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## New Members

## Front Cover
This is a watercolor portrait of my medical office building, 155 East 61st Street, in Manhattan. Featured in front are our building receptionist, Linda, and our doorman, George. I made color copies for them, the other doctors in the building, and for some of my patients, who found them comforting transitional objects. David V. Forrest, M.D.
Message from the President:
On Mentorship

by César A. Alfonso, M.D.

Illustration (in the public domain) by John Flaxman (1810), of Mentor and Telemachus, from The Odyssey

More than an advisor, a mentor is an agent of change, catalyzing intent, purpose, spirit and passion in a dyadic and joyful process. One of the joys and privileges of membership in the Academy is that it provides opportunities for mentorship. Mentorship can precipitate turning points in professional and personal development. In a recent Issue of the Academy Newsletter I related some of my own formative experiences through mentorship. Similarly, I will make the theme of mentorship the central focus of this Academy Forum “Message from the President” column.

Méntor, the elderly Ithakan and friend of Odysseus/Ulysses, was a parent-like character in the Odyssey, who presented often as Athena/Minerva in disguise, promoting safety, security, and guidance, while imparting counsel, sponsorship and wisdom. Mentor was an avuncular protector and adviser of Odysseus and Penelope’s son, Telemachus. Mentor was left in the position of caring for Telemachus as Odysseus travelled to Troy in search of a diplomatic resolution of conflict amidst a war. Consider this example of a virtuous conversation between Athena/Mentor and Telemachus:

And the Goddess, bright-eyed Athena, spoke first to him, and said: Telemachus, no longer has you need to feel shame, no, not a little bit. For to this end have you sailed over the sea, that you might seek news of your father, - where the earth covered him, and what fate he met.

But come now, go straightway to Nestor, tamer of horses; let us learn what counsel he kept hidden in his breast. And do you ask him yourself that he may tell you the very truth. A lie will

continued on page 4
Message from the President (continued from page 3)

he not emit, for he is wise indeed.

Then wise Telemachus answered her: Mentor, how shall I go, and how shall I greet him? I am as yet all unversed in subtle speech, and moreover a young man has shame to question an elder.

Then the Goddess, bright-eyed Athena, answered him: -Telemaechus, somewhat you will of yourself devise in your breast, and somewhat heaven too will prompt you. For, it seems to me, not without the favor of the Gods, have you been born and brought up.

The historicity of the use of the term mentor is subject to debate. In eighteenth century Europe usage of the word mentor, synonymous to trusted elderly friend, teacher, counsellor and adviser, became popular after the publication during the Age of Enlightenment of François Fenelon’s Les Aventures de Télémaque (1699). In this novel, Mentor denounces war, libidinal excesses, egocentrism, and promotes sacrifice towards social justice. Through the character of Mentor, Fenelon evokes the classical ideals of democracy, simplicity and equality. Les Aventures de Télémaque became a European best seller (also known to be among Thomas Jefferson’s most cherished books). The book ends with Mentor disappearing by rising into the air; enveloped in glory (“d’un nuage d’or et d’azur”), as the wise at last Télémaque himself reaches Ithaca.

Les Aventures de Télémaque provided inspiration for the plot of Idomeneo, Mozart’s first operatic masterpiece, which premiered in 1781, two days before Mozart’s 25th birthday, where the character of Mentor is called Arbace. Consider the following arias:

Arbace:
Oh, temerario Arbace!
Dove trascorri? Ah, genitor, perdona:
Eccomi a’ piedi tuoi; scusa i trasporti
D’un insano dolor. Tutto il mio sangue
Si versi pur, non me ne lagno; e invece
Di chiamarla tiranna,
Io bacio quella man che mi condanna.

Artabano:
Basta, sorgi; purtoppo
Hai ragion di lagnarti;
Ma sappi . . . (Oh Dio!) Prendi un abbraccio.

Arbace:
Per quel paterno ampioless,
Per questo estremo addio,
Conservami te stesso,
Placami l’idol mio,
Difendimi il mio re.

To listen to Kiri Te Kanawa’s performance of this aria, visit: http://www.youtube.com/watch?v=ahJ_SvzwJTU

Idomeneo:
Peace returns to my heart, and my ardor is reborn;
Youth flourishes in me.
Thus spring makes the ancient tree bloom, and gives it new vigor.

To listen to Richard Lewis’ performance of this aria, visit: http://www.youtube.com/watch?v=mNe9HPDBAQ

If we deflect from a Eurocentric perspective, consider, for instance, the work of Yasuhiko Taketomo, who in 1989 reflected on his admiration and reverence toward magnificent teachers, coining the term the “teacher’s transference” as a positive pre-conscious transference observed in transcultural analyses and student-teacher interactions.

In Buddhist cultures, the mentor-disciple dyad is embodied symbolically in the Bodhisattvas, messengers of compassion who assist with social and spiritual turmoil. In Buddhism, the genuine desire of a mentor is to be surpassed by his or her disciples. In Buddhism mentoring is about facilitating self-discovery rather than following by imitation.

The Vedas and Upanishads in Hinduism seldom mention mentors or gurus as prominent figures. Gurus do not transmit spiritual knowledge, but rather have the duty of being initiators, leaving the young alone after spiritual initiation, encouraging the struggle to seek revelation and enlightenment thereafter on their own.

Taoists emphasize that since individuals are intrinsically different, mentors must carefully mold content and form of guidance based on the individual’s needs. Therefore, Taoists warn against adhering to rigid pedagogical precepts or formulas in master-student dyads. Taoists find great merit in subtle encouragement.

An Academy Charter Member, Marianne Eckardt, once asserted: “I do not have great confidence that abstract conceptualizations assure our road to wisdom. Knowledge in our field requires experience.” (Presidential Address, presented at the 18th Annual Meeting of the American Academy of Psychoanalysis, Honolulu, Hawaii, May 1973). In May 2011 we will travel to Honolulu, 38 years after these words of wisdom were uttered, to honor Marianne Eckardt for being our guiding light and mentor of mentors.

The Hawaii 2011-55th Academy meeting promises to be spectacular in every sense, after immeasurable efforts under the leadership of Joe Silvio and Eugenio Rothe, and program committee members Raúl Condemarin, Mary Ann Cohen, Mariam Cohen, David Mintz, Eugene Kim and Silvia Olarte, with support from Jackie Coleman and Jacqui Davis. The Scientific Program and Continuing Medical Education Committees have made an effort, by adding emphasis on workshops and small group modalities, to continue provide a forum for the development, communication and discussion of ideas, concepts and research in psychoanalysis and dynamic psychiatry.

Kim Best, as Chair of the Education Committee, and committee members Eugene Beresin, Deborah Cabaniss, Jennifer Downey, Debra Katz, David Mintz, Charmaine Rapaport, Eugenio Rothe, and Scott Schwartz, have been charged with the task of devising and implementing a mentorship program for medical students, psychiatric residents, analytic candidates, and early career psychiatrists who are Academy members. At the time of this writing there are 92 Academy members in these categories that would qualify for formal and informal mentorship. It is encouraging to know that this group of younger colleagues with interest in psychoanalysis and dynamic psychiatry constitutes a substantial part of our roster. I hope you will join in the development and implementation of a mentorship program, to help our younger colleagues experience the Academy as a place for personal and professional development. In the words of Mohandas Gandhi: “Be the change you want to see...”
The Academy last held its annual meeting in Hawaii in 1973. Since then it has undergone many changes that will be reflected in the program for Hawaii 2011. The theme for this meeting, *Psychodynamic Approaches to Treatment Resistance and Therapeutic Obstacles*, echoes the expansion of our membership to include psychodynamic psychiatrists as voting members and Fellows, and our name change to the American Academy of Psychoanalysis and Dynamic Psychiatry. It also reflects our stronger affiliation with the American Psychiatric Association and our efforts to promote greater training of psychodynamic psychotherapy for psychiatry residents and early career psychiatrists.

I am especially excited about this upcoming meeting because Dr. Marianne Eckardt, who was President of the Academy 32 years ago when it last met in Hawaii, is my Honorary Co-Chair and because the Planning Committee has developed a new experimental format for the program. Members of the Planning Committee, Drs. Mariam Cohen, Mary Ann Cohen, Raul Condemarin, David Mintz, Eugenio Rothe (Chair of the Committee on Programs), César Alfonso (President of the Academy), and myself (Program Chair), reviewed the evaluations and comments by attendees of past meetings and focused on suggestions to have greater participant involvement in workshop formats and more scholarly presentations with clinical relevance.

The new program format will shorten the meeting by eliminating the Sunday morning sessions, as was done for the New Orleans meeting to contain costs, and will offer the traditional two tracks of three hour panels in both morning and afternoon sessions and a different format for the Saturday program. Saturday will begin with a single morning session featuring two distinguished plenary speakers who will each present for 45 minutes and then interact with the audience for 30 minutes. The first plenary speaker will be Dr. Eric Plakun, Director of Admissions for the Austen Riggs Center and an esteemed member of the Academy who has been writing about psychodynamic approaches to treatment resistance for many years. The second plenary speaker will be Dr. Efrain Bleiberg of the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine, a recognized authority on the treatment of complex psychopathology in children and adolescents.

The afternoon program will offer two sessions of 1 ½ hour workshops focused on specific topics pertinent to the theme of the meeting. We hope that this new format will be attractive to psychiatrists interested in learning more about psychodynamics who are coming to the APA meeting that begins Saturday evening, May 14. We are also excited about our other invited speakers! Dr. John McDermott of the University of Hawaii, a leader in child and adolescent psychiatry, will be our Opening Night Speaker and Dr. Carol Bernstein of NYU School of Medicine and current President of the APA, will be our Keynote Speaker. To have all of this in the unbelievably beautiful setting of Hawaii is an irresistible opportunity for Academy members! I hope to see each of you there.

The 54th Annual Meeting of the AAPDP was held in New Orleans, Louisiana from May 20-22, 2010 on the theme *Trauma, Resilience and Psychodynamic Psychiatry*. As we all know, New Orleans was tragically affected by Hurricane Katrina that struck the Gulf Coast of the United States in August 2005. More than a million people were initially displaced from their primary residence resulting in multiple challenges that included physical injuries, impoverished living conditions, and significant mental health distress. Opening night speaker Howard Osofsky, MD, PhD, Chair of the department of Psychiatry at Louisiana State University, mesmerized us with narratives and photographs of survivors. Dr. Osofsky is recognized as a leader for his efforts to help children and families exposed to violence, terrorism and welfare. Along with Joy Osofsky, his wife, he has published a large study to examine factors related to the development of PTSD in children and adolescents after Hurricane Katrina.

Trauma continues to be a prominent area of study among
psychoanalysts and dynamic psychiatrists. In this meeting we learned that, overall, trauma affects patterns of psychological life and throws relational systems into disorganization. There are, however, protective factors that can improve treatment outcomes in our patients and this is the concept of resilience. Meeting co-chairs, Raul Condemarin and David Lopez, and the Chair of the Scientific Program Committee, Eugene Rothe, were gratified with the final result of the program. Other members of the planning committee included Silvia Olarte, Matthew Tolchin, Debbie Katz, Nisba Hussein and Tim Lacey.

A productive dialogue between psychoanalysis and neuroscience culminated in a panel under the direction of Matthew Tolchin and included Ralph Wharton, Mary Ann Cohen and Tor Wager. These presenters described a neuro-relational framework for interdisciplinary practice, a representational framework for dynamic phenomena, and long-term schemes to help manage suffering including pain and AIDS.

It is well known that childhood maltreatment is a risk factor for adverse influences in the infant development and alters the developmental capacity of the self. Debbie Katz and Nisba Husain organized a Child Psychiatry panel that included Charles Zeanah, Martin Drell and Joy Osofsky. Charles Zeanah is Director of the Child and Adolescent Psychiatry program at Tulane University and his academic interests and research include disturbances and disorders of attachment and PTSD symptomatology in young children. Dr. Zeanah has published widely on attachment disturbances in Romanian children. Joy Osofsky recently published a study in PTSD in children after Hurricane Katrina. Our star discussant for this panel was Claire Kestenbaum.

Richard Friedman, incoming Editor of the Academy Journal, gave us an innovative overview of the field of Psychodynamic Psychiatry. He believes that this area of study and discipline is one of the best experiences I have had as a psychodynamic educator.

I had the honor of being the AAPDP Teichner Scholar both in 2009 and 2010. In 2009, I traveled to the Department of Psychiatry at Vanderbilt University in Nashville, Tennessee, and this year, 2010, I visited the UCLA/Kern program in Bakersfield, California. At each program, I was greeted with open arms by enthusiastic residents and wonderful faculty members who were eager to learn. I approached these visits as one facet of an ongoing relationship with a department which has the overall goal of improving psychodynamic teaching.

The relationship begins months before the visit. First in e-mails and telephone calls, the training director and I begin the “consultation,” thinking about what the program needs and how to structure the visit. Each visit was an admixture of direct teaching of residents, faculty development workshops, and curriculum consultation, designed to instill enthusiasm for psychodynamics and to “kick-off” new curriculum initiatives that were to continue long after my plane took off to return to New York City. Built-in social time (picnics, lunches, dinners etc.) allowed faculty and residents to get to know me and facilitated alliance building as we worked together to try new things.

The two training directors I worked with – Jeff Stovall at Vanderbilt and Tai Yoo at UCLA/Kern – are visionaries who know that psychodynamic education is vital for psychiatrists, no matter their specialty area. They both gave me a wide berth, clearing whole afternoons for residents to have seminars, bringing faculty together for grand rounds and teaching workshops, and inviting key educators to strategy meetings designed to rethink psychotherapy teaching in the department.
For me, though, the most exciting thing was discovering the untapped potentials of the departments. Both programs were filled with smart, enthusiastic educators who did much more psychodynamic psychotherapy teaching than they thought that they were doing. My message in both places was clear: you can teach psychodynamics ANYWHERE with ANY PATIENT. In the ER, on the CL service, on an inpatient unit – any interaction with a patient can facilitate the teaching of psychodynamics. Interviewing a patient with a resident? Time to talk about unconscious motivations. Beginning to work with a recently hospitalized patient? Time to talk about setting the frame. Doing an intake in the ER? How about discussing the assessment of ego function? You get the idea. Over a few days, faculty members who initially said that they were sure that they didn’t have the skills to teach psychodynamics realized that this was exactly what they were doing.

Simultaneously, after discussions about an integrated model of psychodynamics that includes both uncovering and supporting interventions, residents who were sure that they had NEVER conducted psychodynamic psychotherapy began to suspect that, in fact, they had been doing just that all along. Rather than showing them that I knew something that they did not know, I hope that I empowered them to think that they had skills and potentials that they had not been acknowledging. I left both groups working on curriculum task forces to reshape their psychodynamic teaching with newfound confidence in the resources right in their own departments.

I was overwhelmed by the receptions I received at both teaching institutions. At Vanderbilt, after a four hour seminar with all of the residents, I was treated to dinner with key faculty and the chairman of the department. In Bakersfield, CA the first evening was capped by a department-wide picnic at a local park, replete with several varieties of barbeque. At both programs I did one marathon seminar for all the residents, followed by individual seminars for each resident year. At Vanderbilt I did a workshop for all of the psychoanalytic supervisors (and there were quite a few!) which brought them together for the first time in many years. In Bakersfield, I gave Grand Rounds, conducted ER, CL and inpatient rounds, and discussed the use of video in psychodynamic teaching.

Thanks to Debra Katz, Vice Chair for Education at the University of Kentucky and host of the first Teichner Scholar, Jennifer Downey, I sent pre- and post-visit surveys to the faculty and residents at each program. In both cases, interest in psychodynamics and psychodynamic psychotherapy went up after the visit. My guess is that the reason for this was that something about the visit made them less afraid of psychodynamic psychotherapy. For the faculty, they were less afraid that they were not competent to teach it; for the residents, they were less afraid that they were not competent to conduct it.

Dr. Volney Gay, a training analyst at the St. Louis Psychoanalytic Institute, subsequently became the Director of Psychotherapy Training in the Department of Psychiatry at Vanderbilt. In Bakersfield, a Task Force on Psychotherapy Teaching is actively at work to transform both classroom teaching and supervision – and I am cc’d on all of their e-mails. I co-authored a paper with the Vanderbilt Chief Resident on The Role of the Psychotherapy Chief Resident published in Academic Psychiatry and I am putting together a panel for AAPDPT that will bring together the Teichner Scholar leadership (Sherry Katz-Bearnot and Eugene Beresin) with all of the host program directors and the two Teichner scholars.

I hope that my work with these programs has left them excited about psychodynamic psychotherapy and has helped them to discover the skills they need to keep this excitement alive with ongoing teaching and learning. My visits introduced me to new colleagues with whom I am likely to have continued contact over the years. I now have a better idea about how psychodynamics is conceptualized in different parts of the country by faculty and residents from a wide range of backgrounds. My Teichner visits have sharpened my sense of the kind of teaching that can foster the conviction that psychodynamics will help psychiatrists with whatever kind of work they do - and that it can be taught in ANY setting. Sherry, your inspiration and hard work have turned your dream into an incredible reality! I feel fortunate and proud to be part of this remarkable program of the AAPDP.
A Brief History of Psychoanalysis in China

by Elise Snyder, M.D.

Most Americans are surprised to learn about the intense interest in psychoanalysis in China. In October of 2009 a group of 25 psychoanalysts and psychoanalytic psychotherapists led by Elise Snyder, the president of the China American Psychoanalytic Alliance (CAPA) and Cesar Alfonso, President of the Academy, visited China: 5 cities in 20 days. We followed Freud's 1921 suggestion to Zhang Shizao, translator of An Autobiographical Study and an important dissident intellectual, who received the following letter from Freud:

"Most esteemed Professor,

I am pleased by your intention, in whatever manner you care to carry it out…(to) introduce psychoanalysis to your native country, China.

Very respectfully,

Yours Freud"

Thus, Chinese interest in psychoanalysis has a ninety year history. In the teens and the twenties of the last century, many psychoanalytic books were translated. In 1921, the Chinese Psychological Society (only the seventh established in the world) was organized. In 1932, Dr. Richard S. Lyman, a graduate of Johns Hopkins University, became professor of Psychiatry and Neurology at Peking Union Medical College Hospital. He included what was probably the first course in psychoanalysis in a medical school curriculum anywhere in the world. By the mid-1930s Freudian theories were familiar not only to Chinese intellectuals but also to a broad sector of the Chinese population. Bottles of cough syrup with Freud’s picture on them were sold everywhere.

There is something very congenial about psychoanalysis to the Chinese. Psychoanalytic theory maps surprisingly well onto aspects of Buddhism and Confucianism. There is an enormous literature both in America and in China about Buddhism and Psychoanalysis. Many CAPA students are Buddhists.

The Japanese invasion ended work and interest in psychoanalysis and later, after the Revolution, psychotherapy and psychoanalysis were disparaged. During the Cultural Revolutions (1966-1976) all schools (middle schools to universities) were closed. Two generations of teachers and clinicians were lost. Since the “Opening Up,” interest in psychiatry, psychotherapy and psychoanalysis has revived and increased exponentially. The huge increase in the size of the middle class, the enormous migration from rural to urban areas, smaller families, greater intensity and expectations from personal relationships, and changes in mores, all contribute to a growing interest, awareness and need for psychoanalytic psychotherapy. Recently a high government official stated that because of the increase in stress-related anxiety and depression in urban areas, too many people are treated with medication by their local physicians when what they need is psychotherapy.

I first visited China as a tourist in the early '80s. In 2001 I was invited to give two papers in Beijing. I searched among colleagues and on the Internet to find anyone in China interested in psychoanalysis. I found a group in Chengdu (the capital of Sichuan) where the government had given the university (a major Chinese university), and a man who had some Lacanian training in Paris, permission to teach a non-clinical graduate program in psychoanalysis. The group invited me to give a number of lectures. One of these was a public lecture with about 100 attendees: professors, bankers, housewives, truckers, businessmen etc. On my first day, a graduate student asked to speak to me privately. He described his problems (amazingly the ones of the graduate students I was treating at Yale) and finished by saying “I need an analysis.” I was in total accord and said, “Yes you do, but this is China. There are no analysts here.” Two years later when I saw him again he said, “What about Skype?” I said, “What is Skype?” and thus CAPA was born. Since then, I have returned to China for a month at a time once or twice a year. Other CAPA people have also visited: teaching, meeting their patients, and supervising.

CAPA in China

By 2005 many mental health professionals were in analysis, psychotherapy and supervision. There were increasing numbers of requests for some kind of organized systematic training. Other groups of analysts were teaching in China: mainly small groups of analysts would come to China for a week once or twice a year. All their teaching was done in English although many of the teachers were not native speakers and spoke with accents. (It is difficult enough for the Chinese to understand unaccented English). They often used as translators people who are now taking our training who had no knowledge of psychoanalysis and whose English is quite imperfect.

In 2006, CAPA was incorporated as a non-profit organization. There are almost 300 CAPA members: psychoanalysts, psychoanalytic psychotherapists, North Americans, Europeans, Australians, and Middle Easterners. They are members of APsaA, AAPDP, Freudian Society, IPA, WAW, Division 39, IPTAR and IARPP. As far as we know, CAPA is the only program in China with weekly systematic training and weekly individual supervision. At present there are 43 people in 3-5 session/week psychoanalysis and 34 in 1-2 session/week psychotherapy all via Skype, the ONLY secure audiovisual protocol. Our program is registered with the Chinese Psychological Association and is, as far as we know, the only such foreign program.

At present there are four first year classes and four second year classes with 10-12 students in each. The students come from 10 different cities. More than 100 people have applied for the September 2010 class of which—after 2 interviews each—only 50 were accepted. We also have a two year child program for our graduates and, beginning in September 2011, we will have a two year advanced psychotherapy training program. Classes are taught on Skype, Webex and Oovoo in English. The program entails:

• Three classes per week for 30 weeks
• Theory Class 1 hour 15 minutes/week
• Technique Class 1 hour 15 minutes/week
• Continuous Case Seminar 1 hour 15 minute/week
• Individual Supervision 45 minutes/week
• 4-7 days /year face-to face teaching
• Certificate on graduation
• All students receive membership in PEPWeb

Next year we will have a course in Supervision for our senior students many of who are already professors and chairpersons of departments of psychology and psychiatry. Soon they will be co-teaching our courses.

CAPA’s goal is to train the leaders and teachers of tomorrow. Please contact elise.snyder@yale.edu to find out you too can be part of this bold, exciting, important, trans-cultural adventure as a therapist, supervisor or teacher.

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12th Joint Meeting with OPIFER
by Joan Tolchin, M.D.

The Academy held its successful Twelfth Joint Meeting with the Organizzazione di Psicoanalisti Italiani Federazione e Registro (OPIFER) at the historic and beautiful Palazzo Ducale, in Genoa, October 16-17, 2010. The theme of the meeting was Trauma and Identity: In the Footsteps of Silvano Arieti, continuing the topic of trauma which was the focus of the Academy’s May meeting in New Orleans.

The American Keynote Speaker was Dr. Clarice Kestenbaum, a Past President both of the Academy and of the American Academy of Child and Adolescent Psychiatry. Her excellent presentation, Secure Attachment and Traumatic Life Events, explored secure attachment as a protective factor in dealing with trauma. The Italian Keynote Speaker was Dr. Pietro Andujar, President of OPIFER, who spoke on Trauma and the Disintegration of Identity, describing his innovative work with challenging patients.

Academy Fellow Dr. Marco Bacciagaluppi, Founder and Past President of OPIFER, reviewed the topic of trauma in his presentation, The History of the Study of Psychic Trauma. Stimulating case studies were contributed by Academy Trustee Dr. Erminia Scarcella, and by Past President Dr. Matthew Tolchin. Dr. Richard Brockman presented a moving, personal paper, Trauma and Identity: A Psychological Autopsy.

The discussions of the presentations and the warm camaraderie of the audience continue to be a highlight of our joint meetings. Academy members will be kept informed as soon as we have more information about the Thirteenth Joint Meeting with OPIFER.

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18th Annual CPR Conference with Phil Lebovitz, M.D.
by Gerald P. Perman, M.D. and Sheila Hafter Gray, M.D., Meeting Co-Chairs

The 18th annual meeting of the Consortium for Psychoanalytic Research (CPR) will take place in Washington, DC on Sunday, February 27th, 2011. You will receive inexpensive CME credits, a continental breakfast and a good box lunch! The February CPR conference is the de facto winter meeting of the Academy. The CPR is the ONLY organization of its kind in the US and is composed of organizations of psychoanalysts and psychodynamic clinicians of all theoretical orientations from classical through Jungian to relational.

At this year’s conference, Phil Lebovitz, M.D. will describe research that he and clinicians at the Chicago Institute for Psychoanalysis have been pursuing over the last 30 years to assess the outcome of psychoanalytic treatment and to identify technical factors that account for the observed changes. Their primary methodology is a set of follow-up interviews of both the patient and the analyst two or more years after completion of psychoanalytic treatment. Early in their work they found that a psychodynamic developmental perspective was particularly useful to identify factors that postdicted outcome. Dr. Lebovitz will show how their findings can inform treatment paradigms and can be used to guide clinicians toward more effective interventions both in psychoanalysis and in other dynamic psychotherapies. This framework also provides a means of articulating which areas showed change and what issues were inadequately engaged, resulting in inadequate or compromised change.

Participants will use a rating scale developed for this study to evaluate clinical material. Members of the audience will then engage in an interactive discussion with Dr. Lebovitz to learn more about his method of evaluating change. Special attention will be focused on the concepts of defense transference, cycling and the development of a self-analytic function. Participants will be encouraged to adapt these ideas to their own clinical work, to refine their interventions and enhance their ability to
Contact with Japan - A Reprise

The upcoming Academy meetings in Hawaii, May 2011 will be the second time that the Academy has chosen this venue for our meetings. The first time we met in Hawaii was in May 1973. A post meeting trip to Japan, in which several Academy members participated, was also part of this meeting. This was an historic cutting edge occasion, since it was the first time that Western psychoanalysts met with their Japanese counterparts. What follows is an account of that trip, written by Leon Salzman and published in the Academy Forum, summer issue in 1973.

Post Honolulu Meeting In Japan

Following the meeting of the American Psychiatric Association in Honolulu, the American Academy of Psychoanalysis held a joint meeting with the Japanese Psychoanalytic Society on May 13th and 14th, 1973 at the Hotel New Otani in Tokyo. This joint meeting was well attended by a group of 25 Americans and an equal number of Japanese psychiatrists and psychoanalysts. The program, published in an earlier edition of The Academy, stimulated much discussion by our colleagues.

One recurrent issue was the marked effect of cultural differences on the theories and practices of psychiatry and psychotherapy in the United States and Japan. The publication, now under preparation, of the papers presented at the Joint Meeting, and the cooperation between the Academy fellowship and our Japanese Colleagues growing out of the Joint Meeting, are expected to help us toward a deeper understanding of these transcultural issues. In particular, it became clear to me that concepts that were acceptable in the United States, such as the issues with regard to homosexuality, were of little concern to Japanese psychiatrists since homosexuality is more culturally accepted and rarely becomes a psychiatric problem.

Morita therapy is a unique kind of psychotherapy utilized in Japan for some neurotic problems, namely obsession, depression and hypochondriasis. It was originated by Dr. Shoma Morita in about 1920 and is carried out in approximately 10 Moritist hospitals in Japan.

A most interesting occasion for our group was a visit to a hospital where Morita therapy was utilized, the Sansei Hospital in Kyoto, the Director of which is Dr. Momoshige Miura, the son of the founder of the hospital. We spent a few hours with the Director in viewing the whole hospital and outlining the concepts of Morita therapy. This hospital has 50 patients of which two-thirds were male, and the diagnostic categories were largely in the area of obsessional disorders. The patients remained from 40 to 70 days and have a recovery rate of about 80%.

The treatment program is significantly designed for obsessional patients since the focus of Morita therapy is presently the opposite of what is in traditional psychoanalytic therapy. It is an attempt to refocus the individual’s attention from inside to the outside. In this way the obsessional circle is broken and spontaneous behavior is permitted to evolve. In summary, therapy consists of 4 stages. The first stage is that of absolute bed rest and the patient is prevented from doing anything for a period of from 4 to 7 days. He is not allowed to do anything except to eat and to go to the toilet. In the second stage, which runs from 3 to 7 days, he is permitted to do light work, to attend lectures, write in his diary and to talk and associate with others. For each of these stages there is a series of instructions and directions that the patient must follow precisely. Mild work is allowed but the focus is on performing only realistic tasks. The patient is allowed to converse with the therapist but not about his problems. During the third stage (from 7 to 20 days) there is an increase of the work habits and the individual takes on more activities and chores around the hospital. Finally, in the 4th period the complicated, practical life issues are stressed through particular projects and the patient gradually moves out of the hospital.

The Morita therapy achieves its goal when the patient spontaneously concentrates on the realities of his daily life and moves away from obsessional preoccupations with his difficulties and problems. This point of view is typically Eastern and is very closely related to Zen and the whole concept of the involvements in reality and the focus away from internal preoccupations. That it is effective in some instances is certain. However, it appears to work mostly in the milder obsessional states since we saw nobody at the hospital who had severe rituals or who was severely ill. Unlike psychoanalysis or insight therapy, the patient is discouraged from exploring the historical or psychological roots of his illness. There is no dream interpretation, free association, or symbolic interpretation of any kind. The patient is encouraged to accept to accept himself as “he is” rather than what he “should be.”

On the last evening in Japan, Leah Davidson, Charlotte Bruskin and myself met with a group of young residents and
students who are interested in psychotherapy and we had a most interesting dialogue with the group. The thing which impressed me most was the recognition that our traditional way of explaining the Japanese character was far less meaningful than the observation that the Japanese character can be understood by its intense need for homogeneity and non-uniqueness. Any heterogeneous individualistic or idiosyncratic behavior or idea is avoided and looked upon with considerable guilt and shame. This makes great difficulty in the traditional practice of psychotherapy since the psychotherapist, as the pointed out, couldn’t tell a patient that his behavior is unsatisfactory or unpleasant because this would threaten his own (therapist’s) acceptability. Consequently, the whole group agreed that they could not do psychotherapy in the manner that we do it here because none of them could tell a patient or present to a patient some of the negative aspects of his personality or his living. However, they indicated that this situation is changing with the impact of Western culture and the recognition by some of the younger psychologists and psychotherapists that Freud’s views have some validity and can be applied to the Japanese character structure. The group also confirmed what we had heard earlier that homosexuality as a problem does not exist in Japan as it is culturally acceptable and part of the arts and not looked upon as a distorted way of living.

The trip was extremely interesting. Japan is a fascinating country and while this report deals specifically with the psychiatric aspects of our visit, one could go into raptures about the beautiful wooded country with its clean and colorful mountainsides, the Zen rock gardens, or the more elaborate clean-shaven moss gardens, magnificently tailored and thoroughly interesting.

Group meetings were held regularly during the trip and conferences and papers were delivered in Tokyo, Kyoto and Hong Kong. The group had scientific discussions and the papers were presented by various members of the group on these occasions. A program of these events is available.

In addition to being a most enjoyable sightseeing visit, it was a scientifically and culturally stimulating occasion for the members of the Academy who attended. Except for a weak dollar and a strong yen and a heavy schedule of walking, sightseeing and a biological rhythm that required several days to be reestablished, there was unanimous enthusiasm about the trip and an eagerness to begin organizing further Academy functions overseas.

A Commemoration of Alice Miller

by Marco Bacciagaluppi, M.D.

I was writing a review of Alice Miller’s last book, Free from Lies (Norton, New York & London 2009) when I discovered on the Internet that she had died a few days previously, on April 12, 2010. Thus my review became a commemoration.

Born in Poland on January 12, 1923, Alice Miller became Swiss after World War II and published all of her books in German. A psychoanalyst, she received a classical Freudian training. Since her first book, The Drama of the Gifted Child (Faber & Faber, London & Boston 1983; original German edition 1979) her main concern had been childhood trauma. At the time, this received the customary disapproval on the part of the orthodox Freudian establishment, which led to her resigning from the IPA in 1988. In her subsequent books she became radically critical of psychoanalysis and no longer wished to be defined as a psychoanalyst. Predictably, a circular process set in: if she ignored psychoanalysts, including the non-orthodox, psychoanalysts ignored her. As in the case of Fromm, her excommunication took the form of a wall of silence. Miller responded by pursuing her solitary road with a number of other books, 13 in all. She relied on a public of staunch readers with whom she kept in contact through her website (www.alice-miller.com).

In addition to childhood trauma (abuse and neglect) in general, she was constantly concerned about how the body develops psychosomatic symptoms unless that trauma is addressed emotionally and not just intellectually. Her most explicit book in this connection was The Body Never Lies (Norton, New York & London 2006; original German edition 2004).

Destructiveness to others is another consequence of the denial of trauma. On p. 50 of her last book she writes: “All the childhood biographies of dictators and serial killers that I have studied show them, without exception, to have been victims of extreme cruelty, although they themselves steadfastly deny this.” This destructiveness is not innate but is the result of early relational experience. Later it is expressed in the search for scapegoats. Miller describes this situation repeatedly in the case of Hitler. She dealt with him in For Your Own Good (Faber & Faber London & Boston, 1983; original German edition 1980), in Banished Knowledge (Virago Press, London 1991; original German edition 1988), in The Untouched Key (Virago Press, London 1990; original German edition 1988) and finally in her last book, Free From Lies.

I find Miller’s work admirable. It may be viewed as an expression of the primordial matriarchal culture, characterized by a caregiving approach to children. A predatory patriarchal culture was superimposed on matriarchy 4-5 thousand years ago. In order to perpetuate itself, this patriarchal culture has subjected children to violent socialization in every generation.

Miller’s limitation was her isolation that prevented her from having contacts with other authors and that she would have found congenial. When she speaks of “real experiences” in childhood, the obvious reference is to Bowlby’s concept of “real-life events.” When, in discussing destructiveness, she says that what one suffers at the hands of someone stronger is then inflicted on someone weaker, she is describing the authoritarian personality. This was the title of the famous study by Adorno and co-workers (Adorno T.W. et al., The Authoritarian Personality, Norton, New York 1950) that was the outcome of years of research by the Frankfurt school of critical sociology to which
Fromm made important contributions. Fromm himself made use of this concept in his first book, *Escape from Freedom* (Farrar & Rinehart, New York & Toronto 1941). In discussing Nazi Germany, on p. 50 of *Free From Lies*, Miller says: “Hitler’s henchmen were victims of their upbringing.” She is saying that Hitler and millions of Germans shared the same character structure. Here, Fromm’s concept of “the social character” is relevant. Finally, after observing the ill effects of violent upbringing, Miller is unable to trace it to its sociocultural roots and that goes beyond the commandment to honor thy father and mother. Here it is also relevant to cite the book by Riane Eisler, *The Chalice and the Blade* (Harper & Row, New York 1987), on the advent of the predatory patriarchal culture, not to mention *Oriental Despotism* by Karl Wittfogel (Yale 1957).

Notwithstanding Miller’s admirable work, the issue of childhood trauma has not yet gained widespread acceptance. When

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**ARTICLES**

### Medical Practice in Cuba

by Jane Simon, M.D.

In 1959, a revolution usurped power from the hands of the dictator Batista, turning Cuba into a communist country under the leadership of Fidel Castro. Once a popular vacation spot for tourists from around the world, after Castro’s rise, travel to Cuba became restricted by the United States’ government, permissible under certain circumstances, like a religious mission.

My father was a communist in the late 1930’s and 1940’s when it was fashionable among many young, idealistic, intellectuals. For many years, I’ve been curious about Castro’s Cuba and eager to travel there. In December, I received an email from The Jewish Museum (in affiliation with the Jewish Theological Seminary) with an invitation to join a group for a visit to the Jewish communities in Cuba in February 2010.

After an overnight stay in Miami, we boarded a charter plane for a 45-minute flight to Havana. Our group numbered 37 people mostly middle aged and all from the United States; coincidentally, seven of us employed in the medical field, including a cardiologist, a pediatrician, a dentist, an ophthalmologist, and 3 psychiatrists (one of whom was myself). We were especially curious to learn about the practice of socialized medicine on this island. At our request, Dr. Alberto Gonzalez, a Cuban physician, was invited to speak with us. For this article, I supplement his information with data obtained from the Internet resource, Wikipedia.

Dr. Gonzalez volunteered to speak to us one evening at our hotel, the Melia Cohiba (under joint Cuban and Spanish management). We bombarded him with questions nonstop for an hour and a half, forced to conclude because the dinner hour had arrived. Otherwise I suspect we would have continued to question him on into the night.

Dr. Gonzalez, a light skinned native in his mid-thirties, neatly groomed in jacket, shirt open at the collar, and a well-trimmed beard, spoke English in a deep voice with a thick accent, adequate to express simple concepts. For subtle details and word finding he deferred to our experienced and well-informed Cuban guide.

Educated in a Cuban medical school, Dr. Gonzalez encountered no barriers from either Cuba or the United States when he decided to enroll for a yearlong fellowship in California to specialize in neuro-ophthalmology. He had no trouble negotiating the “bureaucracy.” He completed an application and obtained letters of recommendation. He chuckled when he told us about the alien experience of having to complete “tax returns.” After a year in San Diego, he returned to Cuba as a super-specialist, and because of his competency, personality, and specialized training he was appointed to the head of the ophthalmology department. Someone in our group asked if he was a member of the Communist party and he answered in the negative. We were surprised to hear about Dr. Gonzalez’s professional success in spite of his lack of involvement in party politics.

**The Three-Tier System**

Dr. Gonzalez explained the three-tier system of medical care: general practice and family medicine comprise the first or primary level. Hospital care constitutes the second tier. Specialists and Researchers classify as the third tier. The specialists are designated to order diagnostic tests like MRI’s.

The government encourages three specialties, gynecology, internal medicine and anesthesiology, for which there is greatest need by making these residences easier to obtain. Specialists are paid at a slightly higher salary than general practitioners. (See below for more information).

Cuban medical practice has several remarkable features. Medical care is free and available to all; medication is provided at a low cost, and free to those who can’t afford it.

Medical education may be acquired by anyone who applies to become a physician and passes the entrance exam. Fourteen medical schools provide free education to medical students around the world. A statistic from 2004 states that 90 U.S. medical students were enrolled in the Cuban educational system.

Physicians are educated and produced in abundance, which

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in May 2009 I opened a discussion on trauma in my Italian association, OPIFER, there was just one (literally) response from the audience. This confirms what Judith Herman (*Trauma and Recovery*, Basic Books, New York 1992) states: “The study of psychological trauma has a curious history – one of episodic amnesia.” It is therefore gratifying that trauma should be the theme of the 2010 AAPDP Annual Meeting, as well as of the 2010 AAPDP/OPIFER Joint Meeting.

One last word on Miller’s approach to death. On p. 41 of *Free From Lies*, written when she was 84 in connection with “the process of aging and the increasing frailty of the body,” she wrote: “even then I will know that I have lived my own, true life.” She proved true to her word and, in February 2010 at 87, she gave an interview that was published on her website. Alice Miller was vital and active to the end.
allows their emigration to serve other countries without causing a hardship in their own country. Many Cuban physicians were already working in Haiti at the time the earthquake struck. More came in response to the need.

Dr. Gonzalez participated in a campaign inviting people blinded by cataracts from around the world (especially the indigent from Latin America) to Cuba for free surgery. Even a few Americans showed up to be operated on free of charge, Dr. Gonzalez informed us proudly. He operated on twenty patients a day. “People completely blind could see again,” he reported enthusiastically, clearly gratified by the results of the many hours he spent in the operating room.

Cuba’s ability to provide physicians to the world can be seen as generous though skeptics spin a negative tale, labeling “generosity” as “propaganda.”

The situation of physician surplus is unique in the world. On my visit to the countries of Scandinavia in 2000, I learned that the Scandinavian system incorporates free education for physicians and free medical treatment for patients. However physicians tend to be dissatisfied with the system that includes: low pay, high taxes, heavy workload, and little opportunity for advancement. Many emigrate leaving the country depleted of physicians. Increasingly, medical care is provided on an emergency basis by overworked, stressed physicians in the emergency room.

25,000 Cuban doctors man Cuba’s missions in 68 countries and medical teams have worked in crises such as the 2004 tsunami in South Asia and the 2005 earthquake in Kashmir. Nearly 2,000 Cuban doctors are currently working in Africa in countries including South Africa, Gambia, Guinea Bissau and Mali. Since the Chernobyl nuclear plant exploded in 1986, more than 20,000 children from Ukraine, Belarus and Russia have traveled to Cuba for treatment of radiation sickness and psychologically based problems associated with the radiation disaster. In response to the 2005 Hurricane Katrina disaster, Castro offered to send a ‘brigade’ of 1,500 doctors to the US to provide humanitarian aid, but his offer was never accepted according to the BBC News. (September 20, 2005, Wikipedia).

Although Dr. Gonzalez emphasizes the benefits of the system, when prodded, he answers questions about the pitfalls. He acknowledged that anyone might drop by a clinic to ask to have his pulse and blood pressure checked without obvious reason. The physician must attend to him. However, before elaborate tests are performed, he would be required to be examined by a specialist.

A woman psychiatrist in our group who injured her foot when she tripped on a small step in the hotel, reported satisfaction with the treatment she received at the hospital. This included a thorough examination, x-rays and in spite of no broken bones, a follow up clinic appointment. A few days later, our guide accompanied her to the clinic while we waited in the bus for half an hour for his return.

An ardent Castro supporter who loves his island, our guide remarked impatiently about the length of time it took simply to register her for the designated appointment. “This is a problem with the system—little motivation to be efficient,” he grumbled.

The cost of our tour included health insurance for our stay here. According to Wikipedia, “Cuba attracts about 20,000 paying health tourists, generating revenues of around $40 million a year for the Cuban economy.

Focus on Prevention

Prevention of disease is a major focus of Cuban medicine. Research is emphasized; vaccines developed by Cuban physicians for hepatitis and meningitis are sold abroad. In the 1980’s Cuban scientists developed a vaccine against a strain of bacterial meningitis B, which eliminated the serious disease from the island. This vaccine is used throughout Latin America. After outbreaks of meningitis B in the U.S., the U.S. Treasury Department granted a license in 1999 to an American subsidiary of the pharmaceutical company SKB to enter into a deal to develop the vaccine for use in the U.S. and elsewhere. (Wikipedia)

Mobile units drive through the island to perform routine mammograms, chest x-rays, etc. for people unable to travel to the centers. Transportation is a major problem on the island. Busses are few and far between, and those we see on the streets and highways are crowded with people, many standing, packed together like sardines.

According to Dr. Gonzalez’s perception AIDS is a problem on the island. According to data I found on the Internet, compared with world statistics, Cuba is far from the worst afflicted country. Specialized hospitals no longer exist in Cuba for the treatment of AIDS victims who are now treated in general hospitals. Drug cocktails are available in limited quantities. In 1996 Cuba began the production of generic anti-retroviral drugs reducing the costs to well below that of developing countries. In 2003 Cuba had the lowest HIV rate in the Americas and one of the lowest in the world. (Wikipedia)

Drug addiction is not a problem. Rarely a ship drops off contraband on its way from Colombia. Drugs are not readily available, and there is little money to purchase them.

All kinds of organ transplants are performed. To receive a corneal transplant there is no wait time; for other less common procedures, a wait list exists with priority determined by a hospital commission.

Every Cuban carries an ID card, which must be presented to obtain the monthly food allotment. The same card indicates a person’s permission for organ donation at the time of death. In response to my question, Dr. Gonzalez has observed that the level of satisfaction of doctors and patients has remained constant since the 1980’s. Unfortunately I didn’t have the chance to ask Dr. Gonzalez what happened at this point in time. In any case their situation contrasts to the United States where doctors and patients seem to become more dissatisfied every day.

On our walking tour of the Havana streets, we pass a variety of hospitals and clinics: a maternity hospital, which our guide explains treats women who suffer from complications of pregnancy. Another hospital, specifically for ophthalmology, is located across from an apartment house, noted for its outstanding construction and art deco style.

We visit the towns of Santa Clara and Cienfuegos, located about one hundred miles outside Havana. Here, the people express satisfaction with the quality and ease with which medical care is obtained.

The leader of one of the small Jewish communities we visited was a middle-aged woman physician. She had a husband and two grown sons. She corroborated the low pay for physicians and the paucity of medical supplies and machinery. Earning between fifteen and twenty dollars a month, however, she is still the major breadwinner of her family. A doctor’s salary in the late 1990’s was equivalent to about 15-20 USD per month in
purchasing power. Therefore, many prefer to work in different occupations, generally in the lucrative tourist industry, e.g. taxi drivers, where earnings can be 50 to 60 times more. (Wikipedia)

Additional data from Wikipedia:
In 2007 Cuba announced it had undertaken computerizing and creating national networks in blood banks, nephrology and medical imaging. Cuba is the second country in the world with such a product, preceded only by France.

In 2007, the life expectancies at birth from the World Bank data were: Cuba 78.26 years; the United States, 77.99 years. The mortality rates for children under five in 2007 were: Cuba, 6.5; United States, 7.60. In 2007, infant mortality rates published by the World Health Organization in 2009: Cuba, 5; United States, 6. The proportion of elderly people is increasing as is the life expectancy, and the birth rate is falling.

According to the World Health Organization, Cuba provides a doctor for every 170 residents, and has the second highest doctor to patient ratio in the world after Italy. In 2005, Cuba had 627 physicians and 94 dentists per 100,000 population. That year the US had 225 physicians and 54 dentists per 100,000 population. The Cuban medical care suffers from material shortages caused by the US embargo. Soviet subsidies stopped in the early 1990’s and shortages of medication and equipment have caused hardship.

The patient who can afford it pays for some aspects of healthcare: drugs prescribed on an outpatient basis, hearing, dental, and orthopedic processes, wheelchairs and crutches. When a patient can obtain these items at state stores, prices tend to be low as these items are subsidized by the state. For patients on a low-income these items are free of charge.

The US embargo for medicine and medical supplies has been lifted. The US government licensed more than $227 million in humanitarian donations of medicines and medical supplies to Cuba between 1993 and 1997. Other factors besides the embargo explain the lack of imports, in particular Cuba’s lack of hard currency. Those with dollars can easily buy medicine and food in Cuba from Latin America and Canada.

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The Relationship of Religion and Trauma
by Samuel Slipp, M.D.
Presented at the 2010 Annual Academy Meeting in New Orleans

Religion is called a delusion or a poison and blamed for the violence in history by militant atheists. However, name calling is intolerant and useless since religious belief cannot be proved or disproved rationally. In the 16th century, Machiavelli (1469-1527), the brilliant Italian philosopher, recognized that religion was not the cause of violence, but could be used politically as a force for good or evil. Religion has been used to gain political power, and violence occurred when it was intolerant and imposed belief to force ideological submission. But religion has also motivated political freedom by offering comfort in dealing with trauma and everyday living. I will explore the context of how religion has been used and how anti-Semitism influenced Freud’s attitude toward religion.

Religion has existed in all cultures since the Stone Age to cope with the power of nature over man. The forces of nature were anthropomorphized into gods who controlled people’s destiny. Gods could then be placated by offering prayers, gifts, or even human sacrifice. Freud (1927, The Future of an Illusion, S.E. 21) noted that religion, before the scientific era, served as a defense against helplessness. Later, religion dignified individuals by stating they were made in the image of god. In addition, rituals to dignify life stages were established, as well as burial ceremonies, to deal with the mystery of death. From a positive perspective, religion offered a sense of meaning, mastery, and comfort to cope with trauma, thus offering hope and to enable survival.

The atheist author, Christopher Hitchens (2007, God is Not Great: How Religion Poisons Everything, Warner Books, New York, N.Y.), prescribes eliminating religion as the cure-all to stop violence. Hitchens mentions that the Catholic Church, under Pope Pius XII, capitulated to the Fascists and Nazis. But, the Nazi’s could have destroyed the Catholic Church: priests and pastors, such as Dietrich Bonhoeffer, were imprisoned and killed by the Nazis. Pope John Paul II was anti-Nazi during World War II and later helped emancipate Poland from the totalitarian grip of Communism. He apologized for past Catholic anti-Semitism and established diplomatic relations with and visited Israel.

Hitchens makes the categorical statement that human decency is innate and is not derived from religious ethics. He advocates a renewal of the Enlightenment, with reason replacing religious belief. Enlightenment philosophers after the Thirty Years’ religious war had hoped that placing reason above belief would stop wars. But wars did not stop in Europe, nor did reason in the Enlightenment prevent anti-Semitism. Anti-Semitism is contained in the book Candide by the major Enlightenment author Voltaire. Anti-Semitism surfaced openly in 1894 when Captain Dreyfus, a Jewish officer in the French army, was falsely convicted and imprisoned. In the streets, French crowds shouted “kill the Jews.” Dreyfus was later proven innocent and reinstated militarily by the efforts of Emile Zola.

How did this anti-Semitism occur, when Jesus himself was Jewish? Bruce Chilton (2000, Rabbi Jesus: An Intimate Biography, Doubleday, New York, N.Y.) noted that Jesus offered hope to the poor, sick and alienated, and was against corruption and exploitation by the powerful elite. What happened to the humanistic and inclusive teachings of Jesus? Historically, the Roman emperor Nero (54-68 CE) blamed the Christians for setting fire to Rome and he burned them alive or fed them to the lions in the Coliseum. For the next 300 years, Christians were massacred. They did not accept the divinity of the Roman emperor, were excluded as nonbelievers, and killed. The Roman emperor Constantine (324-337) legitimized Christianity but used it to win military victories over western and eastern branches of the empire to achieve sole political power (Carroll, J. 2001, Constantine’s Sword: The Church and the Jews, A History, Houghton Miflin,
New York, N.Y.). The belief in the divinity of the Roman emperor continued into feudal Europe as the divine right of kings and aristocracy, as well as of the church, to rule. Nonbelievers were again excluded and killed, but no longer the Christians. Now it was the Jews. Genocide of Jews occurred during the Black Plague, the Crusades and the Inquisition.

The 16th century Enlightenment evolved from the scientific understanding of the world and the writings of philosophers. This enabled individuals to gain power over nature so that theocracies were dethroned and secular democracies established with separation of church and state.

Another atheist writer, Richard Dawkins (2006, The God Delusion, Bantam Books, New York, N.Y.), offers the same solution to violence as Hitchens: eliminate religion. He is like the reverse of Dr. Pangloss from Voltaire’s novel Candide. Dr. Pangloss justified violence by idealizing religious belief. Dawkins idealizes atheism and implies that this will be the best of all possible worlds because of reason. Dawkins claims religion holds no monopoly on moral values, since there is a “Zeitgeist” making society progressively more moral. This mysterious ideology is pure Herbert Spencer’s Social Darwinism, which is unscientific and a corruption of Darwin’s evolution. Darwin noted that only biological changes in a species can help adaptation and survival to an environment.

The hypothesis of an innate social morality, a “Zeitgeist,” is contradicted by the psychological research of Milgram (1974). Milgram showed that 65% of people conform to the power of authority. In the experiment, a subject inflicted increasing shocks to a “learner” (an actor) even though she was told that her actions might inflict damage. This experiment confirmed Nietzsche’s observations about conformity, which he called a “herd mentality,” where people feared being an outsider. Conformity generally trumped morality. Dostoevsky in the book The Brothers Karamazov also comes to a similar conclusion that security trumps freedom.

The English psychoanalyst, Wilfred Bion (1959, Experiments in Groups, Basic Books, New York, N.Y.), noted that when people feel helpless and their survival threatened, they may regress to a “basic assumption group” and look to a messiah to save them. The thin veneer of civilization disappears, and the group members behave as amoral barbarians, committing violence against others. This occurred in an advanced Enlightenment country, Germany, which descended into unspeakable genocide under a perceived messiah, Hitler.

Dawkins claims there is “scientific” proof for an innate altruism that is independent of religion. Although Dawkins acknowledges that there is probably no single gene but a combination, he then proceeds to label a single gene for selfishness and a single gene for altruism. This is unscientific. Finally Dawkins contradicts himself, saying that morality can be transmitted through language.

Genes alone do not determine destiny. Eric Kandel (1983, From Metapsychology to Molecular Biology, American Journal of Psychiatry 140:277-293) found that gene protein expression, that determines behavior, is influenced by the environment. Some genes even need to be environmentally triggered during critical periods before four years of age. For example, when mothering is unattuned, later emotional problems can develop in the child, such as alexithymia (Schore, A.N. 2003, Affect Dysregulation and Disorders of the Self, Norton, New York, N.Y.). In alexithymia individuals don’t have the language to express their emotions.

Dawkins also ignored the work of ethologists. Konrad Lorenz (1966, On Aggression, Harcourt, Brace, and World, New York, N.Y.) found that geese in the first 24 hours after birth imprinted with the first moving object they saw. When Lorenz placed himself before these newly hatched geese, they imprinted on him and were later sexually attracted to him. Imprinting made the geese more adaptive since, if their mother died in childbirth, they could attach to another female for mothering. The strength of the social environment is also found with monkeys, who were genetically ferocious. When they are brought up in a peaceful community of monkeys, they become peaceful. Another example is of goats raised amongst sheep. Later the goats prefer to have sex with sheep. Sheep raised amongst goats prefer to have sex with goats.

In summary the impact of early child rearing and later socialization interacts with genetic endowment to influence sexual as well as aggressive or peaceful relations. Socialization is reflected in the brain by the lateral prefrontal cortex, which can influence the amygdala and hypothalamus to inhibit the fight or flight response.

Religion also has been responsible for bringing about political freedom. Moses was the religious leader who liberated the Jewish people from Egyptian bondage. He has been a model and his words, “Let my people go,” have been repeated by other religious leaders. The religious leader who brought political freedom to India was Mohandas Gandhi (1869-1948). He was called Mahatma, meaning great soul, as well as Bapu, the father of India. He proclaimed God was in each human being. Truth (satya) is God, and nonviolence (ahimsa) was his means of achieving truth. Another example is Archbishop Desmond Tutu who, along with Nelson Mandela, brought freedom to South Africa. In the United States, Rabbi Abraham Joshua Heschel supported Reverend Martin Luther King, Jr. in the success of the civil rights movement.

What about Freud’s negative view of religion? Because of his traumatic experiences with anti-Semitism, one can speculate that Freud may have thought that by calling all religions an illusion, it would eliminate anti-Semitism. He also described religious rituals negatively, as a form of obsessional neurosis. But, obsessional neurosis is out-of-control in an individual, while religious rituals are performed voluntarily by two persons or groups of people. In my new book (Slipp, S. 2010, The Quest for Power: Religion and Politics), I propose a totally different view of religious rituals. My view is from an evolutionary and scientific perspective. Religious rituals facilitate close interpersonal and group relations that enable survival.

What is the evidence? Susan Langer (1942, Philosophy in a New Key, Penguin Books, New York, N.Y. Chapter 8) noted that when people eat, speak, sing, or move together, this fosters group bonding. Synchrony between people who are functioning together under a circumscribed framework is a definition of ritual. This occurs in religious ritual, yet Freud focused on individuals and not relationships. British object relations analysts, such as John Bowlby (1969, Attachment and Loss, Vol. 1 Attachment, Basic Books, New York, N.Y.) emphasized the infant’s attached relationship to the mother for survival. Donald Winnicott (1965, The Maturational Process and the Facilitating Environment, International Universities, New York, N.Y.) noted their mutual eye contact in attachment. He also noted that the mother’s “primary maternal preoccupation” occurred in synchrony with the infant’s need for attachment. We now know that oxytocin, a peptide hormone, is released in the pregnant mother to stimulate maternal interaction. Emde, through direct infant observation (Emde, R.N., 1987, The Role of Positive Emotions on Development, Presented
at a conference at the Columbia University Center for Psychoanalytic Training and Research), and others noted that attunement of mother and infant was important for normal child development. Schore noted that fMRI studies show that neural synchrony in the brain occurs between the mother and child during attachment.

Charles Darwin (1872, *The Expression of Emotions in Man and Animals*, John Murray, London) wrote that facial expressions of emotions are inborn and universal. N.Kanwisher (2004, *Investigations of Human Extrastriate Cortex: People, Places and Things*, presented at the Columbia University 250 Conference: Brain and Mind) found that the right fusiform gyrus is devoted to facial recognition and is responsible for social behavior. In summary, we are hardwired genetically to be social beings and not isolated individuals.

In my recent book, (Slipp, S. ibid.) I hypothesized that this original synchrony between mother and infant formed a mimetic and empathic template in the mind, via mirror neurons, which is responsible for later group attachment. But Freud (1921, *Group Psychology and the Analysis of the Ego*, S.E.18) hypothesized that the loss of individual identity in an authoritarian group or a mob was due to aim inhibited libido and involved the Oedipus complex. Each individual in the group identified with the leader, who represented a father figure. This father figure replaced the internalized ego ideal of the father that Freud considered was established at the resolution of the Oedipus Complex. Other psychoanalysts such as Michael Balint (1968, *The Basic Fault*, Tavistock, England) disagreed with Freud’s individualistic framework. Balint noted the importance of the undifferentiated good pre-Oedipal relationship with the mother. I postulated that regression to this undifferentiated stage between mother and infant occurs in a mob when the individual identity again becomes submerged into an undifferentiated group identity.

An example of this was Adolph Hitler, who did not differentiate from his mother, but acted as her surrogate against her abusive husband. Feeling helpless and demeaned, Germans also regressed as a mob, giving up individual for group identity - Hitler was Germany and Germany was Hitler (Stierlin, H. 1976, *Adolph Hitler: A Family Perspective*, Psychobiography Press, New York, N.Y.). This regression to merging with the mother/Hitler and the German people resulted in loss of individuality of not only the self, but of others as well.

This lack of differentiation was found in some families coming to Bellevue with a depressed adolescent. The mother pressured the child and lived vicariously through the child’s achievement, but it was never good enough. Also, lack of achievement would result in the threat of rejection. The child could not feel secure and confident by winning or losing and had difficulty differentiating and separating from the family. This was similar to the learned helplessness noted in animal experiments of Seligman and Maier (1967, *Failure to Escape Traumatic Shock*, Journal of Experimental Psychology 74:1-9), where a rat was shocked no matter what choice it made. At Bellevue, laboratory experiments of subliminal stimulation were conducted which employed the message “Mommy and I are one.” Whalen, Rauch, Etcoff, Melnerney, Lee, and Jenike (1998, *Masked presentations of emotional facial expressions modulate amygdala activity without explicit knowledge*, Journal of Neuroscience 18:411-418) noted that subliminal stimuli registered directly in the amygdala and bypassed conscious perception.

This maternal merging message had been found to be beneficial in differentiated schizophrenics, phobic and alcoholic patients by Lloyd Silverman (1971, *An Experimental Technique for the Study of Unconscious Conflict*, British Journal of Medical Psychology 44:17-25). The subjects in one experiment were neurotically depressed females. We found that only those who had a gratifying, non-pressured relationship with their mothers improved after receiving subliminal maternal merging messages. In another laboratory experiment with underachieving high school students of both sexes, the subliminal maternal merging message was continued four times a week for six weeks. Higher achievement occurred only in those boys who did not have a pressuring and non-gratifying mother. It did not improve the performance of girls, who came from suburban homes where feminine stereotypes and fear of loss of attractiveness to boys by being smart prevailed. Thus not only did the original merging with mother have significance during infancy, but it prevailed, even unconsciously, into later life. For further details about these experiments, see the Journal of the American Academy of Psychoanalysis, Summer 2000, 28:305-320.

People behaving in regulated synchrony in adult rituals can retain their individuality and only partially identify with the group. Examples are parades, dancing, and sporting events. For example, adolescents dress and behave alike to be part of their peer group. This is a stepping stone to separate from parental dependency to achieve independence. As adults, groups offered protection against predators and hostile groups, offered comfort after a loss, and dignified life stages. The moral standards of religion, and compassion for others, elevate the individual and create rules to make relationships predictable and to facilitate group trust.

Yes, religion has been used politically and has resulted in violence. For example, religious conflict between Muslim groups is occurring in our own time because of a past military defeat of the Shiites by the Sunnis. The distinguished psychoanalyst Vamik Volkan (2006, *Killing in the Name of Identity: A Study of Bloody Conflict*, Pitchstone, Charlottesville, Va.) was part of the Carter Commission and studied the conflict between large groups. He found that the recent Balkan war could similarly be traced back 600 years, when the Muslim army defeated the Christian army and killed Prince Lazar. The collective group memory of the Christian defeat persisted and Christians sought to undo this old traumatic loss of power by attacking Muslims now.

In summary, religious rituals are not an uncontrolled obsessional neurosis within an individual, as Freud stated, but are a voluntary activity by two persons or by a group of individuals that fosters bonding. From a positive perspective, rituals that foster group bonding provide dignity to life stages and facilitate survival. Religion may offer social support and comfort after traumatic events. During adolescence, identifying with a peer group facilitates separation and individuation from the family. But religion has been used to gain political freedom and it also has been harnessed by demagogues to achieve political power. Under dire circumstances, when people feel isolated, helpless, and demeaned, they may regress to one of Bion’s basic assumption groups and look to a messianic leader to be saved. When this occurs, they replace their rational individuality and can function as an emotionally driven mob, seeing themselves and others only in terms of group identity. In tribal and authoritarian societies, group identity can be greater than individuality. Thus religion, rituals, as well as groups can function for good or evil. Machiavelli spoke the truth in this regard not only in the 15th century and his insight holds for today as well.
“This above all, - to thine own self be true” (Hamlet, Act 1, scene 3)

Following on my paper on long-term psychotherapy, previously published in the Forum (Bacciagaluppi, M., 2009, Long-term Psychotherapy, Academy Forum, Vol. 54, #2), I wish to present another case, by far the longest of my long-term therapies. I first saw this patient when he was a University student and he came back, after a very long interval, when he was 48, a middle-aged man. I shall concentrate on the second phase of his treatment because I wish to make the point, already mentioned in my previous paper, that unsuspected and decisive changes can occur at the end of a long therapy.

The First Therapy

The first therapy took place in 1969-70 and lasted 1½ years. His presenting problem was shyness and embarrassment with girls. He was ashamed of his father who was elderly and did not earn much. His mother was dissatisfied with his father for the same reasons. When he was a child the parents did not allow him to play soccer in the street as the other children did. As a result he was very insecure when he went to school. His insecurity provoked the other children to tease him and this increased his insecurity. Things improved when he went to the University. He made friends and got interested in Marxism and left-wing politics although his insecurity persisted in his relations with girls.

We worked on these issues for some months. When he came back for the second therapy he told me that after the first therapy he met a girl with whom he had sex for the first time. He did not find her attractive and left her, met other girls, and finally met one whom he married. He therefore successfully separated from his parents. But in his choice of a technical faculty, he chose a safe job to avoid his father’s financial insecurity rather than following his own intellectual interests.

The Second Therapy

When the patient came back after 26 years, he stayed in therapy for seven more years, then broke off, then came back again for an additional three years. So this is a case of what, following Olarte (Olarte, S.W., 2006, presentation at the 8th OPIFER/AAPDP Joint Meeting, Florence, Italy), I referred to as intermittent long-term psychotherapy in my previous paper.

At the outset of the second therapy he told me his wife died prematurely, two years earlier, of a degenerative disease of the nervous system. She had become very demanding during her illness. The patient reacted with detachment although he continued to look after her until the end.

He was left with two children, ages 13 and 11, at the time of his return to treatment. After his wife’s death he felt duty bound to look after his children himself and especially to cook for them. This compulsion caregiving (Bowlby, J., 1980, Loss, New York, Basic Books, p. 16) was carried on until his children were young adults. It created resentment in him against them yet he still carried on.

One year after his wife’s death he met a divorced woman with two children, a boy and a girl, and this woman became his partner. She had a traumatic background: her psychotic mother had killed her younger brother. She was also in therapy. Their relationship was stormy and punctuated by occasional separations yet persisted during all of his second therapy. The patient maintained that he was not in love with her but was sexually attracted to her and they agreed on many issues. This woman’s children were one source of difficulty in their relationship. She was very attached to them whereas the patient developed a strong dislike for them, especially toward the boy. This was an obstacle to any plans for marriage.

This review of the patient’s interpersonal relations confirms a remark he made in the first session of the second therapy: that he was able to hate but maybe not to love.

The patient worked in a firm as an efficient engineer. In the course of the second therapy the firm encountered financial difficulty and required the patient’s early retirement. This meant that his pension was lower than it might otherwise have been.

I have reviewed the main issues that were discussed during the second therapy. I consider this patient to have been unlucky in addition to his personal problems. He may have contributed to his difficulties as when he elicited teasing on the part of his schoolmates. But he also had two strokes of bad luck, to which he had no contribution: his wife’s illness and death, and his forced retirement both of which created bitterness and resentment in him.

The patient was preoccupied by his recent and current real-life problems and perhaps I was misled into limiting the therapy to a discussion of these issues. If I had made a head-on attack on his detached character armor, in the tradition of Reich and Davanloo, the therapy might have been shorter. However, when in the final phase there was a spontaneous opening up of his character armor, I seized the opportunity to accomplish what I had neglected to do previously.

The Final Phase

In the last year of therapy an accidental occurrence proved to be a turning point in the treatment. After an interruption the patient came back to report that his cat had died of old age. The patient was deeply moved to the point of tears. He told me that since then he had slept poorly and felt apathetic. I realized this was an opening in his detached character armor and I decided to follow it up. He associated his visits to the grave of his partner’s little brother who had been murdered by his mother. He used to be deeply moved on thinking that this little boy had done no harm. I remarked that he was not only detached but also capable of intense feelings.

In the next session I asked him if the little boy reminded him of himself. He associated two incidents of his childhood. As a little boy his mother used to say with a smile: “How pretty you were as a baby.” He remarked: “My mother was sweet.” Then he went on to relate an incident that occurred before he was one year old. His parents went away for two days and left him in the care of two aunts. He cried a lot. Later, his mother would recall the incident saying that the aunts had complained that his crying bothered them. I remarked that by recalling this incident he had moved closer to his infantile experience.
In the next session he brought five dreams. He himself remarked: “My unconscious has been stimulated.” I went back to the two incidents of his childhood. I remarked that when the mother used to say “How pretty you were as a baby,” there was concealed hostility at the verbal level because the obvious sequel was “and now you are ugly.” Moreover, this hostility, already concealed at the verbal level, was belied at the non-verbal level by her smile. The latter message prevailed when he said “My mother was sweet.” Then I went back to the separation in his first year of life. I said that his crying was a protest that not only had he not been understood but he was disapproved of. He had no conscious recollection of the incident but his emotions were stored at a non-verbal level and were resurfacing right now with his bad sleeping and his apathy.

Discussion and Conclusions

I start with my response to the patient in that fateful session in which he spoke of being moved by his cat’s death. When he showed this opening in his character armor I sensed the possibility of him reaching his true self and this stimulated me to use all the intellectual tools at my disposal and respond to him in the same key. The possibility of his reaching a vital core had a vitalizing effect on me. The intellectual tools I used were the product of keen intellects doing the same, trying to reach to the heart of the matter, to the truth of things. Thus, I was helped by Reich (a very vital intellect, before he apparently became psychotic) with his concept of character armor (Reich, W., 1962, Character-Analysis, New York: The Noonday Press), Winnicott, with his distinction of the true and false self in a concise and clear presentation of the subject (Winnicott, D.W., 1989, Psycho-Analytic Explorations, London: Karnac Books, p. 43) and especially Bowlby, always vital in this intellectual sense, in the admirable Chapter 4 of Loss (Bowlby, J., op. cit.). In this chapter Bowlby discusses differential memory storage making the distinction between semantic and episodic memory. Maybe the central part of this chapter is a section on the self. Bowlby’s question at the outset is how to conceptualise Winnicott’s concept of true and false self in terms of the more recent literature on memory storage. Here we see one keen intellect reaching back to the concepts of an earlier one and trying to take them one step further. Bowlby concludes this section by saying that it is the self that has the reader access to the images from episodic storage that the patient would experience as his real self. Bowlby does the same later on in the book, in a footnote on pages 234–235, in which he again reaches back to Sullivan’s concept of reflected appraisals and adds: “in the view advanced here it is postulated that a child not only passively accepts the appraisals of others but that he also actively arrives at his own, perhaps totally different, appraisals both of himself and of others.”

Another relevant contribution of Bowlby’s is his empirical observation (Bowlby, J., 1973, Separation, New York: Basic Books, p. 22) that a child’s reaction to prolonged separation goes through three stages: protest, despair and detachment. Protest includes anxiety and anger (the subtitle of the book). The patient’s crying during the separation of the first year of life was an expression of protest. Of course a separation of two days can hardly be considered as prolonged but it was followed by emotional separation (Bowlby, Separation, p. 23). By not allowing him to play with other children, the parents showed that they were not in touch with his real needs. Thus, the disapproved protest led to despair (depression) and finally to detachment, that hardened into a character armor. Since the first separation was experienced in a preverbal stage when, by definition, semantic storage is impossible and the awareness of the later emotional separation was discouraged (“my mother was sweet”), the three phases were encoded in episodic memory. After the cat’s death his reactions were resurfacing at a nonverbal level through sleeping badly (anxiety) and apathy (depression). Anger, instead, was allowed expression but was redirected onto other objects.

In the session after the fateful one, in commenting on his mother’s remark “How pretty you were as a baby,” I made use of Gregory Bateson’s concept of the double bind (Bateson, G., 1979, Mind and Nature, Toronto, New York, London: Bantam Books, page 128). The mother’s remark is a perfect example of the double bind: two conflicting messages sent on two different levels. The concept of the double bind is complementary to Bowlby’s discussion. Whereas Bowlby is concerned with conflict between memory systems in the child, Bateson points out that conflict may already be present in the incoming messages that then have a paralyzing effect on the child.

Great writers have described situations similar to the patient’s in which antivital and sadistic parents or parental figures try to stamp out the vitality of the children in their care, thus creating a “compliant false self” (Winnicott, op. cit.). Samuel Butler, in his autobiographical novel The Way of All Flesh (Butler, S., 1994, The Way of All Flesh, Ware, Herts., G.B.: Wordsworth Classics), published posthumously in 1903, describes how Ernest Pontifex, the protagonist, who is actually Butler himself, b. 1835, was whipped practically every day by his clergyman father because he allegedly did not know his lessons. This treatment was accompanied by reproaches to the child for not being grateful to his self-sacrificing parents. George Orwell, b. 1903, in an essay titled Such, Such were the Joys…(Orwell, G., 1981, originally published in 1946, A Collection of Essays, New York: Harvest) describes how the headmaster of the private school to which he had been sent at the age of six used to cane him every time he wetted his bed. This is the explicit version of what my patient’s mother did in much more subtle ways, which prevented the patient from protesting and led him to store the memory of his real experience in a memory system subordinate to the main system that contained the mother’s messages.

These are examples of what German jurists called “soul murder.” The term was applied by Schreber to himself in his famous autobiography that was analyzed by Freud (Freud, S., 1911, Psycho-Analytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoide) S.E., Vol. 12, pp. 9–82, London: Hogarth Press) and was the title of books by Schatzman (Schatzman, M., 1973, Soul Murder: Persecution in the Family, New York: Random House) and Shengold (Shengold, L., 1989, Soul Murder: The Effects of Childhood Abuse and Deprivation, New York: Fawcett Columbine).

I realize I have not referred to Freud as a relevant author in this case. Freud had a brilliant intellect but his work was marred by what Bowlby (Bowlby, J., 1984, Violence in the Family as a Disorder of the Attachment System, Am. J. Psychoanal. 44, 9-27) termed Freud’s “disastrous volte-face” in 1897, when he denied the reality of childhood trauma. Thus, in discussing Schreber (Freud, S., op. cit.), he ascribed Schreber’s madness to his impulses. Schatzman, instead, in his book on Schreber
(Schatzman, op. cit.) ascribes Schreber’s madness to his father’s sadistic educational methods. So, by definition, Freud was not relevant in the case of my patient who had indeed undergone childhood trauma.

To sum up: in the final phase of treatment, the patient was rediscovering his real self and realizing that, although he had not been literally murdered like his partner’s young brother, he had undergone soul murder. He then identified with the aggressor (Freud, A., 1962, originally published in 1946, The Ego and the Mechanisms of Defense, New York: International Universities Press) and developed a dislike for his own and his partner’s children. Maybe it took him so long to reach the turning point because in his childhood he never had a corrective emotional experience (Alexander, F., French, T.M. et al., 1946, Psychoanalytic Therapy, New York: Ronald Press). I think I provided it by responding in the opening up of his character armor in addition to the secure base I had provided in the course of this long therapy.

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**Discussion of The Widening Scope of Psychodynamic Psychiatry At the May 2010 New Orleans Academy Annual Meeting**

*by Gerald P. Perman, M.D.*

The Widening Scope of Psychodynamic Psychiatry was a panel given at the 2010 Annual Academy Meeting. One of my colleagues encouraged me to publish my discussion of this panel believing that it had value as a stand-alone paper. I hope that you agree.

The four presenters and the titles of their presentations were: Scott Schwartz, M.D. - Framed Fantasies: Improvisation in Music and Analysis; David Lopez, M.D. - The Psychodynamics of the Double Agent; Ruth Lijtmaer, Ph.D. – The Analyst Suffers Trauma; and Richard Brockman, M.D. - Episodic Memory, Neuroanatomy, Psychotherapy: Learning from the Untreatable Patient.

In Framed Fantasies: Improvisation in Music and Analysis (to be published in the next issue of the Academy Forum), Dr. Scott Schwartz took us on a rapid historical musical journey—perhaps a Magical Mystery Tour—from prehistoric times to the present, traversing ancient Greece, Egypt, Mexico, Spain, England, Italy, Germany and France and finally landing us in the Mississippi Delta. It is in this last locale that he likened the blues to “a frame into which a fantasy can be projected,” hence the title of his paper.

Freud described himself as being “ganz unmusikalisch” — “totally unmusical” — although he did enjoy certain operas such as Don Giovanni and The Marriage of Figaro. Wikipedia tells us that these operas are more “conversational or narrative” than other operas and gave Freud cognitive control over the affective impact of the musical sounds. According to Paul Roazen, Freud became anxious if he felt emotionally moved by something without knowing what was moving him, or why.

Dr. Schwartz remarked on the importance of “meditation” in almost all religions and creating a “state of trance” enhanced by drugs, by chanting and by the grandeur of the place of worship. A patient in China I had been treating over Skype once a week for a year entered into a phase in therapy in which he wanted us both to be quiet — to say nothing for parts of the sessions. He said this allowed him to feel closer to me and to come into deeper contact with his unconscious thoughts (this is, of course, a fantasy), and he believed that words between the two of us interfered with this process. Hence he added a meditative aspect to our work together.

In his presentation, Dr. Schwartz moved from meditation, to the verbal and emotional exchanges on which the “talking psychotherapies” are based. “Confession and rituals” — central tenants in certain Western religions — came next in his description of the evolution of psychotherapy. In my view, one of Freud’s greatest contributions to the treatment of mental illness was his discovery that the “entry” into his understanding of the human mind was to allow for free-association, that is, in listening, in a dispassionate way, to the “reminiscences of his patients” in an effort to understand and to help them understand the meanings that were hidden behind their words and their symptoms. There is a hugely confessional aspect to this process and I’m sure we have all likened it to the Catholic Confession at one time or another.

Toward the end of his paper, Dr. Schwartz told us that “analysis can, with discipline, be carried on through meditative introspection, without necessarily requiring an external listener.” This is something that all of us do, to a greater or lesser extent, both inside and outside of the consultation room, although “with discipline” may be the operative words. Self-analysis has its limits since the old adage: “the doctor who treats himself, has a fool for a patient,” sometimes still applies.

Dr. Schwartz made the claim that psychoanalysis is more oriented toward the prevention of problems, whereas therapy is more geared toward their treatment. I find this a provocative idea. Over thirty years ago as a psychiatric resident, I asked my beloved supervisor, Irwin Marril, how often we should meet with our patients. He replied: “Whatever the traffic will bear.” This was, in fact, a nuanced response. He was referring to the ego strengths of the patient and to the ability of the therapist to tolerate the patient’s countertransferences, and not just to the adequacy of the patient’s health insurance coverage and the depth of the patient’s pockets. I agree with Dr. Schwartz that, other things being equal, analysis has the potential to do a better job of preventing future problems, this because it can do a more thorough job of treating the presenting problems.
As I began to read Dr. David Lopez’s paper *The Psychodynamics of the Double Agent* in preparation for my discussion, I felt increasingly anxious. I became more and more convinced, paranoid we might even say, that Dr. Lopez was going to be discussing a situation within a well-known psychiatric organization, in which there was, embedded within it, a double agent, who was creating havoc within the core body of the leadership of that organization. I even began to believe that he might “blow the cover” of this double agent and that this person would turn out to be, previously unbeknownst to himself, the very discussant who was reading his paper!

On the one hand, I told myself, “If the shoe fits, I must wear it!” But on the other hand, I reminded myself that “people who live in glass houses should not throw stones” and I’ve never been to Dr. Lopez’s house to see what it is made of. How relieved I was, when I got to his three case examples and learned that his paper had nothing to do with me or with the unnamed psychiatric organization.

Now back to the paper. After describing the traits that characterize the double agent, Dr. Lopez reviewed Fairbairn’s and Andre Green’s formulations of the psychodynamics and psychogenesis of such individuals. He then provided us with his own view that double agents only function as such under situations of regression to protect their sense of vulnerability and defenselessness that is brought about by the stress of group processes. His first patient was, in fact, a real double agent. He remarked to Dr. Lopez that “if his country, family, or friends had been in any danger, he would have hesitated to pursue his war espionage activities.” This attitude reminded me of Stalin’s quotation: “The death of one man is a tragedy. The death of millions, a statistic.” How Dr. Lopez’s patient seemed to have deceived himself about the Holocaust and the concentration camps was impressive. And yet it touches close to home when you and I pass homeless persons every day, and do not regard them and their situation as our personal responsibility in which to intervene. Or when so-called-civilized nations stand by while genocide and other gross human rights violations are occurring in countries other than their own. I won’t deny that these are complex issues, but at the same time they illuminate man’s inhumanity to man on multiple levels.

I was also taken with Dr. Lopez’s first patient’s statement that “war is war and has a different set of rules than conventional morality.” Whereas his patient used this statement to rationalize his behavior as a double agent, it is also true that, in all wars, soldiers are taught to dehumanize the enemy a greater or lesser degree — perhaps they HAVE TO — to allow them to kill their opponents. In this way, war is the opposite of psychoanalysis in that the latter emphasizes helping patients by “humanizing” them, as it were, through enhanced mentalization and empathy with others, as much as possible. At the same time, many of us would agree that there is evil in the world and it must, at times, be confronted.

Dr. Lopez’s third case — in which a smaller and larger psychoanalytic institute merged together — reverberates as an object lesson for our times, as psychoanalytic and psychodynamic organizations attempt to cope with falling applications and membership, for reasons about which we are all familiar.

What I was hoping to hear in Dr. Lopez’s case presentations, were the infantile components of his patients’ histories that would have helped us account for WHY each of them became a double agent, bridging the gap between his theoretical speculations at the beginning of this paper and the clinical outcomes. But as with all good psychodynamic presentations, we are always left wanting to know more.

Dr. Ruth Lijtmaer, our third panelist, gave us a deeply personal and scholarly presentation on how she was affected by the trauma of massive damage to her house - and to her home - two separate but related entities. She summarized some of the psychoanalytic literature on trauma and loss, the meaning of inanimate objects in people’s lives, and the analyst’s attitude in times of trauma. Dr. Lijtmaer then described her capacity to compartmentalize and function well at work in spite of her trauma, and finally she offered some thoughts on the meaning of “home.” She did a fine job of covering these topics.

Perhaps the most clinically useful part of her presentation related to questions she raised around the issue of self-disclosure — how much, with whom, under what circumstances, and with what goals in mind. Dr. Lijtmaer addressed all of these questions around the foil of her work with her patient, Susan, who had a significant, albeit lesser, trauma to her own house and home. After an electrical fire damaged Susan’s basement, Dr. Lijtmaer tells us that the transference changed from her being experienced as empathic and supportive, to being viewed with suspiciousness and as someone who could not understand her patient’s situation, and that this resulted in a treatment stalemate. Dr. Lijtmaer recalled a paper of Fajardo who suggested that self-disclosure, at least when dealing with the trauma of a life-threatening illness, can deepen and facilitate the therapeutic process. Dr. Lijtmaer thought that some self-disclosure might unlock the treatment stalemate with Susan and this appears to have been the case as the transference reverted back to one of mutual empathy and collaboration.

The loss of Dr. Lijtmaer’s home, and of many of the inanimate objects within it, reawakened her feelings of loss and helplessness when she immigrated to the United States earlier in her life. She cited a paper by the prolific psychoanalytic writer Salman Akhtar; two additional books of his that deal with these issues at greater length are: *Immigration and Identity: Turmoil, Treatment and Transformation* and *Objects of Our Desire: Exploring Our Intimate Connections with the Things around Us*.

In my experience, I have found that houses in DREAMS often seem to represent the self. We live in our houses, and in our selves, so to speak. A patient of mine recently dreamt that he was on a beach in a house made only of scaffolding with the wind and the elements blowing through it. This man is a self-employed creative artist and a mostly stay-at-home father, whereas his wife is a successful and driven business woman and the main bread winner in their family. My patient’s parents divorced when he was a young child and he was raised by his mother with minimal contact with his father. Knowing what I do about my patient, even without his associations, I believe that his dream about being in a house that was just scaffolding, spoke to his sense of himself — not feeling as if he had a stable foundation growing up and currently feeling inadequate about his standing in his family.

Dr. Lijtmaer was surprised at her ability to dissociate to a degree, and to function well with her patients in spite of the symptoms she was having. This brought to mind an experience that I frequently have, as well as a piece of folklore present in my work as a mentor to alcoholic, impaired physicians. I am
repeatedly impressed that, when I am down or stressed about aspects of my life, the psychodynamic space with my patients often serves as a refuge from these heavy feelings. My spirits temporarily lift as I am able to put aside the unanalyzed, unmetabolized, self-destructive and hateful affects I am carrying, and enter into the world of my patients. Perhaps this is even an adaptive dissociative defense mechanism. And in my work with alcoholic physicians with the D.C. Medical Society’s “Physician Health Committee,” it is well known that impaired physician’s abilities to care for their patients is often the last component of their functioning to break down. As physicians, we have been “programmed to perform” for many years, beginning with our pre-med curriculum in college, and continuing through medical school and residency training. Later, if we become “impaired” often through alcohol use or depression, we often keep going, going in our work like the energizer bunny, while the rest of our lives collapses around us. Dr. Lijtmaer is to be commended both for her openness and her scholarship.

When Dr. Richard Brockman first saw his patient in consultation, his counter-transference reaction to her was that she was “untreatable.” His initial interpretation, that her sadomasochistic way of defeating every care-giver with her passive, masochistic indifference, was a repetition of behaviors with her parents was, of course, correct, but since he had not yet established a working alliance with her, and had not worked through the layers of her defensive reactions, she was unable to make use of this interpretation. Her symptom of bulimia symbolically represented her approach toward the many therapists she had seen before him: taking them in, regurgitating them, and spitting them out.

His patient told him that she went to her mother after she was beaten by her, presumably older, brother and, instead of sympathy, her mother accused her of teasing him. The patient felt as if her mother hated her. This would become how she felt toward herself as well as her transferential expectation from others.

Dr. Brockman asked the question: what if psychopathology is driven, not by what is forgotten as Freud originally postulated, but by what is remembered? But isn’t this often the case with traumatized patients? Embedded in the DSM diagnostic criteria of PTSD, we are told that the traumatic event is re-experienced in one of several ways — through recurrent, intrusive and distressing thoughts of the event, through recurrent dreams of the event, and through a sense of reliving the event: that is, the psychopathology is also driven by what is remembered.

We then heard more about his patient as a person — her age, education, family situation and that she had pets. As she started to reveal more of herself to Dr. Brockman, an effective treatment had begun. I am reminded of Warren Poland’s paper on The Analyst’s Witnessing and Otherness in which witnessing itself by the analyst is described as an essential element of the analytic process. This was also addressed by Dr. Ingram this morning, as he talked about the importance of “just being there” for our patients (to paraphrase both Nancy Reagan and the movie with a similar name).

Dr. Brockman then delineated the difference between declarative memory, divided into semantic (general, objective information oriented to the present) and episodic (related to personal, specific memory oriented to the past). Whenever I read about these differences in memory systems, I develop instant amnesia and can never remember the difference between them.

Nevertheless, Dr. Brockman’s patient then described the episodic memory of breaking up with her first boyfriend, to which her mother replied: “Can’t you do anything right?” Dr. Brockman interpreted: “So it wasn’t so much the loss of the boy, as your mother’s response?” She looked at him and said, “That was always her response.” Thus, she didn’t directly confirm that what he said was correct — she couldn’t allow herself to do that — but she stayed connected to him through her own, unique reply. Citing Eysenck, Brockman told us that “(her mother’s) dismissive reaction might be enough to augment her self-loathing, without her mother’s actual reaction at all.” We were hearing about the foundation for this woman’s dismissive transferences to her various therapists.

When his patient reported that she felt that “whatever I do is wrong,” why wouldn’t we expect that, through projective identification, she would attempt to make the therapist feel the same way: that he can’t do anything right either and cannot adequately treat her? This she did extremely well!

The patient’s memory of her mother flexing her hand, that his patient incorrectly thought was an invitation for her to hold it, was described in terms of Goddard’s kindling phenomena. It was also a passive-aggressive effort on her mother’s part to deprive her daughter of a sense of being “linked and connected to” others — that is such a crucial part of healthy attachment and helps make us feel human.

Dr. Brockman then introduced his idea that perhaps his patient’s attitude toward herself and her therapists has nothing to do with “the sadomasochistic drive to communicate suffering” and “to thwart the best efforts of others.” He asks: “What if this was not about masochism but about memory?” It is of course not “either-or” and I believe we should do our best to keep both possibilities in mind simultaneously.

His patient worried that Dr. Brockman would terminate treatment with her because she pointed out that his office was a mess. To paraphrase Harvard psychiatrist Elvin Semrad: “a psychotherapist is just one big mess trying to help clean up a bigger mess.”

Dr. Brockman told his patient that “you’re going to have to reach for me, for my hand, in order to get out of the grip of the past.” She would have to trust that he would not pull his hand away: he would be a better mother. He told us that he needed to become a “new memory,” an “oddball stimulus.” He then went further, and advised his patient that she should take a job with “City Alliance” and thereby be allied to the city and connected to a connecting organization. He noted that this went against the grain of the opaque analyst who was no longer just witnessing and analyzing, but instead directed the action.

We are new objects for ALL of our patients — not just for our child and adolescent patients but for our adult patients as well. Many come to us beaten down and battered, both by the outside world and by their chattering, inner demons as well. As we gently point out their flaws, their failings, and their self-destructive defensive maneuverings, it is also helpful to tell them that they are attractive, intelligent, caring, and capable individuals. Some might say this is too “supportive” for an expressive therapy: but I don’t agree. It is more Kohut than Kernberg in this instance.

Toward the end of his paper, laughter has crept into the treatment. His patient’s defenses, ala Anna Freud, are becoming more mature, she is getting better. Finally Dr. Brockman speaks to the importance of connection, of his patient’s link to him, by offering his office for her to work in. Whether she accepted or
not, this was a powerful statement he made to her – with the implication that he believed she was a valuable enough person to enter into his world, into his office. Also, by enhancing her interpersonal connectedness to him, he was increasing her neuritic and dendritic connections within her brain that we all know by now that psychotherapy does.

Dr. Brockman’s paper ended with a dream, in which the thera-

picture of Julia showed a severely anorexic young person with a head too large for her body dressed in expensive designer clothes. What appears to be a ritualistic eating disorder is thus promoted as a model for young women to admire and copy.

Dr. Ann Turkel in All About Barbie (Journal of the American Academy of Psychoanalysis; 1998, Vol. 26, No. 1; pp. 169) wrote about the destructive developmental effects of such role models as follows: “If we look at the Barbie Doll world we can explore eating disorders, the sexual politics of body image, mother-daughter control issues (as the two of them cross the shopping mall trying to gain self-esteem through shopping) and archetypes of fertility all wrapped up in the huge commercial success of an orifice-less plaything with a predilection for pink.”

“Advertisements,” Turkel continues, “promote an eternal vigilance in women about their looks as the key to personal happiness and security. Instead of gaining self character and self-respect through good work, advertising tells us that these changes are to be purchased through good looks.” Just as destructive in my opinion is the promotion by our media of celebrities as stereotypic icons and models of beauty. These images, adult equivalents of the Barbie Doll, cater to male sexual fantasies and encourage women to become objects of insatiable desire.

Variety of personality or expressions of intellectual activity seem to be absent from these projected stereotypes. Instead of feelings and personal opinions, clothes, make-up, hairdos and company promoted goods become introjected transitional objects that define who they are and are projected to the viewer as self representations. Defining oneself by commercial standards then deprives the person of a real productive self and simultaneously substitutes another’s values for lost potentials. Erich Fromm spoke of the productive character and personality as “a fundamental attitude, a mode of relatedness in all realms of human experience.” (Man for Himself, 1947, Fawcett Premiere Books, Greenwich, CT, p.9) The stereotypic personality is, in contrast, either superficially related or totally alienated.

The depression that follows the loss of a real relationship to oneself and others results in a feeling of emptiness and can also lead to addictions as relief is sought by substituting more goods for real feelings. A patient I saw briefly for an uncontrollable shopping addiction that had bankrupted her and her family described her sense of self as “I don’t know - it feels empty.” Her addiction began in the context of a failed love affair with a materialistic person who valued designer goods and betrayed her with a wealthy lover who could supply those values and goods.

Stereotypes of masculinity in our society also create problems, especially obesity. It is of interest to me that so many of our television shows portray the average man as slightly corpulent and inept. Big, muscular, and tall signify the perfect man as projected by young movie stars. Thus the average man falls short in his attempts to reach masculinity and cannot assert himself with his female partner according to these standards.

Another problematic, politically linked stereotype has been the perception of skin whiteness as the standard of beauty. A recent Newsweek article by Raina Kelly, an African American, reported on a research study in the Journal of Personality and Psychology done at the University of Washington in 2009. The study revealed that 70% of people of all races preferred being white to all other colors. Kelly further states “being black doesn’t get me a pass on unconscious negative feelings about African Americans.” Forty-five years after desegregation it appears that black is still not beautiful!

The recent history of the life and death of the pop star Michael Jackson is the clearest example of a death generated by this developmentally destructive centuries old cultural stereotype. Jackson, already a celebrity by the age of five, grew up in the segregated environment of Gary, Indiana in the 1960’s. In addition to the abusive rearing he received from his perfectionistic, fame-driven father, he had a sense of permanent imperfection from society.

This sense is documented in James Baldwin’s writings about Jackson (Freaks and the American Ideal of Manhood, 1985,
quoted in “Michael” by Hilton Als; New York Review of Books, vol. 56, No. 13, August 13, 2009) and is reiterated in an article by David Gates in July 2009 (Tragedy Superstar; Newsweek, July 13, 2009, pp. 35-40) as follows: “He performed his dance of death as a central figure in America’s long racial horror show.” Why did he feel so deeply uncomfortable with himself? The hopeless task of sculpturing and bleaching yourself into a simulation of a white man suggests a profound loathing of blackness.” In Jackson’s case no amount of major talent, success, money or adulation by the public could overcome the early imprint of racism or stereotypy. And in the end this is what killed him. How many more less visible destructions of human potential may be going on unconsciously in the 70% of people who regard whiteness as the pinnacle of beauty?

With many patients of mixed racial backgrounds it has been my task to help them reclaim rejected parts of the self which often carried rich legacies of creative potential. These have been buried under defensive conformist layers of behavior and symptoms that prolong treatment. I can only surmise that my task would have been simpler without the early input of political and commercial brainwashing.

That there is a backlash against stereotypic approaches and a return to basic humanistic approaches among young people is evident in their more ethnically diverse relationships and the recent burgeoning of arts, crafts, good writing and music. Also evident is their more sophisticated search for a more integrated sense of personal identity, genderhood, and a new sense of a “global self.” Perhaps with the changing times we can once again look at more authentic approaches to a personal sense of beauty, and can then abandon current contrived and unrelated commercial models.

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The Process vs. The Answer in Treatment: Two Dilemmas

by Anna Alayeva, M.D. in collaboration with Scott Schwartz, M.D.

The Internet, popular media “therapists,” cultural heterogeneity, and more open attitudes toward mental illness have made the idea of “the therapeutic alliance” a much larger affair. These factors inject a significant note of uncertainty into the therapeutic dyad and can turn treatment into a group or family process. In the past, decisions were made and information was maintained within the doctor-patient alliance. Now, Dr. Phil, Wikipedia, Oprah, the pharmacist, Tom Cruise, and even the nosy neighbor become part of the equation. The choice of medication or interpretation is subject to critical attack from people who do not know the situation, not to mention misinterpretation by the patient of information so obtained. This dilutes the strength of the therapeutic dyad and makes the therapist’s opinions subject to multiple critiques, and can create insecurity in the therapist and even elicit a power struggle over who is conducting the treatment.

This paper is an attempt to examine a therapeutic approach to such potential power struggles, utilizing two clinical dilemmas that emerged during my residency training at Metropolitan Hospital in New York. I am grateful to our Chief of Service, Dr. Ronnie Swift, and our Training Director, Dr. Charmaine Rapaport, for their enthusiastic support of this project.

First Dilemma

A female patient was afflicted with a severe grief reaction over the murder of her son. This was superimposed over a long history of post-traumatic stress disorder stemming from physical, sexual, and psychological abuse suffered as a child. She had been in treatment with a series of residents over the previous three years consisting of anti-depressant and neuroleptic medications with short, bimonthly assessments that were devoid of any interaction other than brief updates on changes in her mental status. While hospitalization was prevented, there was little change in her demeanor or in her mistrust of other people. In listening to her, I was struck by the isolation that had resulted from her long history of trauma and loss, the unfortunate responses she had gotten from previous residents, and her fear of sharing information with anyone. I offered gentle, empathic support and non-pressuring interest. She gradually began to feel more comfortable talking to me and was able to begin to touch on some of the trauma she had experienced.

As the year was drawing to a close, I needed to plan our termination and refer her to my successor. In our penultimate meeting, she asked if she could share a secret that she had never told anyone and that was a source of embarrassment and self-deprecation. Intrigued, I encouraged her to proceed. Tentatively, she uttered that, for a long time, she had the habit of pulling out her hair, had no idea what this was about, and that despite extensive reading, she could not find a satisfactory explanation or treatment for this problem. It caused her to have to wear a wig, which was perfectly acceptable in appearance, but she wanted to know what this obsessive illness might be. I was perplexed! All manner of thoughts ran through my head! Numerous TV commercials of “Talk to your Doctor” flashed by. I had no idea what this was. I also thought, “What?!? You bring this up at the very end of our penultimate session!!?” I did not want to give her a trite answer such as “Oh, people sometimes do that when they are stressed.” I was grateful that our session was ending!

In discussing this dilemma with her, I came to focus on a different process, namely that of the therapeutic trust issue. What had enabled her, after many years of this symptom, finally to share it with another person? What was it that allowed her to talk about this question with me, after years of humiliated silence, and having met with a string of previous therapists? This was an area that I felt I could work with, even if for only one session before terminating. I had studied about transference and therapeutic alliance. I also felt that the topic of trust was important to her, since one of her treatment goals was to re-establish trust in the world around her. This also concretized her ability to seek out and focus on aspects of the therapy that allowed her to be more open in a productive way. Finally, it kept me from having...
to guess and offer interpretations that likely would have been of little value and would have side-stepped the deeper question of attachment in a meaningful way.

Had there been more time for this growing awareness of the therapeutic alliance, there could have been other directions to take: What was it like to open up about this? Did our sessions ending create a “time-protection” factor? Was she seeking an intellectual answer to avoid deeper transferential issues? And how did I feel about being the “answer-provider” and how much did I fear letting her down because I didn’t know the answer?

Second dilemma

A bright, perfectionistic, Hispanic, professional woman had entered treatment for anxiety and social avoidance that, like my previous patient, was also related to early sexual abuse and trauma. She had been in treatment for a few years and had done well, not requiring medication, crisis-intervention or emergency treatment. Her therapy was characterized by her strong allegiance to her Puerto Rican cultural identity, her distaste for the types of men coming in and out of her life, and her concrete day-to-day frustrations. There was no evidence of psychotic or autistic thinking. She often felt that I needed to be “culturally educated” and she brought in multiple articles about Latino culture, beliefs and trends.

My patient worked in an advocacy agency, had a strong sense of allegiance to her cultural roots, and at times mentioned that she had Spiritualist roots in her family. She clarified that this was a power that certain people were born with and allowed for greater vision. She did not consider this to be abnormal or magical but merely an attribute that some people possessed. The articles she gave me tended to be general and non-specific in regard to what these “gifts” might actually be. She found the subject fascinating and, although she did not see herself as a Spiritualist in any deep way, she owned several statuettes of Saints.

One day she came to a session more anxious than usual and reported an incident that happened two nights before. As she was lying in bed she noticed that a statue of St. Martin in the opposite cabinet began to light up and its head started to rotate on its axis. At the same time, the suitcase on the ground moved by itself 10 feet across the floor to the front door. This caused some level of upset in the patient who could not explain this phenomenon. It caused almost equal upset in me as I feared that I might have to try and explain the phenomenon to my patient. Thoughts rushed through my mind…. was this a transient psychosis? a hypnagogic event? a psychotic break? Was it a cultural phenomenon for which I could find an explanation through a review of the literature on Voodoo? What was I going to tell this patient? What was I supposed to know about this stuff?

As I struggled with this morass of uncertainty, I suddenly recalled a lesson that I learned while studying dream interpretation: Stay with the affect, with the big picture. What are we dealing with here? We are dealing with anxiety about not knowing. “The unknown” was establishing a mental claim on both of us: her unawareness of the cause of this event and my uncertainty about how to explain it to her or to reassure her that she was not crazy. A sudden calm enveloped me as I worked in the direction of how to handle “not knowing” and how to interpret this shared phenomenon. I approached the dilemma from the viewpoint of a shared awareness that “the unknown” can create anxiety under any circumstances. We don’t really know how the government works, why Tsunamis happen, where your taxes really go, what explains a spark of love, or why we feel down on a particular day. Yet these unfathomable realities exist on a constant basis and we unthinkingly respond to them. It is far more valid to explore the way the realities of life affect us, than the reason for their existence. This approach framed the puzzling concept in a workable format and permitted resolution. In fact, the patient then talked about some inexplicable frustrations in her job and was able to enter into an area of charged emotionality. She left the session feeling better and fulfilled, even though we never did figure out why St. Martin’s head rotated and lit up. Happily for us both, the event never happened again.

Discussion

Karen Horney and other neo-Freudian theorists emphasized the importance of the idealized self in understanding psycho-pathology. The need to protect ourselves against self-doubt and self-reproach creates a defensive stance leading to attempts at psychological safety. This stance in its ultimate form becomes an idealized self, an image that is all-encompassing and that completely shields us from any vestige of insecurity. However, such defenses create a vicious cycle that becomes a source of anxiety due to the fear of “falling short” of the comprehensive solution. In actuality, we can never be as perfect as the dictates of this self-created self-image and therefore a gap is always present. We experience interminable worry of failing and becoming unworthy. This issue becomes all the more acute in the field of medicine, where we may take on the image of near God-like knowledge, infinite patience, and unflinching empathy.

The patient’s world is constantly flooded with accessible and generalized explanations presented by the popular press, talk shows, and informal chats with people, that eventually wind up in our consultation room. As clinicians, we want to view ourselves as being sufficiently up-to-date and knowledgeable to answer any issue raised on any topic. At some point in the past, such an approach may have been possible. Today, with the intense degree of stimulation and information with which people are bombarded, no clinician can attempt to answer every question with this extreme degree of certainty. As a result, we must re-establish our fundamental view of our relationship with our patients and address the reasons behind their questions, rather than attempt to answer their questions directly. In seeking the larger issue of our therapeutic approach to the unknown, we are once again bolstering our treatment alliance through affective rather than academic congruence, and touching on the emotional rather than the cognitive underlay.

This goes hand in hand with Franz Alexander’s concept of the “corrective emotional experience,” based on interpersonal foundations. In the orthodox model of treatment, trust established through transference serves to augment the search for greater knowledge about, and the working through of, infantile conflicts. In the interpersonal model, the knowledge and trust that develop serve to augment the positive transference leading to greater growth and relatedness. This model is essential in working with patients who are alienated in a world where information is readily available in a superficial way. It is tempting for us to try to be the Guru or the Oracle, but the media complexity that exists today makes such omnipotence impossible. This realization benefits both the patient, who falsely believes that an academic answer will provide the satisfaction she is looking for, and the clinician, who mistakenly believes that providing such answers is our ultimate goal. An idealized image maintained by the
of the musicians who influenced Dylan, from Hank Williams (Sr.) to Dave Van Ronk and Odetta; The Carter Family; Muddy Waters; Bobby Vee (huh?); and, of course, Woody Guthrie. Scorsese had access to D.A. Pennebaker’s footage of Dylan’s tours in 1965 (for the 1967 film, Don’t Look Back) and 1966, and footage from Murray Lerner’s 1967 film, Festival, covering the Newport Folk Festivals of 1963 through 1966. The contents of a private vault of Dylan’s memorabilia were made available to Scorsese, the first time Dylan had permitted any outsider that opportunity. (The two had worked together on The Last Waltz, the 1978 film of the final concert of the musical group, “The Band.” But, curiously, they had no contact whatsoever during the making of No Direction Home.)

II. An Unusual Situation for Scorsese: A Product Burdened by Limitations, Flaws

At the Newport Festivals in the summers of 1963 and 1964, we hear the acoustic Dylan and feel the adulation of adherents of the folk music movement, the folkies, who saw in him someone who might carry on the political protest musical tradition established by Pete Seeger and so many others before him. Then, at the 1965 Festival, we get the notorious scenes of Dylan alienating the crowd with his 15 minute raucous, amped up electric set of non-protest songs, backed by the Paul Butterfield Blues Band. On tour subsequently in Britain and around the U.S., we watch and hear the boos and jeers of crowds who perceived him as a turncoat, a traitor to the counterculture protest movement.

In interview snippets, besides Ginsberg’s and Seeger’s, comments that further describe the youthful Dylan are offered by Joan Baez, Liam Clancy, Al Kooper, Maria Muldaur, Suze Rotolo and Dave Van Ronk, among many others. Curiously, Ramblin’ Jack Elliott is absent here. In the 2000 film, Ballad of Ramblin’ Jack, made lovingly but honestly by Elliott’s daughter, Aiyana, the Ellittos claimed that it was Jack who introduced Dylan to Woody Guthrie’s music. Arlo Guthrie, also absent from Scorsese’s film, agreed.

Other omissions include references to Dylan’s drug use, and the fact that not long after JFK’s assassination Dylan said that he identified with Lee Harvey Oswald, though we do see footage from the occasion when he said this. One gets the sense that the Dylan profiled in this film has been airbrushed some by Scorsese, which is why I think the term “tribute” is a fair appellation.

The interviews with Dylan himself that were made for this film are also problematic. They were conducted by Dylan’s own agent, Jeff Rosen - neither a practiced nor impartial interviewer - and were completed even before Scorsese joined the filmmaking project. Dylan seems thoughtful and earnest enough, but often bland and sometimes slow off the blocks, perhaps insufficiently

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challenged by an overly sympathetic host. Dylan maintains, as he always has, that his motivation to write songs in the early 60s was his intense desire to perform music. “I wrote because I wanted to sing.”

Scorsese doesn’t showcase Dylan’s own work as well as I wish he had done. In the sequences of Dylan performing at the Newport Folk Festivals, hardly a song is screened unbrokenly from beginning to end. This is the most egregious intrusion in any documentary about a musician. To repeatedly interrupt signature songs midway through, in favor of some talking head, is deplorable. Numbers like “Don’t Think Twice, It’s All Right,” “A Hard Rain’s A-Gonna Fall,” “With God on Our Side,” “Like a Rolling Stone,” and “Blowin’ in the Wind” are cut off after a minute or two in No Direction Home.

It isn’t clear whether Scorsese’s team were responsible for this ham-handed editing of Dylan’s songs. It certainly wasn’t necessary because of time constraints. Remember, Scorsese had 3 ½ hours to cover five years. No room for a complete song? Come on. On the other hand, you wonder whether the problem lay instead with the archival footage itself that Scorsese had to work with. Murray Lerner’s Festival has similar abrupt cuts during songs. Is this all the Newport footage that was supplied to Scorsese? Lerner obviously had more and better Dylan footage from those same festivals. He presents complete Dylan sets - with every song played through in its entirety - from the same years (1963-1965) in his recent film, The Other Side of the Mirror, one of the films I mention at the end of this review.

III. Conduct, Personality Development and the Rush to Make a Hero

For years it has been the custom to describe Dylan as enigmatic, mysterious and contradictory. Early on such impressions became fixed in the media and in the public mind, where they have remained, unmodified, over the ensuing four decades,abetted by Dylan’s own reclusiveness since the mid-60s, to be sure. So, does this film help dispel or at least shed some light on the Dylan mystique?

Watching No Direction Home I thought about the incalculable stresses to which Dylan surely was exposed as a youngster early in his career. He had stupendous talent, and, as so often occurs with persons of magical celebrity, everyone wanted a piece of him: often older people and potential mentors, people who in some instances should have known better. Ginsberg wanted to hand him the Beat baton; Seeger, the folkies’ protest banner. The youth counterculture regarded him as a personal spokesman for their declarations of freedom. Some black leaders perhaps saw him as a useful, racially enlightened Caucasian.

Journalists alternatively scorned him or regarded him as a savant, but either way, they tracked him like bloodhounds. He seemed always to be newsworthy. Dylan’s songs may have conveyed a sense of welschmerz, of a deep wisdom beyond his years; and his poetry often did seem to speak for others, old and young. But he was at the same time a wet-behind-the-ears kid from Hibbing, for Heaven’s sake, who had spurned his roots and family and at 21 was living hand to mouth playing harmonica in the Big Apple. True, he didn’t act the innocent: he radiated whip-smart street sense and had a canny capacity for self-reinvention - for role playing and creating false stories about himself - that bordered on the psychopathic.

Because of his songs and his manner, many people regarded Dylan as more mature, more in control, more self aware, than he actually was, and they measured his conduct and decisions by a standard that would be tough to meet for many older, more settled individuals. These same people were at first incredulous, then sorely disappointed, and finally outraged, when, instead of social ideals as a guiding light, Dylan began to live out (and sing about) highly personal strivings of the sort often evident in smart contemporary kids. Dylan could be self-aggrandizing. Opportunistic. Full of swagger. Rude. Callous toward women. An insulting tease to journalists (though just as often they insulted him…one asks in the film how many protest songs exist; Dylan shoots back, “142.” When challenged, he wryly revises the number to “136.”)

What’s worse, for those who idealized him, he rejected being categorized or adopted as the new leader of any social or political movement. In this light, some of his gestures – for example, touring the south with Seeger and playing at the 1963 Lincoln Memorial gathering where Martin Luther King Jr. delivered his “I’ve Got a Dream” speech – have always remained difficult to interpret. Was he being disingenuous? Inconsistent? Self-promoting? Well, quite possibly, all of these. I think he was being a kid - a youngster whose personality was far from being fully formed, under constant, enormous psychic pressure. Finding his way by trial and error. Understandably erratic.

Dylan claimed that all his songs were protest songs, and I believe they were: the protests of a rebellious youth. Get off my back, go hitch your wagon to some other star, his lyrics and deportment kept announcing. He said over and over again that his goal was simply to make music, to follow his muse (“Mr. Tambourine Man”). And if that’s not acceptable, stick it in your ear (“It Ain’t Me Babe,” [I Don’t Want to Work on] “Maggie’s Farm” [No More]). He had a postmodern kid’s ironic, cynical outlook that nearly everybody was a cog in some vast “system” and thus simultaneously someone to be distrusted, a victim of circumstance, and a possible catalyst to assist his own advancement. That is how he could write the lyrics about Medgar Evers’ assassin (“He’s Only a Pawn in Their Game”) and at the same time identify with Oswald. These stances fit into a kid’s conspiratorial worldview.

Prodigious talent like Dylan’s is intrinsically mysterious, never reducible to psychological terms. But his youthful rebelliousness was in step with his times, and this fortuitous phase-of-life circumstance was central to the flourishing of his talent. The psychological costs, however, had been high. His motorcycle accident in mid-1966, the event that marked the end of his most creative period, was a wake up call. (Scorsese doesn’t allude to this accident either.) In a 1985 interview for Spin magazine, Dylan said that the accident forced him to realize that (far from being a cool, self-possessed young man) he had reached the point where he lacked “any kind of perspective,” could not have sustained his “wound up” pace much longer, and “probably would have died” if he had persisted.

After the accident Dylan withdrew from public appearances for 18 months. Six months after that, according to biographer Robert Shelton (No Direction Home: The Life and Music of Bob Dylan, New York, Beech Tree Books, 1986), when Dylan attended his father’s funeral in Hibbing, his younger brother David described him as having a “quietude, firmness and serenity befitting a fifty-year-old man.” By then, we might infer, the kid had walked down enough roads that one could call him a man.

(No Direction Home: Bob Dylan first aired on the Public
Broadcasting System in late September, 2005, and the DVD was released simultaneously.)

THREE OTHER RECENT FILMS ON BOB DYLAN


Strength: the songs are presented in their entirety, not cut short.
Weakness: as one might expect employing outtake footage, this film seems choppy, lacking the coherence of the earlier film.
Grade: B.

The Other Side of the Mirror: Bob Dylan Live at Newport (Murray Lerner, US, 2007, 83 min., black & white). Dylan’s sets at the 1963, 1964 and 1965 Newport Folk Festivals are shown here. Every number is presented in its entirety. This film provides an opportunity to watch Dylan’s growth and his controversial (for the “folkies”) crossover into electronically amplified rock in his 1965 set. A pure concert film, without commentary or talking heads. Grade: B+ (as an early Dylan archive: A).

I’m Not There (Todd Haynes, US/Germany, 2007, 135 min., color). In this imaginative but strange account of Bob Dylan’s life, the (Roman à clef) conceit is to personify the complex and contradictory nature of the singer/songwriter - a complexity carefully nurtured in the public eye by Dylan himself, as well as by the press - by having six different actors play out various personas that purport to represent different aspects of Dylan, who does not appear in this film. What you’ve got is an unusual sort of roman à clef narrative, and the result is a somewhat unwieldy mixed bag.

The three fictional characters are all at least decently wrought. They are singer/songwriter Jack Rollins (Christian Bale); actor Robbie Clark (the late Heath Ledger), the weakest of the three in terms of credibility as Dylan; and the most Dylanesque of the six characters, Cate Blanchett, of all people, in drag as Jude Quinn, a dead ringer for the Dylan of 1965 on his tour of Britain, a segment shot in black & white that is a stunning homage to Bob Dylan’s first visit to the Newport Folk Festivals in 1963. The film seems choppy, lacking the coherence of the earlier film.

Weakness: as one might expect employing outtake footage, this film seems choppy, lacking the coherence of the earlier film.
Grade: B-

Coasting in the Countertransference: Conflicts of Self Interest Between Analyst and Patient
by Irwin Hirsch
Reviewed by Richard D. Chessick, M.D., Ph.D.

This is a book by a very experienced and very clever psychoanalyst. It is written in the first person, like a memoir, and the author is purposefully using this style as a raconteur because he wishes to illustrate the contrast between the more strictly speaking and thinking and technical sounding psychoanalytic writing that determines the practice orientation of traditional psychoanalysts and ego psychologists, and the writing and thinking that characterizes his form of relationship therapy. I found the book very repetitious, more or less like a collection of papers which have not been edited before they were put into a book. I was also put off at first by the loquacious Forward and Acknowledgements sections which I thought were overdone. These complaints aside, I think Hirsch’s book would be worth reading by anyone who is in the practice of psychoanalysis - as long as they keep in mind that it is written from a very one sided relational point of view.

The book is essentially about the role of the analyst’s self interest and the conflicts of self interest between analyst and patient. It lives up to its aim by discussing this matter in a number of contexts all the way from what he regards as the problem of baldness to the very serious problem of finances. He emphasizes the situational factors in analyst’s lives as well as their unique personalities and explains, “These enduring and/ or transient states generally lead analysts, usually unwittingly at the start, to shape the analytic relationship to conform, more or less, to their most comfortable and preferred relational states” (p.3). He goes on to explain that eventually these interactions, according to him, “inevitably” come into the analyst’s awareness, leading to the necessity for a choice of “whether to create a disquieting equilibrium by using these interactional data to productively address the transference-countertransference theme, or, conversely, whether to coast with the status quo and maintain what might be a mutually comfortable equilibrium between patient and analyst” (p.3).

Over and over again Hirsch makes the point that in his opinion analysts choose to maintain the status of equilibrium for a whole variety of reasons which can be included under the rubric of the analyst’s self interest. In this sense he is writing an elaboration of the chapter entitled “The secret life of the psychoanalyst” in my book The Future of Psychoanalysis (State University of New York Press, 2007), although he does not refer to that publication. He discusses analysts’ lapses, avoidance of important transference themes, and role of the analysts’ various affective states as well as their encouraging other affective states in the patient. He sums this up basically as the reluctance to address transferences and he states that the most common intervention he makes when he is supervising others is to point out this reluctance. He writes, “Analysis of transference is usually in direct opposition to coasting in the countertransference, and forcing oneself to use countertransference experience to address destabilizing mutual patterning is, I believe, the best analytic hedge against a comfortable status quo” (p.17). I agree with Hirsch that avoidance of addressing transference issues (in my opinion because they
are often missed) is a very common problem and “often” (p. 16) (I say “at times”) can be explained by the self interest of the psychoanalyst who has recognized them but chooses out of self interest not to disturb the patient. It remains polemical as to whether or not forcing one’s self to confront these transfersences is the best way to go. In relationship therapy it is clear from the technique that is described by Hirsch in the various case histories he gives that he has no compunction to interfere aggressively in the treatment by confronting these various transference-countertransference developments as he sees fit.

There is no doubt that Hirsch is correct when he tells us that, “Analysts’ levels of comfortable self-interest always operate in some tension with the best interest of patients” (p. 39) and many of his brief case histories illustrate this very well, a feature of the book which I think is quite interesting and makes it a “must reading” for anyone who practices psychoanalysis or psychotherapy or any of the helping professions.

He correctly points out that the turn in psychoanalysis toward relational therapy which I have deplored (see Returning to Freud, Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, in press) corresponds to the waning of any agreement about a standard technique for the practice of psychoanalysis. The extreme of this relational therapy is the so-called deliberate self disclosure of thoughts and feelings, which, as Hirsch correctly states, “remains the most controversial dimension of analytic procedure” (p.47) and he does not seem to advocate very much of that. But for Hirsch psychoanalysis is “enlightened by the two-person, interpersonal, mutually participating analyst of the relational turn” (p.51) with its emphasis on mutual enactments and the analyst’s unconscious participations in them with patients. He is concerned that these enactments persist even after the analyst becomes aware of them, what he calls “indulging of countertransference” (p.58) for reasons of the analyst’s self-interest. The implication of this, it seems to me, is that many analysts are plainly crooks. Of course these indulgences are often rationalized away as Hirsch points out, by various explanations from the analyst as to why what he or she is doing is in the best interest of the patient. But it is one thing to misunderstand the transference or miss it entirely and lack insight into what one is doing with a patient, and another to deliberately mismanage a case in the interest of financial or other gain. It is one thing to be stuck in a transference-countertransference configuration that one is unable to resolve without recourse to consultation with a colleague or return to resume one’s psychoanalysis, and another to coast consciously in such a configuration for self-interested purposes. It is one thing to rationalize a procedure that one knows is secretly for one’s self-interest, and it is another to believe one’s own rationalizations with no insight into the reason for them!

There is a great deal of self revelation in the book, including a description of his ideal day which consists of seeing eleven people (p.20) or sometimes twelve or even thirteen although he does not prefer it. I have encountered analysts like this and I’ve often wondered about what kind of therapy patients number nine through twelve will get after the analyst has sat through the first eight or nine patients. The case histories he offers, as I suggested above, are deliberately written in a raconteur fashion to show the contrast between relational therapy and attempts at a scientific treatment such as Freud and the ego psychologists would call psychoanalysis. Many of them reveal Hirsch’s intel-

ligence, experience, and insight. As he himself points out however, there are many over-generalizations in his writing which, to my mind, give the impression of a kind of superficiality or populism to his approach. There is not space in a book review to discuss the various case histories that he gives which would demonstrate this and he deliberatelyeschews “highly technical terminology” (p.82n), which seems to be his béte noire.

There are excellent discussions of why analysts prefer certain patients, why some patients are considered unanalysable (a very questionable concept these days), the role of analysts’ “love for preferred theories, and the inclination to coast with these cherished systems” (p.113), and a direct confrontation with some contemporary analysts (such as myself) who “still argue for psychoanalysis as science, minimizing analysts’ irreducible subjectivity in the understanding of patients” (p.115). He claims that “the scientist-analyst inevitably discovers the evidence that confirms the theoretical positions already held” (p.115), which paints a very dreary picture of their approach. So he says, “The long-standing hegemony of Freudian theory and ego psychology in the United States has broken down. Though most analysts, at least privately, believe that their own theoretical affiliation is actually better than others, deeper reflection is likely to lead to the recognition that there are multiple ways of understanding patients and of being analytically useful. I believe that any analyst’s personality, and how this intersects with his or her engagement with each individual patient, will account for far more of the variance in outcome than anything related to subjective theoretical preferences” (p.121).

Hirsch concedes that his kind of interactive relational therapy can be experienced as very intrusive: “The greater license to interact indeed may produce a situation wherein the patient is usurped or overtaken by the all too noisy presence of the other” (p.124). He criticizes Freudian writing and the “highly technical Freudians” (p.126) and tells us that although in the past he could never understand “why so many respected peers and teachers seemed to enjoy Freud as a writer” (p. 126) now he can “enjoy Freudian writing as long as it is not highly technical” (p.127). Basically Hirsch’s point is that, “In the trenches of the transference-countertransference matrix, the technical inevitably breaks down, exposing analysts’ personalities and their degree of emotional connectedness and intensity toward each unique individual patient” (p.127). This is an extremely important point and needs to be kept in mind by all of us in assessing our work.

Another of Hirsch’s most important points is to remind us that the fact that analysts are economically dependent on their patients leads to, “an inherent and profound conflict between self-interest and patient interest, and this conflict always has the potential to severely compromise analytic work” (p.156). One consequence of this, according to Hirsch, is that analysts keep patients in treatment too long and develop excessive dependency in their patients as a result of this. It has to do with the choices of how often to see a patient and the development of patients who are, according to the analyst, going to be “patients for life” (p.161). He writes, “Many patients who can pay high fees will be seen multiple times per week for many, many years, long after it is easy to rationalize that analytic goals still prevail” (p. 161). He argues that these are compromises “propitiated by analysts’ anxiety about money” (p.161) in which the analyst wants to be liked by the patient, keep the patient, and not get the patient angry so the patient stops treatment. He correctly
points out that this often is a reason why the negative transfer-
ence is not confronted, although the word confrontation that he
dercharacteristically uses connotes an approach that bothers me and
I would prefer to speak of interpretation of the transference. In
a way this is a verbal contrast that delineates the difference be-
tween Hirsch’s relational approach and classical psychoanalytic
practice. The two chapters on the problem of money at the end
of the book are especially important and discuss these matters
at length. He even points out that being too unchallenging and
unquestioning may backfire because the patient may leave a
treatment that is insufficiently stimulating. It is typical of Hirsch
to write, “Patients are often more resilient than their dependent
analysts expect” (p.197).

In his summary Hirsch maintains that “The potential ther-
apeutic value of any analytic activity” is largely a function of
whether it is motivated “primarily by the desire to be of use
to the patient or to ourselves” (p.197), and this is certainly
correct. In the chapters on money and in other places Hirsch
acknowledges that what he is writing “may appear bleak and
cynical” (p.199) and in my opinion it does, implying a rampant
conscious crookedness in psychoanalysts. In this sense the book
is overwritten. That allows it to be more or less a polemical
treatise but it is a polemical primarily to remind us that too many
of the decisions that are made in the therapeutic process by
the analyst could result in the placing of our patients’ interest
ahead of our own. So we as psychoanalysts have the obligation
to investigate ourselves continuously and to evaluate all of our
choices in our analytic work from the point of view of whether
these are primarily in the interest of the patient or not.

The Infinite Question
By Christopher Bollas
Routledge Taylor & Francis Group, NY 2009, pps. 153,
paperback $23.95
Reviewed by JoAnn Elizabeth Leavey EdD

In “The Infinite Question” Christopher Bollas uses everyday
clinical practice to illustrate psychoanalysis and questioning.
Bollas examines the role and desire to question, to dig deeper
into meanings to find answers, and to ask further questions.
Bollas suggests that each of us is a hidden novelist, composer,
painter, sculptor, dancer. We create our own realities through
each of these milieu and we understand our worlds through our own
unique lenses. We compose for our realities and we incorporate
these realities into our dreams for further sifting, development
and understanding. Bollas concentrates on Freud’s idea of
exploring the notion that the majority of unconscious ideas are
non-repressed. Bollas tells us that most psychoanalysts focus on
the repressed unconscious and this represents the core of Freud’s
theory of the unconscious: the mind pitted against itself.

Bollas acknowledges that clinically, the repressed unconscious
is an important element. However he chooses to focus Freud’s
theory of non-repressed ideas understood as the logic of sequence.
If we speak our thoughts as they occur to us, and not

in a scheduled way, our thoughts can move in an unobstructed
sequence that would appear to be random. However, as Bollas
points out, Freud discovered that if we speak our thoughts as
they pass through our minds, they reveal an inherent “logic of
sequence.” The conscious mind to free associate and, when
analyzed, we can find a hidden logic in the associations. At first,
the ideas may appear to be unconnected, hence Freud’s definition
of the logic of sequence theory.

To illustrate these points, Bollas draws on three clinical
transcripts of cases on which he comments. These cases are
further utilized in Bollas’s wider theoretical framework using
Freud’s logic of sequencing as described above. By following
this method, Bollas purports that we are much able to learn more
about clients by allowing clients to speak their conscious thoughts
and paying attention to Freud’s idea of “the logic of sequencing.”
Bollas believes that this is a more comprehensive way to probe,
understand and integrate conscious and unconscious meanings.

It is clear that the most critical skill is to listen patiently and
to allow time for the patient to free associate with no immediate
conscious interpretation from either patient or therapist. That can
be done later. The difficulty in the immediate free associative
method is to allow the words to materialize through speaking
logical chains, lines, twists and turns. This will permit a natural
thread of thought or pattern to allow for an eventual understanding
or meaning to the seemingly unconnected thinking through
the process of “logic of sequence.”

Further, it is questioning, after listening, is the second most
important feature of the logic of sequence method. Questions
can help reveal hidden meanings in what we are thinking, free
associating, dreaming, and repressing. According to Bollas,
our “interrogative self” is driven by dreams that drive free
associations and conscious experiences that drive new ways of
thinking. Phenomena previously understood as the unconscious
self are enriched by the free association logic of sequence method
as applied to the conscious self. The unconscious self carries
the wisdom of the self’s history and engages the analyst in the
deep work of processing the details of lived experience through
symbolism, while the conscious self work helps us organize our
conscious thoughts into a stream of meaning through voice.

Bollas cleverly uses metaphor to describe these two mental
phenomena: the unconscious and conscious mental processes are
analogous to understanding the culture of a country by pointing
out its geography. The physical aspect of the country is to the
conscious mind as the meaning derived for the people living in
their particular culture (the unconscious). Thus meaning cannot
be separated from location in terms of understanding the overall
effect.

Bollas lays bare that inquiry is essential to the analytical
process and only later should the analyst and patient move to
interpretation. However a self-propelling interrogative drive is
required to facilitate this process of self-discovery as it seems
that human beings are fascinated by deriving meaning from their
thoughts, unconscious or otherwise. Bollas provides us with
method and process to explore these phenomena.
Vienna Triangle
by Brenda Webster
Published by Wings Press, San Antonio, Texas, 2009, $16.95, 228 pages, paperback
Reviewed by Michael Blumenfield, M.D.

The year is 1968. Helene Deutsch is 84 and, while vacationing in Provincetown, Massachusetts, meets Kate, a young woman who, by coincidence, is writing her PhD thesis at Columbia University about the early women analysts. Dr. Deutsch is one of the most prominent, well-known and respected early women psychoanalysts and who had been in analysis with Sigmund Freud himself. One thing leads to another and in the course of their new mentoring relationship Kate uncovers some previously hidden documents belonging to her mother and which shed light on a family secret that her mother had withheld from her. This secret was that her maternal grandfather was the well-known psychoanalyst Victor Tausk who had been part of Freud’s inner circle and who had committed suicide.

Kate becomes obsessed with trying to unearth the details of her grandfather’s life and to find out why he killed himself. Dr. Deutsch who knew Dr. Tausk and even briefly analyzed him reflects on distant memories and begins to bring forth pieces of the puzzle. These details involve Tausk, Freud and the beautiful Lou Andreas-Salome. Kate also stumbles upon information that leads her to meet her two previously unknown uncles, sons of the late Dr. Tausk.

Author Brenda Webster uses this plot in her novel to explore and describe life in Vienna and the complicated interactions both inside and outside of Freud’s Inner Circle during the birth of psychoanalysis. The personalities of the cast of characters unfold. Freud the creator, the father figure, is portrayed as extremely protective of his newly developed “baby.” Tausk is described as a brilliant young man who is making important contributions to psychoanalysis but who feels he is not quite appreciated by the Master. He develops a love affair with Salome who at the same time has become one of Freud’s favorite pupils. Young Helene Deutsch is making her own contributions about psychoanalytic theory and women at the same time she is having her own love affairs. Freud does not grant Tausk’s request to be analyzed by him and instead refers him for analysis to Deutsch. There is a question about whether Freud’s harsh and rejecting treatment of Tausk contributed to his decision to take his life. Documents that purport to show Freud’s reaction to his junior colleague’s suicide do not paint a flattering picture of the leader of the psychoanalytic movement.

The characters in this book are interesting and well developed. There is love, romance, jealousy, rivalry, narcissism, loyalty, rejection, dedication to the cause, and the mysterious suicide of Tausk that contribute to making this a fine novel. It is a page-turner (or in my case a button pusher - I read books on the Kindle). This book should have strong appeal to all students of psychoanalytic and psychodynamic theory. It is well known that to fully grasp all of these ideas you need to go back to the streets of Vienna and the lives of the people who were bringing forth this revolutionary new understanding of human behavior.

However there may be a problem with this book. It is a novel. It is fiction. If you are thinking of reading it to understand the intricacies and nuances of the relationships that existed in Freud’s inner circle, shouldn’t you really be in the non-fiction aisle of your library, bookstore, or frame of mind (if you are buying online)?

Brenda Webster states the following in her authors note at the beginning of the book: “This is a work of fiction, not of history; nevertheless it is based on the lives and relationships of real people: Viktor Tausk, Sigmund Freud, Lou Andreas-Salome and Helene Deutsch. I have attempted not to violate the known facts, but have invented dialogues, dialogues and secondary characters in order to bring the actors, their ideas and passions to full imaginative life.” This is an ambivalent statement. It does not violate the known facts and yet all sorts of things have been invented.

In the author’s afterword she further elaborates that an important letter mentioned in the book from Freud to Andreas-Salome after Tausk’s suicide is genuine, as are her responses to it. (This is one of the documents to which I referred above.) Webster also cites Kurt Eissner’s writings that she says defended Freud’s treatment of Tausk. This suggests that she made efforts to found the main premise of the book on as much fact as possible.

My advice to potential readers is as follows: If you have been around the block and studied the history of psychoanalysis to the point where you are satisfied with what you know, or if you don’t really care about who said what or who was jealous of whom etc., then consider reading this enjoyable and interesting novel. It is fun thinking about these people even if many of the facts, attributions and nuances may not be correct. However, if you are new student of psychoanalytic theory and want to learn more about these historical figures and how they interacted while coming forth with these ideas, hold off reading this novel. I suggest instead, that you read some of the many historical accounts, biographies and diaries, which are available about this period of time and these important people. Ask your teachers and mentors for suggestions, in particular about areas of your interest. By the time the movie comes around of this intriguing plot, if they ever decide to make one, you will be ready for this version of the story.

The Tavistock Seminars
by Wilfred Bion
Edited by Francesca Bion; Karnac, London, New York, (2005), 118 pp., $14.95
Reviewed by Ronald Turco, M.D.


Bion deals with psychoanalysis in an unorthodox manner “outside the box” of conventional psychoanalytic thinking. This tergiversation does not, however, desert the ultimate goal of psychoanalytic therapy. Bion begins by focusing on the trauma of being psychoanalyzed and the length of time it took before he knew where he was “at.” This highlights the departure from biology when it comes to the question of the mind and the transmission of ideas. Without discussing Beyond the Pleasure Principle he echoes Freud when he notes that pain is a fact of existence - not so very different from pleasure. In supporting the movement towards the freedom of the mind he poses the question: “How do you feed the mind in such a way that it can develop, not get poisoned?” He writes “…it is not so easy to know what ideas are soporific, what ideas are poisonous, and
whether we, as analysts, are not furthering these developments of methods by which thought would become impossible.” With regard to the analysand, he writes of “hearsay evidence,” the evidence he hears said and rates very low “…what I want to hear is something that is buried in all this noise.” He perceives the “third body” in the room and how the analyst is being analyzed all the time by this third party. Thus, the uniqueness of his thinking.

Bion also emphasizes that both the analyst and analysand are analyzing each other. It is not possible to analyze anyone without being analyzed oneself by the patient and…. “So both parties are almost inevitably engaged in an occupation that arouses feelings of hatred and anger - not to mention also the wish to run away.” Both individuals are a prisoner of the information one’s senses bring – the sense of touch, sight, hearing and so on. The development of the analysis occurs when the shell is broken and the mind is freed of its chattels.

Bion’s definition of psychoanalysis is that it is an attempt to know what it is that interrupts us or makes it impossible to think clearly or to have any respect for the facts at hand. It is an attempt to investigate what it is in ourselves that causes so much trouble. Where is the source of the interruption? He quotes Shakespeare: “The fault dear Brutus, is not in our stars, but in ourselves, that we are underlings.” (Julius Caesar, I ii) Sooner or later we will have to correct our own faults. He de-emphasizes the technical vocabulary of countertransference, transference, resistance in favor of a comprehensive approach to the human being whom we most often do not consider as suffering. We lose sight of the patient’s suffering as the patient helps you to lose sight of it. “We can only hope to be able to detect, in time, whatever is menacing that particular attempt at a creative cooperation between two people. Sexual freedom, for example, may be viewed as a “collateral circulation” to avoid the difficulties of a spiritual relationship between two people.

Bion describes the dream in terms that I have never experienced before. His statement is profound “…it is like having the whole of one person at all ages and at all times spread out in one room at one time.” This is a representation of his thinking and one must read the book to experience the sense of his relationship with the patient. His perspective is summed up: “The usual part of life is involved with tragedy, sadness and decaying health…we should consider that suffering and rivalries with other human beings are really the normal standard.” The individual is struggling with the shells that have been built up around him. My words cannot do justice to the profundity of Bion’s ideas.

His disdain for formal organizational arrangements is quite clear and he sums up his ideas of theory by stating: “It is hopeless if bunches of people meet together and argue about Kleinian theory or somebody else’s theory…it is a pure waste of time because there are far more important matters to think about, or even to learn to think about.” From my perspective this work is canonical and ex cathedra.

A Movie Review of The Last Station; written and directed by Michael Hoffman, based on a novel by Jay Perini. Starring: Christopher Plummer, Helen Mirren, Paul Giamatti, James McAvoy and Kerry Condon

Reviewed by Cassandra M. Klyman, M.D.

Last night I saw a really “grown-up” movie. Shakespeare would have applauded it, too, to see how his “King Lear” themes were reworked for Russia at the turn of the 20th Century. Fittingly it is the story of the last years of the great novelist, Leo Tolstoy and his family and their fortunes. For them it was not only their landed riches but the copyrights and royalties that went with “War and Peace” and my all-time favorite “Anna Karenina” that was his estate.

We may presume that as Tolstoy aged and became physically impotent his main source of gratification moved from fused libidinal and narcissistic aims to primarily the latter. He found great admiration for his spiritual, reformist and sociopolitical ideals in Chertkov. Together they conspired to build a nearby agricultural and self-sustaining socialist commune where celibacy and gender-neutral work was supposed to flourish and power for the people to be obtained through passive-resistance.

Even more significantly Chertkov was trying to establish a second will in which the Tolstoy financial legacy of his renowned novels would be passed on to his foundation for the good of the Russian people and not to his wife, the Countess. His children have split loyalties, one daughter with her father, the son with his mother. Helen Mirren, as Countess Sofya, who was acclaimed as Queen Elizabeth several seasons ago, totally drops her reserve in this casting of wife and mother and throws herself literally and figuratively into this role as the genuinely aggrieved, jealous, scathingly bitter and almost mad spouse. She becomes the scorpion mother when she shouts, “I had 13 children, of the 5 who died, why weren’t you one of them?” Yet the audience sympathizes with her plight, delights when she uses barnyard humor to seduce her husband of 48 years, cheers when she unloads a revolver at her rival’s picture. How many of us married to workaholics, TV or computer “addicts” are not tempted to do the same when we feel cast aside?

Christopher Plummer as the Count is also magnificent as the aging, conflicted, reminiscing, then dying icon and finally husband. His hearty contagious laugh when his retired libido is awakened reveals his and his character’s depth of rich feeling. But mostly he forgets, as do we all when we are feeling vulnerable and want to shore up our sense of self, that his great novels were a collaborative effort with his wife - or so she says when she tells how she helped flesh out his characters and wrote and re-wrote “War and Peace” six times!

The sub-plot of the film is about a young male secretary, aptly named Valentin, that Chertkov hires to spy on the household. “Write everything, write everything down” is the directive - as if setting up the creation of another Tolstoy. But the young man, who sneezes whenever he is happy or anxious, is responsive to women. He feels a deep sympathy for the Countess - he can only claim reading “War and Peace” twice - and he falls deeply in love with a young teacher who is disillusioned about the possibility of an ascetic utopia for herself and for him.

Masha is like the child who cries out, “The Emperor has no
clothes.” “Making love is what we humans do,” she exclaims and we should never forget that. The Last Station is a wonderful reminder.

OH! And what happened to the money? Now that’s a Hollywood ending that happens to be true. There are additional themes to be sure - the oedipal in positive and negative forms. Tolstoy’s daughter rivals her mother for her father’s attention by doting on him and admiring all his theory unconditionally and deliberately keeps her mother from him as he lays dying. From the start here is a hint of latent homosexuality between Chertkof and Tolstoy as the former lasciviously twirls the ends of his waxed moustache but it seems it is more a lust for the control of the money than interest in the literary genius himself.

The filming is beautiful both indoors and out - the aspens filter the light like the seconds on a clock and indoors light is used to full melodramatic, chiaroscuro advantage. Is life like art, or does art copy life? In the drama of Sofya and Leo’s domestic warfare we see both war and peace and the conflicted internal world of a woman’s role in a patriarchal society, like bourgeoisie Anna Karenina, where her anger and frustration so often had to be turned on herself and where the love she professed for her child did not stop her from suicide.

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**Obituary**

**Teresa Bernardez, M.D.**

1931-2010

*by Silvia Olarte, M.D., DFAPA, FAAPDP*

Dr. Bernardez, a native from Argentina, came to United States to pursue her psychoanalytic career. She earned her MD at the University of Buenos Aires Medical School, interned at the Hospital Vaugirard in Paris, and did her residency and served on the faculty at the Menninger Clinic in Topeka, Kansas. She joined the American Academy of Psychoanalysis invited by women members that in the late 70’s and early 80’s were committed to challenge the manner in which the psychology of women was understood. She was an active member of the Study Group on Women and a frequent presenter at our meetings of innovative and intellectually provocative papers most often but not solely addressing women’s issues. She was a member of our program committee and finally was a trustee at our council where she was a vibrant participant challenging the “status quo” especially on women and minority issues. At the American Psychiatric Association, mainly through her tenure at the National Committee on Women and during her chairmanship of that committee, Teresa led a rebellion on the revision in 1985 of the Diagnostic & Statistical Manual of Mental Disorders, attempting to remove from that manual three so-called mental disorders: Premenstrual Dysphoric Disorder, Paraphiliac Rapism Disorder, and Masochistic Personality Disorder.

Teresa served as a full professor in the Department of Psychiatry, College of Human Medicine, Michigan State University, and was a founding and active member of the Michigan Psychoanalytic Council. She served at the Tavistok Clinic in London during her first sabbatical, and was a fellow of the Bunting Institute at Radcliff College for her second sabbatical. She was an organizer of a mental health panel at the 2nd World Conference on Women in Copenhagen in 1980. Her passion was her work with patients facing multiple challenges, women and anger, group psychotherapy, and feminism. She was an innovative writer, author of numerous works and articles in her areas of interest, many of them published in our Journal.

More recently, Teresa began writing and performing poetry and had gathered an edited collection of 50 of her poems. She was in private practice at the time of her death. Her enthusiasm, contagious energy, innovative thinking and commitment to issues that she was passionate about, will be deeply missed.
New Member Profiles – Accepted

The Membership Committee is pleased to welcome the following who are new members to the Academy.

Medical Student

Andrew Michael Novick  Vermillion, SD
Sponsors: Clay Whitehead, M.D., César Alfonso, M.D.

Mr. Andrew Novick received a BS degree graduating Summa Cum Laude from the Philadelphia College of Pharmacology in 2008 and is a 1st year medical student at the Sanford School of Medicine of the U of South Dakota in the Physician/Scientist Training Program (MD/PhD) and expects to graduate in 2015. He has several neuroscience publications and posters to his credit and has received seven academic and research awards. He participated in the Psychoanalytic Research Training Program at the Yale Child Study Center. His current PhD work involves modeling the long-term consequences of stress and trauma in adolescence.

Aaron Savedoff  Manlius, NY
Sponsors: Scott Schwartz, M.D., Charmaine Rapaport, M.D.

Mr. Aaron Savedoff received his BA degree from Binghamton University in 2007 where he graduated Cum Laude in Biology. He will graduate from New York Medical College in June 2011. He has had a summer fellowship in cardiology, volunteered in a soup kitchen and with Habitat for Humanities, and worked on a number of research projects in the Department of Pediatrics, Pulmonary Division at S.U.N.Y. Upstate Medical Center. He is a member of the AMA and has co-authored two papers related to hypnosis. He plays the cello.

Heather Forouhar Graff  Unionville, CT
Sponsors: Samar Habl, M.D., David Mintz, M.D.

Ms. Heather Graff is a fourth year medical student at the University of CT Medical School. She graduated Cum Laude from UConn Honors Program in physiology and neurobiology with a minor in neuroscience. She attended the Institute for Healing Arts and Sciences in Bloomfield, CT from 2005-2007 and is attending the Psychodrama Institute of New Haven concurrent with medical school. She did a rotation at Austin Riggs Center and is involved in an ongoing research project there. She has taken on a number of teaching assignments and has received multiple honors and fellowships. Letters from her sponsors described her as an exemplary applicant to the Academy.

Douglas Romney  Chapel Hill, NC
Sponsors: Clay Whitehead, M.D., César Alfonso, M.D.

Mr. Douglas Romney is a second year medical student at the University of North Carolina Doctor of Medicine Program, Chapel Hill, NC and will be graduating in 2013. He graduated UNC Chapel Hill with Honors and Distinction in Philosophy and a minor in Chemistry. He was an Eagle Scout and has received a dozen grants, scholarships and awards since beginning medical school. Dr. Alfonso states in his letter that Mr. Romney “has a genuine interest in pursuing psychiatry residency training…with interests in bioethics and child psychiatry. He is a leader of the Psychiatry Interest Group in his medical school.”

Pschiatric Associate

Jack Castro, M.D.  New York, NY
Sponsors: Scott Schwartz, M.D., Clifford Gimenez, M.D.

Dr. Jack Castro graduated college and medical school (combined) from the Central University of Venezuela School of Medicine in Caracas, VZ in 2004. He is currently a PGY-1 psychiatric resident at New York Medical College at Metropolitan Hospital Center in NYC. Between medical school and residency training he worked as a medical assistant for a family practitioner/allergist, for a hematologist and as a general physician for the Venezuelan Department of Health. He has volunteered with flood victims in Venezuela and assisted with forensic autopsies. He is fluent in Spanish, proficient in French and plays guitar. He is interested in culture, art and literature and Dr. Scott described him as motivated, thoughtful and respectful.

Melissa C. Crookshank, M.D.  Philadelphia, PA
Sponsors: Eugene Della Badia, D.O. Sarah Noble, M.D.

Dr. Melissa Crookshank received her B.A. from Brooklyn College, her M.D. from Temple U School of Medicine in Philadelphia, PA in 2006, and completed her internship and residency at Temple finishing in June 2010. She is currently a staff psychiatrist at Temple and in private practice. She has worked as a research assistant at NIMH and Brooklyn College. She has won several honors and awards and is a member of the Temple curriculum and recruitment committees. She belongs to the AMA, APA and Philadelphia Psychiatric Society. She plans to start psychodynamic coursework through the Philadelphia Psychoanalytic Institute.

Dana DeVito, M.D.  New York, NY
Sponsors: Scott Schwartz, M.D., Clifford Gimenez, M.D.

Dr. Dana DeVito graduated from Cornell University where she majored in Biology, received her M.D. from St. Georges University in Granada, and is expected to complete her psychiatric residency training from New York Medical College at Metropolitan Hospital Center in NYC in June 2011. She made the Dean’s list twice at Cornell, was inducted into two national honor societies in college and is an equestrian. Prior to medical school she worked as a research assistant in the Cornell Department of Behavioral Sciences and was a psychiatric technician at Silver Hill Hospital in Connecticut. She received a glowing recommendation from Dr. Schwartz who attested to her integrity, ethics, clinical skills and warm personality.

Robert Ellis, M.D.  Omaha, NE
Sponsors: Paul Fine, M.D. Sherry Katz-Beanot, M.D.

Dr. Robert Ellis received his BS from Virginia Technical Institute graduating Magna Cum Laude in electrical engineering
Suzanne M. Garfinkle, M.D., Ms.C.  
New York, NY  
Sponsors: Deborah Cabaniss, M.D., Clarice Kestenbaum, M.D.

Dr. Garfinkle received her BA degree from Amherst College, her M.Sc. from University College London, her medical degree from Mount Sinai School of Medicine, and completed her psychiatric residency at Columbia University New York State Psychiatric Institute in 2010. She is a fellow in Child and Adolescent Psychiatry at Mount Sinai School of Medicine. Her thesis at the University College in London was “Does ‘Talking Cure’ without Cure Leave only Talk?” She has received awards, grants and fellowships and has taught in several capacities.

Aerin M. Hyun, M.D., Ph.D.  
New York, NY  
Sponsors: César Alfonso, M.D., Deborah Cabaniss, M.D.

Dr. Aerin M. Hyun received a BS in Bioengineering and a BA in English and American Literature in 1995, her Ph.D. in English and American literature (special field emphasis: American Psychoanalysis – Origins and Influences; thesis title: Evaluating the Borderline Personality: A Study of Identity and Narrative Voice), and MD from the College of Medicine, all at the University of Illinois at Urbana-Champaign. She will complete her PGY-4 year at Columbia University Medical Center, NY in June 2011. She has taught in the fields of Medicine/ Psychiatry, Literature and Film Studies, and Technical Writing and Scientific Communications. She has worked as a copy editor and academic tutor and has done community outreach and volunteer work. She has had multiple professional memberships including the APA, has received numerous honors, has been active on a variety of committees, and studies classical ballet.

Jabari Jones, M.D.  
Bakersfield, CA  
Sponsors: César Alfonso, M.D., Scott Schwartz, M.D.

Dr. Jabari Jones received his BS degree from the University of Toronto in 2003 graduating with high distinction and majoring in Human Biology and Psychology. He received his MD from Albany Medical College in 2007, spent three years in residency training in psychiatry at St. Vincent Catholic Medical Centers, NY, and is in his 4th year of training at UCLA-Kerns Psychiatry Residency Program in Bakersfield, CA. He has been taught by Dr. Alfonso and Schwartz who are sponsoring his application and describe him in complementary terms as a fine addition to the Academy membership.

Maria Consuelo Lozano Celis, M.D.  
Wilmington, DE  
Sponsors: Kimberly Best, M.D., Eugene Della Badia, D.O.

Dr. Lozano Celis received her MD from the Instituto de Ciencias de la Salud en Medellín, Colombia in 1966, did post-residency training at the Universidad de Antioquia in Medellín, Colombia, and is a PGY-4 at the Albert Einstein Medical Center in Philadelphia, PA. She will complete her residency training in psychiatry January 2011. She has also received a degree from the Culinary Arts Institute in Fort Lauderdale, FL and has had experience as a restaurant general manager and chef. She has published on “Association Study of Bipolar Mood Disorder with the 5-HTTLPR Serotonin Transporter Polymorphism in a Human Population.” She is interested integrating psychodynamic and biological aspects in the practice of psychotherapy.

Angela McCarthy, D.O.  
Philadelphia, PA  
Sponsors: Kimberly Best, M.D., Eugene Della Badia, D.O.

Dr. Angela McCarthy graduated Summa Cum Laude from the University of Scranton, graduated from the Philadelphia College of Osteopathic Medicine in June 2005, and completed her residency in psychiatry from the Albert Einstein Medical Center in Philadelphia in June 2010. She has volunteered with autistic children, recruited residents to for Albert Einstein, and performed health research on children and adolescents. She is an American Red Cross Volunteer and is a member of the APA, AMA, AOA and AAHPM (American Academy of Hospice and Palliative Care).

Sarah C. Noble, D.O.  
Philadelphia, PA  
Sponsors: Kimberly Best, M.D., Eugene Della Badia, D.O.

Dr. Noble received her BA degree from Sarah Lawrence College, her D.O. from the Philadelphia College of Osteopathic Medicine, and is a fourth year psychiatric resident at the Albert Einstein Medical Center in NYC. She is on the Graduate Medical Education Committee, the Psychiatric Education Committee, the Post-Partum Depression Screening Program, and is editor of a Resident’s Survival Handbook. She aided in the design of the resident website, was head of a cultural film series, and won the opportunity to perform the Lalo cello concerto for the Sarah Lawrence Concerto Competition. She has performed various kinds of community service and hosts salons and cultural events with her husband at her home.

Karen L. Thomas, M.D.  
Philadelphia, PA  
Sponsors: Kimberly Best, M.D., Eugene Della Badia, D.O.

Dr. Karen Thomas received her BA in Anthropology from University of Pennsylvania, her MS from Adelphi University, PA, her MD from Pennsylvania State College of Medicine, and is in her last year of her psychiatric residency at Albert Einstein Medical Center. She has co-authored five papers, one on children and adolescents with learning disorders (in progress) and another on cultural beliefs vs. psychopathology. She had tutored
NYC children to help them prepare for exams and volunteered in several capacities with homeless and underserved youth. She is a member of the AACAP and the APA. She enjoys running, reading and writing.

**Taya Varteresian, D.O.** Phoenix, AZ  
Sponsors: Mariam Cohen, M.D., PsyD, Robert Ranucci, M.D.

Dr. Taya Varteresian received her B.S. degree from UCLA in Gerontology in 2002 and M.S. degree graduating Magna Cum Laude in Gerontology in 2004. She received her D.O. from the Kirksville College of Osteopathic Medicine, Kirksville, MO. She has been in psychiatric residency training at Banner Good Samaritan Hospital in Phoenix, AZ since June 2008. She has expressed an interest in pursuing further training in geriatrics and psychoanalysis.

**Psychiatric Members**

**Antonio Bullon, M.D.** Boston, MA  
Sponsors: César Alfonso, M.D., Raul Condemarin, M.D.

Dr. Antonio Bullon is an attending psychiatrist at Beth Israel Deaconess Boston since 1997 and an Assistant Professor of Psychiatry at Harvard Medical School. He received his MD degree from the Universidad Nacional Mayor de San Marcos Medical School, Lima Peru, completed a residency in internal medicine at Cook County Hospital in Chicago, did a residency in psychiatry at Harvard Longwood Psychiatry Residency Training Program in Boston, and a two year advanced psychotherapy training program at Faulkner Hospital in Boston. He has served in numerous administrative positions and currently is Director of Latino Mental Health Services in the Department of Psychiatry at Beth Israel Deaconess Boston. He provided an impressive, detailed narrative report of his academic history, interests and activities.

**Allen Kodish, M.D.** Chicago, IL  
Sponsors: Bertram Cohler, Ph.D., Elizabeth Steinhauer, M.D., LLC

Dr. Kodish is in private practice with adults in Chicago. He received his BS degree from Columbia University in NY, graduated from the Abraham Lincoln School of Medicine at the University of Chicago, interned at Cornell University in NY, completed his residency in psychiatry at the Pritzker School of Medicine in Chicago, and was a candidate at the Chicago Institute for Psychoanalysis from 1981 through 1991. He has been director of an inpatient unit, teaches and supervises psychiatric residents, has published book chapters on schizophrenia, and is active in other psychiatric and psychoanalytic organizations.

**Joanne Ahola, M.D.** New York, NY  
Sponsors: Clarice Kestenbaum, M.D., Eve Leeman, M.D.

Dr. Ahola is in private practice and is an assistant clinical professor at Columbia University College of Physicians and Surgeons. She received her BA degree from State University of NY at Stony Brook. She trained in psychiatry at the NY State Psychiatric Institute and Hospital at Columbia University graduating in 1986 and followed by a Ginsberg Fellowship. She trains clinical and legal professionals in evaluating and treating asylum applicants and survivors of torture.

**Psychoanalytic Fellow**

**Michelle Friedman, M.D.** New York, NY  
Sponsors: Deborah Cabaniss, M.D., Sherry Katz-Bearn, M.D.

Dr. Michelle Friedman received her B.A. cum laude from Barnard College of Columbia University, her M.D. from NYU School of Medicine, and her Certificate in Psychoanalysis from Columbia University Center for Psychoanalytic Training and Research in 1990. She did her residency training in several institutions in NYC. Since 2000 she has been Director of Pastoral Counseling, YCT Rabbinical School, NYC training clergy in the fundamentals of interviewing, intervention and referrals. She teaches and supervises residents at Mount Sinai Hospital and Medical Center. She has written a number of peer-reviewed articles and book chapters and given numerous presentations. She should be invited to present at future Academy meetings.

**Elise Snyder, M.D.** New York, NY  
Sponsors: César Alfonso, M.D., Sheila Hafter Gray, M.D.

Dr. Snyder received her BS degree from Queens College, NY, attended P&S Medical School, and did her residency in psychiatry at Einstein School of Medicine in NYC. She did a post-residency fellowship in psychiatry and neurology. She completed psychoanalytic training from the Western New England Institute for Psychoanalysis in 1980. She is Clinical Associate Professor at Yale University School of Medicine and Professor at University of Sichuan, Sichuan, China. Dr. Synder has had a lengthy and distinguished career and has been active in numerous psychiatric and psychoanalytic organizations. She has been President of the China American Psychoanalytic Alliance since 2003.