic of each of the stepfather's own developmental stages. The stepfather will also help his stepchildren integrate the split-off negative feelings which resulted from their previous loss of the biological father. The stepfather's patience, acceptance and consistency will allow his stepchildren to develop and integrate a new "parental construct" which comprises elements of the child's mother, biological father, stepfather, and the child's own self as well as of the self as viewed in relation to the connections between all the other components. (Rothe, 2001) This new parental construct will serve the child as an anchoring point to complete, inasmuch as possible, the process of mourning over the loss of the biological father and to help the child complete his or her developmental process without interruptions.

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# Rebalancing the Scale: Psychiatry and Healthcare Systems in Pursuit of Integrated Care

By William Butler, MD

Over the past several decades, psychiatry has undergone a profound transformation, moving away from its psychoanalytic roots toward a more biologically driven approach. This shift, driven in part by the financial priorities of managed care organizations, has reshaped the field in ways that have been well described as they continue to unfold (De Leon, 2021). Once focused on unconscious conflicts and dynamic relationships, psychiatry in academic medical centers (AMCs) increasingly prioritizes medication management and cost-efficiency (Scull, 2021). This evolution is especially apparent in consultation-liaison (CL) psychiatry, a field at the intersection of medicine and mental health.

The rise of managed care in the 1970s incentivized a medicalized approach, which some argue led to the 'over-medicalization' and fragmentation of psychiatric care (Barsky & Borus, 1995). The development of these managed care models and the subsequent deinstitutionalization movement ushered new opportunities and challenges for the field. Additionally, unintended consequences of federal regulations, such as the Affordable Care Act, have significantly impacted the mental health landscape with globally recognized effects (Medford-Davis & Beall, 2017; Chow, Ajaz, & Priebe, 2019). While these systemic changes have had a profound impact on the field, it is worth noting that recent innovations in CL psychiatry, such as virtual consultations and the application of artificial intelligence for consultation prediction, continue to pave the way for the future of psychiatry. However, investigations into these newer models of care show that these advancements do not consistently yield improvements in key metrics such as length of stay (Vimalananda et al., 2020). A growing awareness that the field's pendulum may have swung too far is beginning to emerge among some psychiatrists who advocate for reintegrating psychodynamic concepts alongside other therapeutic approaches (Harari & Grant, 2022).

Among this evolving landscape, CL psychiatry has solidified its role as an essential component of medical services in AMCs. The field's origins can be traced back to 1818, when Johann Heinroth coined the term "psychosomatic medicine." James Jackson Putnam, famed neurologist and psychoanalyst, and his associates are recognized as the establishing the first American CL service, providing inpatient services at Massachusetts General Hospital (MGH) in 1872 (Blumenfield & Strain, 2006). Over time, the literature has drawn distinctions between psychosomatic medicine, which focuses on

the theoretical intersection of mind and body, and CL psychiatry, which emphasizes the clinical practice of diagnosis and treatment within this framework.

The role of the CL psychiatry within AMCs, and its impact on patient care, has long been debated, especially its distinction from other medical specialties. A recurring point of debate has been the unique identification of CL psychiatry compared to other medical subspecialties. Unlike other medical specialties who provide inpatient consultation services (neurology, infectious disease, surgery, etc.), CL psychiatry's emphasis on the liaison's role is unique. Thomas Hackett, a former chair of psychiatry at MGH, a prominent figure within CL, downplayed the importance of liaison psychiatry, citing its demands for manpower, funding, and institutional support. In contrast, his contemporaries, like Ralph Kaufman at Mount Sinai Hospital, argued that liaison psychiatry represented the most significant contribution of hospital psychiatry (Blumenfield & Strain, 2006). Today, the ACGME mandates at least two months of CL psychiatry for residency accreditation, with some programs requiring as many as six months, underscoring its importance within psychiatric training in AMCs.

Modern CL psychiatry teams often comprise a CL-trained attending, fellow, resident, and, increasingly, advanced practice providers, psychologists, and other staff (psychiatric social workers, case management, and consultation coordinators). This multidisciplinary approach addresses the complex psychosocial needs of hospitalized patients and reflects the field's integration into standard training curricula. Given the broad spectrum of patient presentations managed by CL services, this team-based approach helps psychiatry most efficiently care for diverse clinical challenges. While psychoanalytic concepts often accompany patients throughout their hospitalization, the literature remains sparse on recent applications of psychodynamic approaches in medical settings.

The literature on psychodynamic approaches in CL point towards a more nuanced and balanced approach to care. Recent scholars have pointed to the psychodynamic contributions to improve clinical psychiatry more generally. They point to foundational understandings in intersubjectivity, understanding the effects of early childhood trauma, the importance of the "holding environment," and the emerging scientific disciplines of neuropsychoanalysis and affective neuroscience and their importance of rigorous study of both the mind and brain (Harari & Grant, 2022). These psychodynamically informed approaches provide an expanded and nuanced view of patients who are frequently encountered in medical inpatient settings. Other scholars have emphasized the significant history of psychoanalytic thought in CL settings, emphasizing a renewed focus on attachment theory, the impact of countertransference, how it relates to extremely difficult and "hateful" patients, and emerging concepts such as the dynamics surrounding physician-assisted suicide (Nash, Kent, & Muskin, 2009).

Although limited, there is an interesting history of psychoanalytic thought in medicalized settings. Engel and Schmale (1967), for example, first suggested that there may be a mechanism by which psychiatric illness precipitates medical illness. They hypothesized that if a patient felt helpless and hopeless, they were likely to be more prone to developing cancer, heart disease, and other chronic medical conditions. Today, we do have increased understanding about the complex interplay between the interconnectedness between various systems like the mind-gut axis and neuroimmunochemistry which may help elucidate the mechanism for the observed phenomenon between chronic stress and increased medical illness. This complex interconnection, in emerging interdisciplinary areas like neuropsychoanalysis and affective neuroscience, can be leveraged for therapeutic progress. There is growing empirical evidence for the role of psychodynamic therapy for chronic pain, biofeedback for hypertension, and mindfulness approaches to stress reduction (Bower et al., 2024; Jenkins et al., 2024; Sayed et al., 2024; Chen et al., 2019; Monsen & Monsen, 2000). These approaches can either be integrated or augment psychodynamic approaches by helping patients to become more aware of internal states rather than utilizing various defenses to avoid those sensations in ways that can paradoxically be harmful. For example, a patient's chronic pain may be understood as a manifestation of unresolved emotional conflicts. Additionally, its function in the patient's life can be understood from a different lens than the traditional biomedical model. Drawing upon third wave approaches in psychodynamic psychiatry, the consultant can model mindfulness approaches which helps the patient to focus on their present sensations and emotions, reducing reliance on maladaptive defenses like substance misuse (Garland, Froeliger, & Howard, 2014).

Emerging research in neuropsychoanalysis, analytic field theory, and clinical pluralism represents the cutting edge of the field and offers new opportunities for integration within CL psychiatry. Since psychiatrists are often the leaders of CL teams, which may include advanced practicing providers, trainees, social workers, and other allied care providers, a psychodynamically informed approach can help set the tone in a way that's cohesive across different therapeutic styles, ways of relating, and experiences for patients. Many patients who are seen on CL services are encountered by an individual clinician for a truncated period of time (typically during their length of stay in the hospital setting, although some may be followed in an outpatient CL clinic). Brief

psychodynamic therapy (BPT), for example, has been implemented inpatient settings due to its time-limited and focused approach making it more accessible and practical for a wide range of patients encountered in this setting (Stein, 2013). This approach aligns with recent writings on clinical pluralism and interdisciplinary integration which fits well within team-based approaches where a different clinician may round on a patient while they are admitted to a general hospital unit. Incorporation of the analytic field, rather than individual subjectivities or dyads, also loosens our approach to patients in more fluid settings.

Psychiatry, especially as it is practiced in AMCs, is at an interesting inflection point. While the financial realities of CL services face many of the same challenges echoed by Hackett in its earlier stages, there is a growing interest in the necessity of providing comprehensive, integrated care for complex patients. As AMCs begin to rethink how resources are allocated to better address these needs, integrative approaches like psychodynamic and psychoanalytic psychiatry provides a potential bridge for going deeper. Moving forward, the challenge lies in training the next generation of CL psychiatrists to navigate this complexity, ensuring that psychiatric consultation remains both scientifically rigorous and deeply attuned to the lived experiences of patients.

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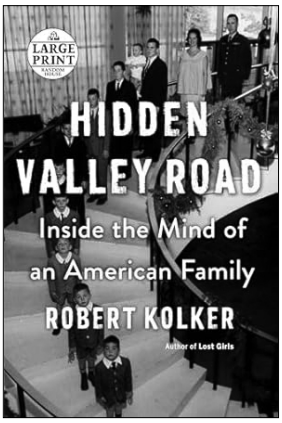
# BOOK AND FILM REVIEWS




## *Hidden Valley Road: Inside the Mind of an American Family*

By Robert Kolker

Reviewed by Gerald P. Perman, MD

Robert Kolker's "Hidden Valley Road: Inside the Mind of an American Family" is the well-written and well-researched story of the Don and Mimi Galvin family that included the parents and their 12 children. Six of the Galvin sons developed severe psychotic illnesses all initially diagnosed under the rubric of schizophrenia. The two youngest children, both girls, were among the siblings who did not develop severe mental illness.

The story of the Galvin family is interwoven with the history of psychiatry's approach to schizophrenia from Bleuler, Kraepelin, Freud, and Jung, with even a nod to Lacan, through research efforts up to around 2015. Kolker does a masterful job in which he extensively interviewed members of the Galvin family, their friends, relatives and acquaintances as well as researchers at the National Institutes of Mental Health and centers in Boston, New York and elsewhere.

I trained in psychiatry at the George Washington University Medical Center in Washington, D.C. where I attended Grand Rounds presentations at which I heard Lynn DeLisi, Danial Weinberger, Richard Wyatt (each of whom plays a role in the book) and others present their work to our department. During my residency, Dr. Weinberger asked me to do chart reviews of patients that were included in his 1982 study published in the Archives of Psychiatry, "Computed tomography in schizophreniform disorder and other acute psychiatric disorders," and he was kind enough to include me, along with himself, DeLisi, Steven Targum, and Wyatt among the authors.

"Hidden Valley Road" reads like a novel (although it is entirely non-fiction) interspersed with a Sherlock Holmes mystery as researchers attempt to uncover the etiology of schizophrenia. The book is rife with intense family drama that includes intra-familial incest, clergy sexual abuse, physical violence by and among the brothers during their many psychotic episodes, and defense mechanisms employed by the parents and siblings in an effort to manage the profound dysfunction within the family.

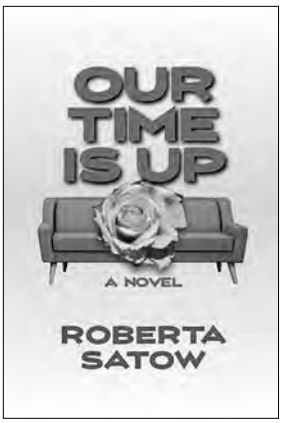
The astonishing fact of Mimi Galvin giving birth to one child after another until the 12th child was born is discussed at length. Don Galvin had a career in the Navy during much of the marriage and he was often separated from the family, only coming home – as someone in the book quipped – long enough to impregnate Mimi before he left again. Kolker describes each family member with great empathy, humility and insight. On the one hand, he pulls no punches with his vivid descriptions of the individual and family psychopathology and yet, on the other hand, he is able to see how each family member is always trying "to do the best they can" given the circumstances of each of their lives.

"Hidden Valley Road" also takes the reader through the history of the development of the psychopharmacology of schizophrenia from chlorpromazine to clozapine, and everything in between. Kolker describes the forces at play within Big Pharma as companies decide whether research into one or another potential drug will be a worthwhile investment and likely offer enough of a payoff to their bottom line.

The psychopharmacological approach of psychiatry to schizophrenia does not come out looking too promising by the end of the book. Members of the family wonder if and how much their siblings actually benefitted from the medications they received. Two brothers died of probable neuroleptic malignant syndrome and others, now in their 70's, suffer from tardive dyskinesia and other side effects. Medication did not prevent one brother from killing his wife by gunshot and then shooting himself. Another brother seemed only to remain in remission with weekly ECT treatments year after year.

The story of the research, especially acknowledging the contributions of Lynn DeLisi, was particularly well done and compelling. Kolker does an excellent job describing the research paradigms in some detail, providing descriptions of DNA abnormalities that affect specific neurotransmitter systems at a level that a knowledgeable psychiatrist can follow, and yet not delving so deeply into the weeds that the non-psychiatric reader will be turned off.

There is a reason that journalist Robert Kolker's "Hidden Valley Road: Inside the Mind of an American Family" was selected for Oprah's 2020 Book Club, was listed as one of the 20 best books of 2020 by the New York Times Book Review, and was a New York Times Bestseller. I can highly recommend "Hidden Valley Road" to our readers. There is also an IMDb 2024 TV Miniseries "Six Schizophrenic Brothers" that Dr. Weinberger told me is "pretty good".




## *Our Time is Up*
By Roberta Satow
Reviewed by
Merle Molofsky

In writing her novel, *Our Time is Up*, Roberta Satow has created a fusion of fiction and memoir well worth reading. The title itself of course is a familiar phrase, practically a joke, a punch line, indicating that a psychoanalyst is informing an analysand that indeed it is time to end the current analytic session. Roberta Satow herself is an accomplished psychoanalyst, which means she herself was in a long-standing psychoanalysis with her psychoanalyst. At the end of the book, on the Acknowledgments page, she writes, "Most of all, I would not be the person I am without my analyst, the late Joan Klein". The book indeed could be read as a tribute to Satow's psychoanalyst, and the title could be understood as a sad sigh, that their time together indeed is irrevocably up.

The novel is divided into three sections, following a Prologue: Part I, Meeting Joan (pp. 3-125); Part II, Meeting Stephen (pp. 129-280); Part III, Endings (pp. 283-358). Each section is dated, and each chapter in each section is dated. Meeting Joan begins January 26, 1967, and ends October 22, 1968, a seemingly short time, less than two years, and an intense, timeless time. The narrator, Rose, begins with her anxiously anticipating her intake interview at Washington Square Consultation Center. Rose meets Joan Wiseman. Indeed, Satow chose to name the interviewing therapist Joan Wiseman, who in some way evokes Satow's actual psychoanalyst, Joan Klein, by her first name, and represents psychoanalytic wisdom by her last name.

The novel is compelling and engaging. The narrative is daring, bold, courageous, and, necessarily, delightfully character-driven. Roberta Satow offers the reader the process of a personal journey of becoming a psychoanalyst. What does that process entail? Each psychoanalyst's journey is unique, befitting the very nature of psychoanalysis, and yet each unique journey shares something in common with every other psychoanalytic journey – it is deeply personal. Thus, Satow's novel has an aspect of a memoir, perhaps drawing on actual memories of her own journey. Rose, the narrator, describes her own personal issues, her own psychoanalysis, her feelings about, and relationship with, her psychoanalyst, and, ultimately, while working with her supervisor, the process of conducting psychoanalysis with people referred to her while she was attending a psychoanalytic institute.

Those personal issues unfold as Satow describes analytic sessions.

As a fiction writer myself, I am fascinated with fiction writers' choices of names. Rose. Would a Rose by any other name smell as sweet? Is Rose afraid that she doesn't smell sweet, that she may be disgusting?

Rose says, "I want to see you three times a week" (p. 3). We learn Rose's presenting problem, framed in psychoanalytic jargon as she amiably shares the desperate situation that brings her to therapy: "My presenting problem… is that I'm the only college graduate who's still a virgin in the city of New York, or maybe the whole country" (p. 3).

An auspicious beginning! We know this will be quite a convoluted, necessary journey. Satow is a convincing writer. And she sure knows her material.

Her material. Professional ambition. Rose teaches, first in a Yeshiva, then at Brooklyn College. Meanwhile, her "other" material is loaded. Being Jewish. Transferential feelings! What will her immediately beloved, admirable Joan think of Rose? Sexual feelings, sexual desire. Shame. Shame regarding her bodily functions. Will this Rose smell like roses, or will she smell like piss or shit? "Asking to use her bathroom was embarrassing, as if urinating, or certainly defecating, would disgust her" (p. 75). She wants to hide a run in her stocking, and Joan offers an interpretation: "I think this is about masturbating, not the run in your stocking. Don't you?" (p. 78). Joan further addresses a fraught issue for Rose, saying, "I think you're afraid that nothing's wrong with you and both you and your mother are sexual women. But I wonder what it is about that that frightens you?" (p. 79). Along comes the inevitable: "Our time is up. We're going to have to stop for now" (p. 79).

The transference further heats up as Rose experiences competitive feelings involving the other analysands she sees coming and going in Joan's waiting room.

ENDINGS indeed is about all sorts of endings, some irrevocably final, including Rose's mother's dementia, where the mother she once knew is no longer present; and, ultimately, the illness and death of Joan.

To encounter the variety of endings, including such sad endings, the reader first gets to encounter a full and vibrant life, the emerging evolution of Rose becoming a psychoanalyst, revealing her striking complexity.

As someone deeply involved with the training Institute of NPAP, where I studied, graduated from, served on the Board, served on the faculty, served as Dean of Training, I couldn't help but be fascinated as Satow describes Rose's experience at that Institute, enrolling at the end of June 1968. She describes a beginning pre-practicum course taught by someone who would become her supervisor, engaging in role-playing as candidates played analysands and analysts, learning through role-play something about what a first session as a therapist would encompass. Issues such as anxiety, boundaries, and silence were discussed.

Transference and competition emerge as a joint theme. Satow describes Rose's concern that as she begins supervision with Anne Shapiro, loving her warmth and admiring her empathic stance, that Joan would feel jealous of the supervisory relationship (p. 117). And then, catastrophe looms. Satow describes the anger and resentment Rose felt at always having to initiate a session, that Joan waited for her to begin. Suddenly, Joan began a session. She told Rose that she would have to stop seeing her for a while, because she was diagnosed with breast cancer and would need an operation. Joan reassured Rose, but the feelings Rose felt were overwhelming, of course (p. 121). Part I: Meeting Joan, segues to Part II, Meeting Stephen.

Rose continues to miss Joan. She continues her involvement with classes at the Institute, and meets Stephen. They date, they are falling in love, and then he has to return to an aspect of his job in another city. "I cried for ten blocks until I reached my apartment, like a little girl whose parents had abandoned her. I had been so lonely without Joan and so filled up by Stephen. Now they were both gone" (p. 133).

As readers we stay close to Rose's intense and complex feelings, and the plot thickens! She begins her clinical work!

And, as we become involved with her involvement with her new status as a clinician working psychodynamically, the plot further thickens. Her mother falls ill with a stroke and is hospitalized. On August 1, 1970, Rose and Stephen get married. These beginnings are intertwined with endings. Rose visits desperately ill Joan every week. The last chapter, "Signs of Life", is two pages long. In a time period of four months, we learn of a major beginning and a major ending.

Beginnings and ending and beginnings and…. We are reading a novel, *Our Time is Up*, that is fiction that reads like a memoir. We are reading a book that is an ouroboros, a dragon swallowing its' own tail, and thereby hangs a tale….

# CONTRIBUTIONS

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