The male wood duck is among the most beautiful of waterfowls in the world. I dreamed for years of being able to photograph one close up and in the open. Last year I had my chance when they started to appear on the C&O Canal in suburban Maryland, probably an unexpected benefit of global warming.
Editorial Policy for THE ACADEMY FORUM

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

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

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

Criteria for Submission:

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 Do NOT use old, outdated programs as we may not be able to open the files.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

Deadlines for Article and Ad Submission

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

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MESSAGE FROM THE EDITOR
Ahron Friedberg, MD

We are pleased bring our members the Fall issue of our Academy Forum.

In his Message from the President, Dr. Joseph Silvio aptly applies the idea of Existential Uncertainty to the national and global crises we help our patients deal with: global warming with its wildfires, droughts, rising seas; the pandemic with over 1 million American deaths; school shootings, political social hostilities, etc.) He believes that as psychodynamic psychiatrists we play a crucial role in our daily practices with patients and educating the general public. Like many of us, I concur and support his initiatives on our behalf.

In our Letters, Announcements and Reports, Dr. Jennifer Downey and Dr. César Alfonzo, Editors of Psychodynamic Psychiatry, announce that the prestigious Journal Prize has been awarded to Douglas Ingram, MD and Kimberly R Best, MD for their distinguished papers, “The Psychodynamic Psychiatrist and Psychiatric Care in the Era of COVID-19” (Psychodynamic Psychiatry, Volume 48, Issue 3, September 2020) and “Five Months Later: The Psychodynamic Psychiatrist and Psychiatric Care in the Era of COVID-19” (Psychodynamic Psychiatry, Volume 48, Issue 4, December 2020).

Dr. Sherry Katz-Bearnot shares with us the selection of two terrific Teichner Awardees this year, Dr. Carlos Velez, Director of Psychotherapy Education at University of Texas, San Antonio, and Dr. Martin Klapheke, Psychiatry Residency Program Director at UCF College of Medicine, Orlando.

Dr. Gerald Perman reminds us of our 66th AAPDPP Annual Meeting Race, Gender and Climate have Entered the Chat: Psychodynamic Considerations in San Francisco, CA, May 18-20, 2023. Deadline for paper submissions is October 31, 2022.

Further, Dr. Alfonzo informs us about the International Federation for Psychotherapy and the upcoming 23rd World Congress of Psychotherapy in Casablanca, Morocco. A clinical symposium, sponsored by AAPDPP, will feature our members Drs. Sherry Katz-Bearnot, Jennifer Downey, and Timothy Sullivan among others.

Finally, Dr. Adam Katz shares a poignant essay about his family reunion and an object lost and found.

Original Articles begins with an elegant piece by Dr. John Tamerin on the untapped use of music in the treatment and emotional lives of our patients. While words are the currency of our work, music (our voices, their tone, rhythm) is what conveys meaning. It is surprising that music has not been seen as more of a resource as an adjunct to psychotherapy.

Dr. Henry Lothane, a consummate psychoanalyst and scholar, makes an exceptional contribution about the free associational process in psychoanalysis and its links to neuroscience.

Dr. Peter Olsson continues his work on former President Trump, this time locating Trump’s tragic flaw in his narcissism of winning at all costs. I think there is little doubt that flaw has contributed to the issues that he and our democracy now face.

Dr. Eugenio Rothe makes an important and timely contribution about the mind of the school shooter with an eye toward treatment and prevention. Its relevance is obvious not only to psychodynamic psychiatrists but to all parents and their children.

Dr. Nathan Szajnberg elucidates the complexities of patient referrals as training cases and the necessarily imperfect solutions that institutes devise. He beautifully brings to life three control cases and honestly describes how they played out.

Finally, Dr. David Forrest gives us a gem on teletherapy. He brings his considerable intellect and astute powers of observation to bear on the differences between teletherapy and in-person therapy in terms of what is lost and, perhaps, also gained with different modalities of treatment.

In our Book Reviews, Ms. Sheridan Goldstein’s excellent review of Malcolm Gladwell’s Talking to Strangers: What We Should Know about People We Don’t Know highlights how we are surprising inept at reading people, often with significant consequences personally and in world affairs.

Cornelia Foss in her book review of Graeme Taylor’s Willem De Kooning’s Women: A Psychoanalytic Exploration brings her unique perspective as an accomplished artist.

In Memoriam notes the passing of Harold Eist, MD, and Brian Crowley, MD.

We hope you enjoy this issue and increase your knowledge of contemporary issues in psychodynamic psychiatry.
MESSAGE FROM THE PRESIDENT
Joseph R. Silvio, MD

I’ve been struck by the simultaneous emergence of two significant phenomena—threats to our survival and the rise of political and social conflict. In wondering how they might be related, I thought of the term Existential Uncertainty, and when I did an internet search, I found it to be a significant concept in the field of oncology.

“Existential uncertainty is conceptualized as an awareness of the undetermined but finite nature of one’s own being-in-the world, concerned primarily with identity, meaning, and choice. This awareness is fundamental and ineradicable, and manifests at different levels of consciousness.

…Humans rely on identity, worldview, and a sense of meaning in life as ways of managing the ineradicable uncertainty of our being in the world, and these can be challenged by a serious diagnosis.” (Dwan and Willig 2021)

According to Kees van den Bos, “…‘under conditions of personal uncertainty people may respond especially positively to events that bolster their cultural norms and values and particularly negatively to persons and events that violate these norms and values.’

I see here a link between the rapid emergence of global crises, which I equate in seriousness with a terminal illness, and the rise of extremist political action. In the past few years we have seen the acceleration of the effects of global warming in increases in number and size of fatal wildfires, droughts, floods, heatwaves, and tornadoes. We’ve seen sea level rise and river flow decline. The direct impact of such events have not only caused loss of home and possessions, but also jobs, community, and personal identity.

In addition, we have endured the Covid-19 pandemic with over 1 million American deaths, schools and businesses closed, socializing severely limited, our sense of safety lost. We have seen a rise in mass shootings and homicides, and the protests for social equality in the Black Lives Matter, Me Too, LGBTQ, and abortion access have encountered violence from elements who feel these ideas threaten their world view and core values. And we see warfare in Europe, Africa, and Asia that threaten our economy and our status in the world. With all this can come existential uncertainty with loss of personal identity, a sense of meaning, and a personal world view. Drowning in despair, such victims reach for the life preservers of a world view they can embrace (the Federal Government is corrupt and has caused all this devastation), a powerful leader who conveys an air of certainty and infallibility and who promises to restore their lost status and pride, and a community of likeminded believers who bolster their convictions.

As psychodynamic/psychoanalytic physicians, it is important for us to understand the underlying dynamics that lead to extremist beliefs, actions, and affiliations. Sharing our perspectives with each other and our communities may not change beliefs but may defuse the level of hostility. And in our practices, keeping these dynamics in mind may help soften our countertransference to patients who embrace extremist views that run counter to our own core values.

During my Presidency, I hope to bring this crucial issue front and center in our educational efforts. If you have an interest in participating in such an “existential uncertainty initiative”. I would love to hear from you.

With best regards,

Joe Silvio, MD
President, AAPDPP

References:


LETTERS, ANNOUNCEMENTS AND REPORTS

Psychodynamic Psychiatry Journal Prize Announcement
César A. Alfonso, MD
Jennifer I. Downey, MD
Editors, Psychodynamic Psychiatry

Every two years, Psychodynamic Psychiatry, the journal of the American Academy of Psychodynamic Psychiatry and Psychoanalysis, awards a Journal prize for the best article published during the preceding two years. For the years 2020-2021 we are proud to announce that the Journal Prize has been awarded to Douglas Ingram, MD and Kimberly R. Best, MD for their distinguished papers, “The Psychodynamic Psychiatrist and Psychiatric Care in the Era of COVID-19” (Psychodynamic Psychiatry, Volume 48, Issue 3, September 2020) and “Five Months Later: The Psychodynamic Psychiatrist and Psychiatric Care in the Era of COVID-19” (Psychodynamic Psychiatry, Volume 48, Issue 4, December 2020). The prize of $2500 will be divided by the two authors.

Douglas H. Ingram, MD
Douglas H. Ingram, MD, Editor of The Journal of the American Academy of Psychoanalysis and Psychodynamic Psychiatry (2001--2011), is Clinical Professor of Psychiatry at New York Medical College. He graduated from Columbia College with a B.A. in 1964. He attended New York University School of Medicine, completing his studies in 1968 following which he accepted a medical internship and psychiatry residency at St. Vincent’s Hospital and Medical Center in New York City. During his residency he matriculated at the American Institute for Psychoanalysis, founded by the psychoanalytic culturalist Karen Horney in 1941. Completing his studies, he eventually became Medical Director of the Karen Horney Clinic and Dean of its Institute. He served as Editor of the affiliated journal, The American Journal of Psychoanalysis from 1991 to 2000. The following year he was elected editor of the Journal of the Academy where he also had served as President 1997-98. A member for the American Psychoanalytic Association and the International Psychoanalytic Association, he is the author of nearly 60 peer-reviewed papers spanning a variety of topics in psychoanalysis and psychodynamic psychiatry. He is the editor of the Final Lectures of Karen Horney (Norton, 1987). In the wake of the COVID-19 pandemic, his most recent research has concerned the concept of the therapeutic space and the impact of various venues—in-person, video, telephone—on the therapeutic process.

Kimberly R. Best, MD
Kimberly R. Best, MD served as Secretary of the American Academy of Psychodynamic Psychiatry and Psychoanalysis (2019-2022) after being a Trustee of the organization from 2009 to 2012. She is also active in the American Association of Directors of Psychiatry Residency Training as a member of its Integrated Care Task Force (2014-2020). Her previous leadership positions include being President of the Philadelphia Psychiatric Society (2000-2001) and the Pennsylvania Psychiatric Society (2007-2008). For the past decade she has been the Director of Psychiatry Residency Education at Albert Einstein Medical Center in Philadelphia. Before becoming a leader in residency education, she worked as a subspecialty certified Consultation-Liaison psychiatrist with a particular interest in Infectious Diseases. Dr. Best’s educational journey includes graduating from Penn State University with a B.A. and completing her MD at Jefferson
Medical College in 1978. She completed a Psychiatry Residency at Thomas Jefferson University Hospital in Philadelphia in 1982 and was chosen Chief Resident during her last year of training. She then pursued psychoanalytic training at the Psychoanalytic Center of Philadelphia. At present she is Assistant Professor, Clinical Educator Track, Sidney Kimmel Medical College, Thomas Jefferson University. Dr. Best is the recipient of multiple teaching distinctions, including the Teacher of the Year Award at Albert Einstein Medical Center in Philadelphia in 2003; the Edward Lawlor Award for Contributions to the Profession of Psychiatry, given by the Philadelphia Psychiatric Society in 2005; the Dean’s Award for Faculty Excellence in Teaching, given by Jefferson Medical College of Thomas Jefferson University in 2007; the Daniel Blain Award for Service to the Profession, given by the Philadelphia Psychiatric Society in 2009; and the Nancy C.A. Roeske Certificate of Recognition for Excellence in Medical Student Education, given by the American Psychiatric Association in 2010.

After the first cases of COVID-19 were diagnosed in the United States in January 2020, transmission of the virus spread rapidly. In March 2020 the White House announced the social distancing requirements country wide. In urban areas of the Northeast, especially New York, the first catastrophic wave of hospitalizations and deaths came. Only a few weeks later, on April 13, Drs Ingram and Best convened a teleconference of 50 Academy members to talk about the impact of COVID-19 on their practices, their patients, and themselves. At that time people reported the rapid adoption of telemedicine to deliver psychiatric services but a host of challenges including over-taxed hospitals and psychiatric residents deployed to other areas of the hospital, effects on patients and practitioners of physical isolation and separation and feelings of loss and grief. Some patients were noted to do surprisingly well during this time including patients suffering from social anxiety and paranoia as well as some severely ill bipolar patients. The authors re-contacted the original meeting’s participants 5 months later for follow-up. The disruption had become even more pervasive with spread of the virus, lockdowns, unemployment, political conflict over public health measures, and emerging adverse health impacts on the poor, mentally ill, and minoritized individuals. Psychodynamic psychiatrists reported diverse clinical challenges and difficult personal reactions to the suffering and isolation of their patients and their own selves, families, and friends.

Two and a half years after the onset of the pandemic, the virus continues to ravage the world in waves. By this time much has been written about many aspects of COVID-19. Public health deficiencies in our country included a lack of preparation, conflicting attitudes toward masking and vaccination, and inequities in access to life-saving treatment. The divisive effects of politics on public health have also been widely discussed.

Drs. Ingram and Best’s two papers were among the first reports of how psychiatrists and psychiatric treatment were affected by the epidemic. They wrote about the interpersonal relationship of psychiatrist to patient and the intrapersonal effects of the pandemic on the clinicians. The editors of Psychodynamic Psychiatry congratulate the authors for this unique and very timely set of papers which were among the first to draw attention to the effect of the epidemic on psychiatric clinicians, psychiatric educational programs, and psychiatric patients.
Victor J. Teichner Award
By Sherry Katz-Bearnot, MD

Dr. Carlos Velez, Director of Psychotherapy Education for University of Texas, San Antonio, and Dr. Martin Klapheke, Psychiatry Residency Program Director at UCF College of Medicine, Orlando are our two Teichner winners for this year.

By way of a short introduction to Dr. Velez: His personal story is unique, and the story of how his program came to win the Teichner is also unusual and special. He applied for the Teichner several times before he won (which is not unusual), but we had just decided to organize and Beta-test the Laughlin Distance Learning Initiative with Dr. Allan Tasman in charge the year before. Two other programs won the Teichner last year, but Carlos’ application was so very compelling, the number of residents he needs to train quite large (70!)--we were all convinced that we needed to offer some help. Carlos worked with Dr. Tasman for a year, reapplied for Teichner, and won the Award this year, along with Martin Klapheke. I had the pleasure of working with Dr. Velez on a couple of APA initiatives, and we met in person in NOLA in May.

We hope Teichner Awardees and faculty of their programs will join us at AAPDPP as well.

66th Annual Meeting
May 18-20, 2023
San Francisco, California

Race, Gender and Climate Have Entered the Chat:
Psychodynamic Considerations

Program Co-Chairs: Gerald P. Perman, MD, Joseph J. Rasimas, MD, Danielle Patterson, MD, E. Grace Cho, MD, Douglas Ingram, MD William Butler, M.D

Co-Chairs of Scientific Programs Committee: Kimberly R. Best, MD and Joseph J. Rasimas, MD

CME Committee Chair: Silvia W. Olarte, MD

We find ourselves in a world of fast-moving unpredictable events prompting general apprehension about what might happen next. Already, the world has been upended by the coronavirus pandemic. By the time of our 2023 Annual Meeting, in the U.S. alone there will have been over 100 million people infected, over one million deaths, and 80 million people having recovered, some with long-haul COVID. The pandemic has had a profound impact on our healthcare, education, livelihoods, families, and how we relate to one another at all levels.

Climate change is affecting our planet with rising sea levels and extreme weather events and threatens the
extinction of our own and other species – not tomorrow, but in the decades and centuries ahead unless serious steps are taken by a politically fragmented world in which many countries have more immediate and pressing needs to address.

The murder of George Floyd, more than any other racially motivated event, resulted in a heightened awareness of racial injustice. The American Psychiatric Association and other mental health organizations around the country – including our own – have begun to examine, not if, but how, we have been guilty of long-standing systemic racial bias.

Finally, there has been an increased focus on sexual orientation and gender identity – LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer/questioning, and asexual…among other categories). We believe that psychodynamic psychiatry has a duty to examine and to explore this important aspect of being human.

These topics have entered our clinics and consultation rooms and have affected our patients at a deep psychological level. The AAPDPP leadership, its Scientific Program Committee, and the Co-Chairs of this 66th Annual Meeting in San Francisco, May 18-20, 2023, invite you to address the interface between these physical, social, and psychological shifts in the world we live in, and how our patients and ourselves have been affected by them.

Closer to home, there are other quotidian and exceptional matters that we encounter with our patients - their anxieties, depressive moods, life-stage adjustments, and relationship and work issues. We also want to learn about how clinicians and our patients are being creative, resilient, and even optimistic, in the face of the above-described challenges.

This will be the first in-person Academy Annual Meeting in three years, and we hope to make it a welcoming, engaging, informative, and fun experience in beautiful San Francisco! We are seeking a robust turnout as we move from two- to three-dimensional multi-sensory interactions between and among our Academy members and guests.

To receive a copy of the entire Call for Papers document and/or the required Disclosure Form, contact the Academy Office at info@AAPDP.org or 888-691-8281

Link to submit your abstract online: https://aapdp.slayte.com/calls/detail/de45f353-e833-11ec-907b-0e0ce905385c/submissions/create

WE HOPE TO SEE YOU IN SAN FRANCISCO!
The International Federation for Psychotherapy and the 23rd World Congress of Psychotherapy in Casablanca, Morocco
César A. Alfonso, MD

The International Federation for Psychotherapy (IFP) is a worldwide organization that promotes psychotherapy practice, research, and educational activities. The Federation is open to professional societies, institutions, and individual members. IFP aims to foster high professional and ethical standards of psychotherapy in practice, research, and training. The Federation furthers an intercultural, interdisciplinary dialogue and mutual learning among psychotherapists, psychotherapy researchers, and social scientists.

The IFP realizes its aims by means of World Congresses, which occur every four years, and regional congresses organized by its 20 member societies. It also works closely with the World Psychiatric Association via interorganizational educational activities. The official journal of the IFP is *Psychotherapy and Psychosomatics*.

IFP has been in existence for almost a century. It started as the International General Medical Society for Psychotherapy in 1934, initially with delegates from Denmark, Germany, Holland, Sweden, and Switzerland, and with Carl Gustav Jung as its first President. By 1958 it had delegates from 13 countries and changed its name to the International Federation for Medical Psychotherapy at a world congress in Barcelona. Presiding the Federation from 1958-1998 were Medard Boss (Switzerland), Pierre-Bernard Schneider (Switzerland), Finn Magnussen (Norway), and Edgar Heim (Switzerland). In 1991, the organization changed its name from IFMP to IFP to be inclusive of psychotherapists from diverse mental health professions besides psychiatry. Presiding IFP subsequently were Wolfgang Senf (Germany), Ulrich Schnyder (Switzerland), Franz Caspar (Switzerland), and Paul Emmelkamp (Netherlands). In 2018, Driss Moussaoui (Morocco) was elected President, becoming the first non-European leader of the Federation.

The IFP has held 22 World Congresses since its inception. The 23rd World Congress will take place (in person, not virtual, not hybrid) on 9-11 February 2023 in Casablanca, Morocco (www.ifpwcp2023.com), under the leadership of President Driss Moussaoui (Morocco), with Norman Sartorius (Croatia) ad Ulrich Snyder (Switzerland) as Advisors, and a Scientific Committee chaired by César Alfonso (USA) and co-chaired by Fiammetta Cosci (Italy), Gisele Apter (France) and Thomas Craig (UK). We anticipate attendance between 500 and 1000 delegates from all continents. To date we have other 100 presenters from 31 countries in the preliminary program, including eleven plenary speakers:

1. Afzal Javed (Pakistan) “Psychosocial Treatments and Public Health Needs”
2. Norman Sartorius (Croatia) “Psychotherapy and Public Health”
3. Mark van Ommeren (Switzerland) “Integrating Psychosocial Interventions in Routine Health Systems”
4. Moussa Ba (Senegal) “Caring for the Caregivers in Challenging Situations – Lessons Learned from the United Nations”
7. Ulrich Schnyder (Switzerland) “Evidence-based Psychotherapies for PTSD: Differences, Commonalities and Future Directions”
10. César A. Alfonso (USA) “Childhood Adversity, Epigenetics, and Psychotherapy as a Biological Treatment”
11. Vincenzo Di Nicola (Canada) “Take Your Time: Seven Lessons for Young Therapists”

The 23rd World Congress in Casablanca will take place over three full days. There will be seven pre-congress courses on evidence-based psychotherapies aimed at an audience of students, trainees, and early to mid-career professionals.

Another innovative educational activity will be the Interactive Panel of Experts Discussions.

The scientific core of the congress will be comprised of symposia, oral communications, paper sessions, research poster presentations and clinical poster presentations. Ten Young Investigator Awards with travel stipends will be given for best posters by first authors under the age of 40.

Some symposia are sponsored by specific organizations and academic groups, such as the World Association of Dynamic Psychiatry, the Psychoanalysis in Psychiatry Section of the World Psychiatric Association, the HIV Psychiatry Section of the World Psychiatric Association, the Psychotherapy Section of the World Psychiatric Association, and the Massimo Fagioli Foundation. A symposium on Clinical Examples of Psychodynamics Used in Everyday Interactions, sponsored by the American Academy of Psychodynamic Psychiatry and Psychoanalysis (AAPDPP) will feature the following presenters: Sherry Katz-Bearnot, Jennifer Downey, Timothy Sullivan, Randon Welton and Erin Crocker.

The IFP is a vibrant organization with a rich and substantial history rooted in psychoanalysis. Casablanca is one of the most prominent and dynamic cosmopolitan cities in Africa. On behalf of the Board of Directors and Council of the IFP, we welcome AAPDPP members to attend the 23rd World Congress of Psychotherapy and participate in rigorous academic activities and lively social events and encourage you to safely travel throughout Morocco this coming February 2023.

Baggage
By Adam Katz, PhD

I arrive at the party wearing a pair of shorts and a bright red tee-shirt. Despite its four good wheels, the suitcase has been weighing me down as I walk with it beside me. I don’t really want to go to this party, but it is better to be invited than feel left out. The atrium of the building is huge and gray.

My dad meets me at the door. He always looked sharp on these occasions—studs shining black and gold, bowtie tied just so, neck a little red from the shaving, but that’s ok. Interspersed threads of grey and black looking elegant as highlights. I guess because I’ve seen him in just a shirt and underwear, this version of him always seems incongruous to me. Maybe it’s jealousy. I never learned to do what he is doing.

Our beards do that funny thing they do when they touch. When we pull away, he sneers a little bit at my outfit. There will be somewhere to change. But there is my cousin Arnold, who just had his bar mitzvah a couple of years ago, looking tall and fine. He smiles sheepishly as I go in for the hug, but he extends his hand to shake.

I start looking around for a bathroom, but he’s leading me by the arm, asking me how my trip was and commiserating that I wasn’t able to even go unpack at the hotel (I’m crashing on a friend’s couch). And now, hey, here is another cousin. I grew up with her, and even though she now works at some bank, I feel really pleased to see her. She, too, glances briefly at my tee-shirt and shorts, then renews eye-contact, as if to ask, “Really?”

“Oh, don’t give me that look. As soon as I find a bathroom I can duck into, you’re going to see a whole new—“

“Ok, let’s find one.”

You can already hear the merry din, and there are slim, elegant women in cocktail dresses standing by the door chatting—like they came out to ‘get some air’ but didn’t find any because we’re half a mile from the front entrance. I feel my clothes like tar and feathers. There is a table topped with brightly colored parcels, and little kids are running around the way they always do, only this time when they fall, they will split the knee of a nicer pair of pants than the pair they would usually have on. My cousin pulls me along.

Past the table laden with brightly colored presents, another table is laden with huge steel trays, heated by sterno, with meat and grilled vegetables, surrounded by condiments and stacks of plates and napkins and... I feel a deep growling in my stomach. Carolina is still holding my arm protectively as she asks the woman where the men’s bathroom might be. Is the woman hungry? Does she get to eat the same food we do? How many parties does
she have to go to like this in a week? Carolina is saying something to me. I don’t catch it, but she says again:

“This way. Where’s your suitcase?”

I look around and the growl in my stomach is replaced by the bottom dropping out. The room starts to lose color at the edges, and I feel dizzy and panicked and there are goosebumps on my arm. I start running back to the door and run smack into the uncle just back from Dubai.

“How are you?” He always has a smile when we see each other, even though that’s only at events like this. If he notices my outfit, his reaction doesn’t reach his face.

“I—I need to go.”

“But how have you been?”

“Oh. You know. Fine.” “And how’s the— the—”

I disengage from his hands and run back past the brightly colored food tables, the brightly colored gift-table, the brightly colored clothing of the children gamboling in between chit- chatting young women in brightly colored cocktail dresses, and back out through the doors of the event space into the drab hallway. I look in all those places—under the tables, in the corners, between the guests, but I already know it isn’t there. I must have put it down when I put my arms around my father, and not picked it up again.

By the vending machines, right? Just up ahead. I can see the bright colors. My stomach feels like it’s trying to digest an anvil. My eyes water but somehow feel like they are also burning. Self-recriminations march across my mind like a stock-ticker: You moron. You always do crap like this. What is wrong with you? Why can’t you just pay attention? Everyone in there takes care of their stuff before they get to the party, and you just waltz in there with your stupid shirt and your stupid shorts and—it’s there.

I tackle it like we’re two puppies sporting with each other in the park. All the fear and misery floods away and for an eternal moment, I feel warm and safe. My breath won’t slow down. My eyes won’t stop leaking tears. The self-recriminations won’t stop ticking across the screen of my thoughts. This is why you lost your job. This is why you had to ask your mom to buy you the plane ticket. This is—

I feel hands on my shoulders, and look up through eyes blurred with tears. Dad is there with Carolina. They came outside—why? To see if I needed help? If I’m alright? How long have I been sitting here? I’m not. I’m not alright, and I don’t know why.

### ORIGINAL ARTICLES

**Music as a Source of Wellness and as a Useful Adjunct in Psychotherapy**

**By John S. Tamerin, MD**

In psychodynamic psychotherapy, treatment is conducted in a language common to the patient and the therapist. The essential ingredient is the spoken word. Ironically, the experience most frequently associated with a therapeutic breakthrough is not language, but rather a feeling or emotion. Franz Alexander referred to this as the “corrective emotional experience,” not the corrective verbal or intellectual experience. Words can and do touch feelings and emotions but often less directly and less effectively than music.

Albert Einstein said, “If I were not a physicist, I would probably be a musician. I often think in music. I live my daydreams in music. I see my life in terms of music” and the great lyricist E.Y. “Yip” Harburg who wrote the words to “Over the Rainbow,” voted the greatest song of the 20th century in a joint survey by the National Endowment for the Arts and the Recording Industry Association of America, said, “Words make you think a thought. Music makes you feel a feeling. A song makes you feel a thought.”

Music is one of the most primal and fundamental aspects of human culture with many researchers even arguing that music (at least in a primitive form) pre-dates the emergence of language itself, a fact, ironically, not lost on some of the greatest writers in history. As Henry Wadsworth Longfellow once observed, “Music is the universal language of mankind.”

Finally, to quote Oliver Sacks author of *Musicophilia*, “We humans are a musical species no less than a linguistic one. We integrate music in our minds using many different parts of the brain. And to this largely unconscious structural appreciation of music is added an often intense and profound emotional reaction… that air, which has almost no substance whatsoever, when moved and when made to hit the eardrum in tiny subtle ways can make people dance, cry, have sex, move across country, go to war and more.”

It’s remarkable that something so subtle can illicit profound emotional reactions in people and, furthermore, hit an emotional target with more precision than could ever be possible with words alone.

Plato once said, “Music gives a soul to the universe,
wings to the mind, flight to the imagination, and life to everything.” More recently, Friedrich Nietzsche stated, “Without music, life would be a mistake.” I totally agree with Plato, and although I never agreed with Nietzsche’s politics, I do applaud his statement about music.

Most mornings, my life begins with a ritual. I turn on the music I love, often jazz or rhythm and blues, and symbolically march up Rampart Street in the usual pattern of the traditional New Orleans jazz funeral. The funeral starts with a sober note, but then quickly shifts upbeat into a spirit of hope, optimism and joy. And I march off to the kitchen to make myself a cup of coffee and start my day on a positive note.

Music is and has always been a huge part of my life. My father was a fine amateur violinist and frequently played quartets with professional musicians. I studied the cello. At age 12, I went off to the National Music Camp in Interlochen, Michigan where I was required to take up an additional instrument. I took up the Eb alto saxophone. My mother was an amateur jazz piano player who studied at Juilliard. Music filled our home and visits to Carnegie Hall were a large part of my upbringing in New York.

My interest in music has always continued but took an interesting turn 20 years ago when I was divorced. Perhaps I might have gone back into psychoanalysis. Instead, I picked up the saxophone which I had not played in 40 years and began to take lessons and then went to the Banff Centre for the performing arts in Banff, Canada to play with other musicians. I have been playing, studying and taking saxophone lessons ever since and I take every opportunity I can to play my sax with other musicians and to listen to the music that I love.

Music has always served as a wonderful way of lifting my mood, inspiring and empowering me, or alternatively putting me in touch with my deepest emotions. Sometimes these emotions are painful or embarrassing, but as an ancient sage wisely commented, “Water which is too pure has no fish in it.” I believe that music has served these same functions throughout the centuries for millions of people all over the world.

That being the case, I have wondered why music is so rarely spoken about either in the scientific literature or even in clinical practice as a factor in lifting one’s mood and/or connecting with one’s deepest emotions as one attempts to cope with and recover from emotional illness in general and depression in particular.

One area where music has been extensively studied and utilized is in the treatment of dementia. Much has been written about this by Oliver Sacks and others who have brilliantly demonstrated that everything and everyone is forgotten with advanced dementia except the music which amazingly restores the memories. People with dementia visualize themselves as adolescents and get up in nursing homes and start to dance and sing. Many also remember an extraordinary amount of detail about precisely what was going on at that time in their lives, though prior to listening to the music they could barely talk, were virtually non-responsive and could barely state their names. The music impacts and restores not only their memory but their mood and vitality. In effect, they have briefly reacquired their identity through the power of music.

Most of us know intuitively the impact that music can have on our emotions, and neuroscience research is now validating the therapeutic properties of music. Indeed, the NIMH has committed a substantial amount of money to support current research in this area.

It is well known that music, if chosen correctly, can dramatically increase the pleasure states in our brains. Music can raise our serotonin levels and boost our norepinephrine and dopamine. Also, studies have proven that music can dramatically affect physiological indicators of emotional arousal such as heart rate, respiration, electrodermal activity and body temperature. I, and many others, believe that we can use individual pieces of great or personally relevant music to change our brain chemistries and physiological states often in a matter of minutes, sometimes in a matter of seconds. Like many, I believe music is a great medicine for the mind, the body and the soul.

Perhaps it should be added that attention, planning and memory have consistently showed activation when people listen to music. So, it might be reasonable to hypothesize that some of the symptoms of depression such as decreased movement, poor attention, poor planning and execution, loss of energy and poor memory might benefit from a “therapeutic regimen” of music. Indeed, I suggest that for optimal results, music might be utilized like medication – prescribed in a specified manner.

Although music is rarely utilized as part of the clinical treatment for the “pain” of mental illness, it has been shown to have a salutary effect on chronic pain. Music is often used with cancer patients in conjunction with chemotherapy. Indeed, the Mayo Clinic has employed harpists to help patients heal following cancer treatments. In a related area of trauma and pain, it has been reported that former Representative Gabrielle Giffords, who was badly injured in a Tucson, Arizona shooting a number of years ago, apparently recovered her speech with the help of music. One might reasonably ask, if she could recover her speech by this means, then why can’t someone else recover their spirit?

Dr. Richard Kogan, who is Professor at the Weill Cornell Medical College, Director of their program on music and medicine and himself a concert pianist has said:

“I think it’s really important for healthcare professionals to not lose sight of the fact that music has an unparalleled
capacity to ease pain, to soothe anxiety, and to lift spirits. When all the scientific findings come in, I think there’s potential for an explosion in the use of music in medical centers.”

I have spoken at AAPDPP meetings in the past and written articles which have appeared both on our website and in the Academy Forum on the value of peer support in general and in particular about our Greenwich DBSA (Depression Bipolar Support Alliance), a support group which began 20 years ago. Initially, much of the discussion by the group members was about the disabling symptoms of the disease or problems associated with medications that were being prescribed.

Over the years the conversation has shifted dramatically from the disease and the pharmacology to the human experience of recovery. Most recently, our Greenwich DBSA group has begun to discuss the role of music in recovery and healing.

To be specific, we have helped members of our group to develop personal playlists that they can utilize whenever they want to lift their moods, inspire themselves, calm down, achieve a sense of balance, or feel more connected to people they love or have loved in the past. Through this process they have also become more aware and better able to deal with their underlying feelings previously numbed by their depression or by the medications they have taken to dull the pain of their illness.

People have put together highly personalized lists of songs from rock, blues, show tunes to opera, symphonies, choral music, gospel, meditative music used for yoga, etc. that have served a wide variety of psychic functions and with modern technology can be easily called up as needed with the touch of a finger. Members have discovered that incorporating this practice into their daily lives literally has become a mood-altering opportunity and experience.

Simply stated by one group member:

“Music has no downside if you create your own playlists in advance and remember to press the button. It is an easy, effortless, risk-free, almost instant mood-altering ‘medication’ that can be life-enriching and life-expanding. I can repeat that every day as often as I wish.”

Another group member added:

“Music has become an essential part of my life no matter what place I am in. I reach out for it and use it as needed, even when I work, and it has saved me from many cocktails.”

Music connects people with who they are, who they have been, what matters most to them and, in so doing, provides a fundamental connection to their identity. So, I began to wonder what might happen if I invited certain patients to share the music that was most meaningful to them as an aspect of their individual psychotherapy in the same way as patients are often asked to share a dream as a component of their treatment.

Recently, I have begun to selectively ask patients to bring into therapy music and lyrics that they have found profoundly meaningful. I could cite numerous examples but perhaps a recent experience will illustrate the point. The patient asked me to listen to “Shallow” from the recent film “A Star is Born” with Lady Gaga and Bradley Cooper. For many of you who are not familiar with the lyrics in which she found great meaning, here are a few of the key phrases:

Tell me somethin’, girl  
Are you happy in this modern world?  
Or do you need more?  
Is there somethin’ else you’re searchin’ for?  
I’m falling  
In all the good times I find myself  
Longin’ for change  
And in the bad times I fear myself,  
I’m off the deep end, watch as I dive in  
I’ll never meet the ground  
We’re far from the shallow now

What is striking, but perhaps not unusual, is that this patient – an elegant married, suburban socialite in her mid-50s – started to cry when she heard this song in the film and had no idea why. She had been carefully trained to maintain a perfect exterior and to suppress any painful emotion so that no one would ever imagine what she was really feeling. She had gradually opened up in therapy but sharing that song with me was a valuable step on her journey. She was ultimately able to admit to me that she had been emotionally disconnected for years. Terrified of the “Shallow,” she had used alcohol to numb her painful emotions and her drinking had enabled her to “dive into the deep.” She currently acknowledges feeling better about herself than she has in over a decade and now welcomes the opportunity to experience and share a wide range of emotions with me and with significant others in her life.

I have spoken recently to a number of other patients about the impact of music on their lives and how they feel music might be best incorporated or integrated into psychotherapy and these were some of their thoughts and suggestions.

One patient said:

“Music can get me moving and moving is important for people who are depressed. When I am depressed, I often go to a heart-breaking song from James Taylor or Frank Sinatra because the music
and the words help me to feel less alone, more connected and less inclined to blame myself for my condition, particularly when I have shared this music with you.”

Another patient commented:

“I have my own playlist and I listen to certain songs intentionally – particularly two hymns: “Be Not Afraid” and “Here I am Lord.” Both the music and the words are important. I want to listen to something slow – something which helps me feel what I am feeling. Music helps me to face my emotions not run away from them. The music that is meaningful to me is not a distraction or a diversion.”

When people are depressed they find it helpful and healing to listen to songs like “Bridge over Troubled Water” by Simon and Garfunkel; “Lean On Me” by Bill Withers; “Holy Mother” by Eric Clapton or “Through the Storm” by gospel singer Yolanda Adams.

One simplistic strategy immediately rejected by group members was “When you are down, listen to upbeat music.” In fact, patients with whom I discussed this said that when they are depressed they found “upbeat music as irritating as people who tell them to smile, laugh, get over it, or be grateful.” More helpful, they agreed, was listening to music that fit their mood and met them where they were and was consistent with what they were feeling. It helped them to feel understood, validated, connected and less alone.

Another patient observed:

“Songs and lyrics often help me clarify my feelings and help to illuminate the underlying issues and perhaps factors causing my depression. Sharing the music with you has helped me to diminish my pain and shame.” The patient continued:

“Music helps me to get in touch with the essence of who I am and how I am feeling. To be more specific, when I listen to Pink Floyd, it takes out my guts and puts them on a silver platter and it shows them to me and says, ‘this is what you are made out of.’ It allows me to connect to who I really am and after listening to it I have a better understanding of and connection with myself. Playing this music to you has opened up a huge channel of communication for us.”

My own observation has been that music may enable patients and their therapists to recognize and share emotions that would be inaccessible without the language of music. Indeed, music is a language, but not a language traditionally utilized in psychotherapy.

My experience is that the introduction of music meaningful to the patient, under the proper circumstances, has accelerated and deepened the therapeutic relationship. The music and lyrics have helped me better truly understand what the patient is experiencing.

In one session with a patient I had known over an extended period, she brought in two songs with which I was not familiar, songs that had a profound personal meaning for her. They were “Fallen” sung by Sarah McLachlan and “Hurt,” by Nine Inch Nails – a song about realizing consequence and regret and that there is nothing worse than being stuck with a label, a pain, a sickness that we know beforehand will leave us only wishing that we could change the choices we made. I immediately felt something very profound, myself, coming from her to me though the music and lyrics. I always believed that I understood intellectually how and what she was feeling. However, the music and words took this all to a new level for me.

I profoundly experienced how trapped she felt, how deep and almost immovable was the guilt and shame that she was bearing, and how extraordinarily hard it was for her to permit herself to “shed the skin” of shame and guilt for something she had done a number of years ago.

Music currently plays a relatively small and usually insignificant role in psychotherapy. My point is that perhaps the role of music should be expanded and appropriately utilized as a valuable aspect of both understanding and communicating with our patients. Furthermore, I have found that music can be comfortably and effectively incorporated into traditional psychotherapy.

Now I would like to conclude by asking several questions, which I hope will stimulate a lively response from those of you who have taken the time to read this paper.

1. As music is such a powerful and important factor in our emotional lives, should we not appropriately and creatively incorporate it into our therapeutic work with those patients who relate deeply to music and have throughout their lives – particularly if we ourselves love music?

2. Might it be helpful in opening up a block or a therapeutic impasse particularly when the patient feels that the lyrics or music express an emotion that they otherwise have found difficult to put into words?

3. It has been noted that Sigmund Freud disliked most music and there was little mention of music in the 24-volume Standard Edition. Is there a possibility that Freud’s distaste for music, but fascination with dreams, may have led psychoanalysts to encourage
their patients to bring their dreams into treatment but not the music that has played such a meaningful role in their lives?

Finally, I would like to suggest that if dreams are the royal road to the unconscious, perhaps the royal road to the preconscious may lie in music.

Free Association in Psychoanalysis and Its Links to Neuroscience Contributions
Henry Zvi Lothane, MD

Editor’s note: A version of this paper was presented in 2022 at the 111th meeting of the American Psychoanalytic Association in Boston.

My thanks to Dr. Blinder to whose generosity I owe addressing you today. One day the paper by Drs. Novac and Blinder landed in my email box. It inspired me to write to Dr. Blinder about my work, whereupon he added my papers on free association (Balter, Lothane and Spencer, 1980 and Lothane 2018) to their article and invited me to join them as a discussant. It was a noble gesture.

Association is a universal phenomenon of mentation. Our present feelings, memories, observations, and thoughts, linked with persons and things, evoke other feelings, memories, observations, and thoughts, either as a glimpse of the past or a guess of the future. All cognition is recognition, based on the memory of past experiences, habits, and reflexes. The Greek word for memory is mneme, hence in Greek mythology Mnemosyne is the goddess of memory and mother of all the nine muses of arts and sciences. From mneme we also get mnemonics, associations that enhance remembering, and phenomena of amnesia, hypermnnesia, and cryptomnesia.

More than two millennia ago, in Plato’s “Phaedo,” the principle of association is definitely stated as the explanation of the way in which, for example, the lyre might remind me of its player or a picture remind me either of the person represented or his friend...based on likeness or unlikeness...The activity of the mind thus supplying the counterpart of any given experience is called Anamnesis, recollection” (Brett, 1912, pp. 77-78). Aristotle asserted that “memory “involves time... The further possibility of reviving an activity with its connection with an existing activity is the condition of Recollection...and presupposes only the laws of habit. ... The art of recollection consists in starting...a train of imagination...The Laws of Association, the laws of similarity, dissimilarity, and contiguity” (Brett, 1912, p. 125), i.e., comparison, contrast, contiguity, and causation. Thus, Plato and Aristotle defined association as a ubiquitous and universal phenomenon of mental life.

Right this moment, everyone in the audience, hearing me speak, is entertaining some kind of association. Association takes place in carrying out any activity or task. Any task may require a voluntary, effortful, and focused associative activity. However, in the 1900 Interpretation of Dreams Freud described effortless association which he called free association, free meaning spontaneous. Otherwise, free means the freedom granted by the analyst to the analysand to say anything he wants to his or her analyst, without fearing criticism or retribution. In 1900 Freud cited Friedrich Schiller: “where there is a creative mind—so it seems to me—Reason relaxes its watch upon the gates and the ideas rush in pell-mell and only then does it...examine them in a mass” (p.103). Similarly, in 1920 Freud learned from reading Ludwig Börne about “‘The Art of Becoming an Original Writer in Three Days’...the prehistory of the psychoanalytic use of free-association” (SE 18:265). The inescapable conclusion is that universal association and free association are connected both in life situations and in the therapy setting.

In their 1893 “Preliminary Communication” to the 1895 Studies on Hysteria, Breuer and Freud aimed at “discovering the precipitating cause, the event that provoked the first occurrence” of the traumatic neurosis; but this task could not be “establish[ed] by simple interrogation of the patient, however thoroughly it may be carried out...As a rule it is necessary to hypnotize the patient and to arouse his memories under hypnosis” (p. 3). Here they showed how “associative thought activity,” applied to the patient’s “restricted association,” brought about an “associative correction” (p. 15) “in accordance with the laws of association” (p. 16). Finally, healing was completed by the abreaction, catharsis, or discharge of pent-up emotions and feelings associated with the memories.

In The Interpretation of Dreams Freud referred for the first time to “the technique of interpreting according to the dreamer’s free associations (freie Einfälle)” (p. 353). When I compared the definitions of “free” in English
and German encyclopedic dictionaries, it became apparent why the word “free” in the Standard Edition has led to misunderstanding of what Freud intended by freie Einfälle. In the Oxford English Dictionary free means from what constrains on one’s freedom; in the German-English Encyclopedic Dictionary the word frei means free to act, e.g., being free-spoken to speak out or up, “with free will,” voluntarily. Strachey was ignorant of the native German meaning of the noun Einfall related to the verb einfallen, translated as “thoughts that come into one’s mind; a thought or idea just enters my head; a thought strikes me; a hundred of strange ideas came rushing into my head.” These native German idioms imbued Freud’s method of free association. In his case studies Freud repeatedly urged his patients, with or without gently touching their foreheads, to give free rein to their associations, without any self-criticism or selection, different from conscious and voluntary thinking.

Novac and Blinder focus on “free association as an interaction between two minds,” summarized in “Table 1. Overview of different perspectives on free association in psychoanalysis, the long lineage of contributions about FA is the foundation of the psychoanalytic method.” This gives me an opportunity to discuss additional perspectives on the interaction between two minds.

In 1980 Balter, Lothane, and Spencer Jr., formerly classmates at the NYPSI, published “On the analyzing instrument,” a concept that had been presented by their teacher Otto Isakower (1900-1972) to the NYPSI faculty in typescripts dated 1957 and 1963. These texts were published in 1992 by Wyman and Rittenberg in an issue of the Journal of Clinical Psychoanalysis, with their introduction and a review essay, and commentaries by 13 other psychoanalysts. The analyzing instrument was Isakower’s name of a method of analyzing based on Freud utilizing FA in dream interpretation. Acting as teacher in supervision of candidates, Isakower recommended that they should “empathize with the patient…regarding the welfare and the therapeutic needs of the patient” (p. 183). Isakower departed from the then reigning psychoanalytic habit of interpreting by “application of patterns, typical trends, and constellations” (p. 187), i.e., by applying formulas derived from theories

Isakower would have known Freud’s 1912 and 1913 “Recommendations on the technique of psychoanalysis,” “only asserting that this technique is only suited to my individuality. The technique consists simply in not directing one’s notice to anything in particular and maintaining the same ‘evenly-suspended attention’ (as I have called it) in the face of all that one hears… and avoid the danger…of deliberate attention” … or to work on a case scientifically” (pp. 111-112). This is “intended to create for the doctor a counterpart to the ‘fundamental rule of psychoanalysis’ which is laid down for the patient. Just as the patient must relate everything that his self-observation can detect…so the doctor must put himself in a position to make use of everything he is told…without submitting to censorship of his own for the selection that the patient has forgone…so that the doctor’s unconscious is able to reconstruct from the derivatives of the unconscious communicated to him to reconstruct that unconscious which has determined the patient’s free association…The doctor is able to use his unconscious as an instrument in the analysis” (1912, SE 12:115-116). And Freud added: “while I am listening to the patient, I, too, give myself over to my unconscious thoughts” (1913, SE 12:134). It is noteworthy how open-minded Freud is about treatment as compared to the vehemence with which he fought those who dared to dissent from his theories, e.g., Adler and Jung. As noted by Galina Hristeva (2018), “Strictly speaking, the fundamental rule is neither an obligation nor a rule but a mutual agreement, a consent given both by the analysand and the analyst in order to protect the freedom of expression within the therapeutic setting” (p. 438).

In unpublished fragments I found in his file at the Library of Congress, Isakower spelled his ideas as follows:

The analyst’s frame of mind when analyzing: while listening, he suspends conscious intellection (reflective thinking) and permits his own unconscious to arrive at a preconscious level. There, influenced by stimuli arriving from the outside—the patient’s productions—compromise formations arise between what the patient is communicating, and the contents of the alert and receptive “analyzing instrument” of the psychoanalyst, the ultimate result being potentially “verbalizable statements.” [Isakower, n.d.; cited in Lothane, 1984a, p. 179]

The analyst conveys to the analysand the desirability of letting images emerge, the analysand is encouraged to acknowledge and to behold visual contents in his consciousness, and to put these into words, in addition to the contents which are already verbalized. When this happens, the patient’s attention is simultaneously directed to that detail, and his own, the patient’s analyzing instrument is being activated. [Isakower, n.d., his italics; cited in Lothane, 1984a, p. 179].

A much-discussed example of a verbalizable statement was told to Isakower by a candidate he had taught. The patient reported to the candidate a dream about erotic feelings and gestures, copulations and orgasms, towards a woman called Esther. And he added, in the dream she
turned around and smiled at him. It was an open and friendly smile that was also experienced as derisive. The image of the enigmatic smile of Mona Lisa occurred to the candidate and he conveyed this image to the patient in the hope of helping him to understand his feelings. The patient confirmed this by saying “When they do smile, I don’t know what they mean.” However, the patient said “he had never seen the original that hangs in the Louvre, but the conversation made him think of another painting, “a reproduction of a Lautrec that he bought and hangs in a prominent place in his living room. He has read the biography of Lautrec and he knows that Lautrec had mixed and highly charged feelings towards women. The patient says he tells his visitors that the painting represents Lautrec’s murder of the model, in painting the dead blue-white lifeless face.” “Isakower then discussed at some length the appropriateness and usefulness of the analyst’s own association in an instance of this sort...it did not constitute an interpretation but rather a way of calling attention to an important aspect of the topic under discussion” (Wyman & Rittenberg, condensed, pp. 209-215). Isakower’s method was heuristic, in the service of discovery, from the Greek eureka, I have discovered, the discovery of gravitation, Watt’s of steam power, and Kekulé’s of the benzene ring. Spontaneous associating also played a role in Newton’s discovery of gravitation, Watt’s of steam power, and Kekulé’s of the benzene ring.

While asleep, dreams, as Freud said, are active processes, they “dramatize and idea on the scene of action of dreams” (1900, p. 536). When awake, daydreams, fantasies, hallucinations, and delusions become motives for action as dramatizations by persons in time and place, in words and pantomime, i.e., body language. Anna Freud (1966) differentiated dramatization in fantasy from dramatization in act: “the child’s ego may maintain and dramatize his pleasurable fantasies” (p. 89). Actions belong to a category I named dramatology (Lothane, 2009). A life is a succession of dramas, i.e., events that become unchangeable historical facts. However, the stories told about the dramatic events are as changeable as the narrators, as illustrated by Kurosawa in his film *Rashomon*. On the scene of therapy, enactments of resistance and transference are expressed in tranquil or tempestuous emotions (Lothane, 2009).
2015). Afterwards, analysand and analyst tell different create different narratives about what happened.

References

Inside the Mind of the School Shooter: What Psychodynamic Psychiatrists Should Know
By Eugenio M. Rothe, MD

Situations involving active firearms shooters in schools have increased exponentially in recent years, especially in the United States. These events result in death and psychological traumatization, not just to the involved school, but also to the surrounding communities and to the rest of the population of United States and the other countries who observe these massacres in the media.

Targeted violence at a school is defined as any premeditated incident where a known or knowable attacker deliberately chooses the school as the location for the attack, and an “active shooter incident” as an occurrence where one or more individuals participate in an ongoing, random, or systematic firearms shooting spree with the objective of multiple or mass murders. In addition to this, increasing racial, ethnic and sexual hate rhetoric seen in many societies worldwide have had significant adverse impact on youth, encouraging aggressive and violent behavior to promote the cause of various ideologies. Youth who engage in such violence are typically marginalized from their own mainstream cultural and ethnic groups. On the other hand, in many parts of the world, youths have been victimized by xenophobia, racial discrimination, rejection or ostracism in the same society they were raised and where their families have belonged for several generations. This can also result in violence generated out of frustration and desperation.

The great majority of school shootings are perpetrated by adolescents, so it is important to understand how the neurobiology of the adolescent brain may, in some ways, contribute to this phenomenon. Adolescence is a time of dramatic changes including: 1) increases in sensation-seeking (motivational tendency to want to experience high-intensity, exciting sensations) and, 2) stronger natural interest in, and pursuit of, contact with peers and potential romantic partners. The brains of adults versus adolescents reveal marked differences in brain functioning during these periods of life. Some studies show that adolescents, compared to adults, experience more negative affect and depressed mood and may feel less pleasure from stimuli of low or moderate incentive value. Therefore, they may seek stimuli of greater hedonic intensity to satisfy a deficiency in their experience of reward.
The ability known as mentalizing, or theory of mind, enables us to understand other people’s behavior and actions in terms of underlying mental states such as intentions, desires and beliefs. In early adolescence the areas of the brain involved in self-awareness and mentalizing become progressively more activated and youth at this age become increasingly self-conscious and more aware of, and concerned with, others’ opinions and social brain functions. So adolescence is a time during which peers, rather than parents, become influential in shaping social behavior.

**Social Consequences of Rejection, Ostracism and Bullying in Adolescence**

Since peer relationships become more important in adolescence, the potential negative consequences of rejection or victimization by peers also increase. Ostracism (which derives from the word Oyster) threatens four fundamental psychological needs: 1) self-esteem, 2) belonging, 3) control and 4) a sense of meaningful existence. So, taking into account our human evolutionary origins as Hunter-Gatherers who inhabited the East-African plains thousands of years ago and moved around in groups of no more than 30-50 people, if an individual was ostracized and excluded from the group, his chances of survival were significantly reduced, which may explain why the reaction of an individual who is being ostracized can be dramatic and violent, with a strong motivation to overturn this outcome in the service of survival.

Bullying is defined as the systematic abuse of power utilizing aggressive behavior or intentional harm perpetrated by peers that is carried out repeatedly and involves an imbalance of power, either actual or perceived, between the victim and the bully. Bullying can take the form of direct bullying, which includes physical and verbal acts of aggression such as hitting, stealing or name calling, or indirect bullying, which is characterized by social exclusion and rumor spreading. Children bullying others, those being bullied, and those who were both bully and bullied had significant common health problems including psychosomatic symptoms, and psychiatric problems including depression, suicide attempts, anxiety, externalizing behaviors, hyperactivity, substance abuse and eating disorders. Bullying is found in all societies, including modern hunter-gatherer societies and ancient civilizations. It is considered an evolutionary adaptation, the purpose of which is to gain high status and dominance, get access to resources, secure survival, reduce stress and allow for more mating opportunities. Oftentimes bullying occurs in settings where individuals do not have a say concerning the group they want to be in. For these children, school classrooms or the home with siblings has been compared to being “caged” with others.

Cyberbullying has become an international public health concern among adolescents. It can be broadly defined as any bullying which is performed via electronic means, such as mobile phones or the internet. This may include sending harassing messages (via text or Internet), posting disparaging comments on a social networking site, posting humiliating pictures, or threatening/intimidating someone electronically. Adolescents who are targeted via cyberbullying report increased depressive affect, anxiety, loneliness, suicidal behavior, and somatic symptoms. Perpetrators of cyberbullying are more likely to report increased substance use, aggression, and delinquent behaviors. Compared to traditional bullying, cyberbullying is unique in that it reaches an unlimited audience with increased exposure across time and space, preserves words and images in a more permanent state, and lacks supervision. The perpetrators of cyberbullying do not see the faces of their targets, and subsequently may not understand the full consequences of their actions, thereby decreasing important feelings of personal accountability. This has often been referred to in the literature as the “disinhibition effect”.

**School Shootings**

The most comprehensive study on the profile of school shooters to date is the one done by Vossekui et al (2002) and expanded by Bonnano and Levenson (2014), who examined 37 incidents of targeted school violence in the United States and found that the great majority of the attackers were males, and 95% of them were current students with 5% being former students. Attackers worked alone in 81% of the incidents. Assistance from at least one other peer in the planning of the attack occurred in 11% of the incidents, but the attackers in those incidents ultimately carried out the attack alone. Two or more attackers committed the assault together in 8% of the incidents.

In terms of weapons, 76% of the attackers used only one weapon, whereas 24% of the attackers had more than one weapon with them at the time of the attack. Handguns were used by 61% of the attackers, and 49% of the attackers also used rifles or shotguns. In 73% of the incidents, the attacker killed one or more individuals at the school, and in the remaining incidents, at least one person was injured by a weapon. Fifty-nine percent of the incidents occurred during the school day. Targets were not necessarily random, although persons in addition to targets were also harmed. Attackers had selected at least one administrator, faculty member, or staff member as a target in 54% of the incidents. Students were chosen as targets in 41% of the cases, and attackers selected more than one target prior to the attack in 44% of the incidents. Persons who were targeted before the attack were actually harmed in the attack in 46% of the cases. Individuals not identified as original targets of the attack were also injured or killed, and of these individuals,
57% were students and 39% were administrators, faculty, or staff.

According to these studies, there is no “profile,” or “set of demographic and other traits that a set of perpetrators of a crime have in common” for student attackers. Attackers came from a variety of family situations, and they differed considerably in social relationships.

Most importantly, 71% of the attackers felt bullied, threatened, or injured by others before committing the attack. This is a significant finding to note if one were to attempt to categorize traits of active shooters. In addition, most attackers had some history of suicidal ideation or attempts, or a history of extreme depression. Most attackers were known to have had difficulties coping with significant losses or personal failures. Academic achievement ranged from failing to excellent grades, and some attackers had no behavioral problems whereas others had histories of disciplinary problems.

Although most attackers had no history of violent or criminal behavior before the attack, 59% demonstrated some interest in violence whether it was through video games, movies, books, or other media. Most attackers did not display any significant change in academic performance, friendship patterns, interest in school, or disciplinary problems before the attack. At the same time, 93% of the attackers engaged in some peculiar behavior before the attack that made others, such as parents, school officials, teachers, fellow students concerned about their behavior.

Targets did not seem to know about the attack beforehand, as most attackers did not threaten their targets directly before the attack. The targeted violence at school was often planned ahead of time with some attackers devising the idea as few as 1 or 2 days before the attack and others holding the idea of the attack for as long as a year before its execution.

Motives for attacks varied, and 54% of the attackers held multiple motives or reasons. For 61% of the attackers studied, revenge was a reason for the attack, 81% of the attackers had some type of grievance at the time of their attack, and 66% of the attackers had told other people about the grievance before the attack. Additional but less common motives of attackers included: trying to solve a problem (34%), suicide or desperation (27%), and attempts for attention or recognition (24%).

In terms of advancing the attack, many attackers had experience using weapons and had access to weapons. Fifty-nine percent of the attackers had some experience with a gun, and 68% used firearms that they obtained from their own home or that of a relative. The majority of these youth have experienced chronic rejection prior to the incident, in addition to bullying, personal loss, and many had been threatened by others. Some may even reach such degree of anger that they kill their parents prior to the shooting. Uncontrolled Strain occurs when the victim reaches a saturation point and it often goes unnoticed by the adults and people responsible for these youth, and this also serves to highlight the lack of meaningful relationships. In some cases, the few people in their lives that constitute meaningful relationships exert a negative influence and may even encourage their plans. A quarter of these school shooters belonged to a group that was outright disliked and rejected by others and a third of these were loners who tended to externalize blame on others. The stage of Acute Strain is reached when there is a loss that is perceived as catastrophic by the attacker and serves as a catalyst for the attack. The loss destabilizes an already troubled individual, and in this study, 98% of the attackers had experienced a personal loss, oftentimes the rupture of a romantic relationship. The majority perceived the loss as a personal failure and loss of status that left them with nothing left to lose. In the Planning Stage, attackers often spend days, months or years planning the attack. These massacres are almost never impulsive and the attackers tend to have a perception of damaged personal identity and self-worth. They associate violence with masculinity. The attack is seen as a reparative act helping the attacker regain a lost pride, power, masculinity and to attain international fame and attention.

Sequential Model of the School Shooter
Levin and Madfis (2009) have described a five stage sequential model that is necessary for a school shooting to occur. In this model each stage is a necessary pre-condition that builds up cumulative strain until the culmination of the fatal event. It is divided into: 1) Chronic Strain, 2) Uncontrolled Strain, 3) Acute Strain, 4) The Planning Stage and the 5) Massacre at School.

Chronic Strain begins with negative experiences in social, family and school relationships that result in frustration, depression, fear, disappointment and anger. The majority of these youth have experienced chronic rejection prior to the incident, in addition to bullying, personal loss, and many had been threatened by others. Some may even reach such degree of anger that they kill their parents prior to the shooting. Uncontrolled Strain occurs when the victim reaches a saturation point and it often goes unnoticed by the adults and people responsible for these youth, and this also serves to highlight the lack of meaningful relationships. In some cases, the few people in their lives that constitute meaningful relationships exert a negative influence and may even encourage their plans. A quarter of these school shooters belonged to a group that was outright disliked and rejected by others and a third of these were loners who tended to externalize blame on others. The stage of Acute Strain is reached when there is a loss that is perceived as catastrophic by the attacker and serves as a catalyst for the attack. The loss destabilizes an already troubled individual, and in this study, 98% of the attackers had experienced a personal loss, oftentimes the rupture of a romantic relationship. The majority perceived the loss as a personal failure and loss of status that left them with nothing left to lose. In the Planning Stage, attackers often spend days, months or years planning the attack. These massacres are almost never impulsive and the attackers tend to have a perception of damaged personal identity and self-worth. They associate violence with masculinity. The attack is seen as a reparative act helping the attacker regain a lost pride, power, masculinity and to attain international fame and attention.
Firearms and School Shootings

In 2009 there were 310 million firearms in the U.S., not including weapons owned by the military, and 110 million were rifles. The increase in guns held by the civilian population in the United States has led many schools and local communities to take the problem into their own hands by providing young students with early gun safety courses to make them aware of the dangers these objects actually are, and also to prevent school shootings. The AR-15 style rifles have been used in a number of the deadliest mass shooting incidents, and have come to be widely characterized as the weapon of choice for perpetrators of mass shootings. They can function like a single shot rifle or as a machine gun, maximizing the number of victims that can be targeted in a matter of seconds. In the vast majority of countries around the world, these types of weapons are only allowed to be carried by the police or the military, and it is considered unthinkable to provide these weapons to civilians (Rothe, 2022).

Treatment and Preventive Intervention

Schools are the first line of defense with school shooters. So it is important to clarify the roles and responsibilities of the school social workers, counselors, psychologists, nurses, teachers and administrators in their work with students who have mental health disorders. “Leakage” is a frequent occurrence prior to school shootings. It happens when the perpetrator “leaks” his intentions, telling others, hinting or trying to recruit others to participate in the attack. So, it is important to educate parents, peers, community members and school personnel to come forth immediately if they observe warning signs that identify a potential perpetrator, focusing on the specific warning signs, psychological profile and the preventive interventions, including referral to the appropriate mental health professionals. It is also important to foster better communication and supervision by parents with their children. In addition, it is important for schools to implement Bullying Prevention Interventions, for the authorities to try to reduce media coverage, in order to avoid copycat phenomena, and for parents to establish gun control in their homes, since most perpetrators find the guns in their home (Tables 1 and 2 summarize some of the contents of this article).

Conclusions

As psychodynamic psychiatrists we are uniquely qualified to provide treatment to perpetrators and to victims of school shootings, and to serve as consultants to school authorities, government officials, and law enforcement in their efforts to develop new prevention strategies to avert school shootings. As psychodynamic psychiatrists we are also uniquely qualified to educate parents, school and government officials, and law enforcement about the mental health issues related to these incidents by utilizing the media in constructive ways in order to propagate this knowledge. For this reason, we should become familiarized with the evidence-based mental health literature on school shootings, so we can be better informed, play an important role, and effectively contribute to avert this national tragedy.

Table 1
Characteristics of School Shootings

1. Incidents of targeted violence at school were rarely sudden, impulsive acts.
2. Prior to most incidents, other people knew about the attacker’s idea or plan to attack.
3. Most attackers did not threaten their targets directly prior to advancing the attack.
4. There is no accurate or useful profile of students who engaged in targeted school violence.
5. Most attackers engaged in some behavior prior to the incident that caused others concern or indicated a need for help.
6. Most attackers had difficulty coping with significant losses or personal failures. Moreover, many had considered or attempted suicide.
7. Many attackers felt bullied, persecuted, or injured by others prior to the attack.
8. Most attackers had access to and had used weapons prior to the attack.
9. In many cases, other students were involved in some capacity.
10. Despite prompt law enforcement responses, most shooting incidents were stopped by means other than law enforcement intervention.


Table 2.
Major Components and Tasks for Creating a Safe/Connected School Climate

1. Assess the school’s emotional climate.
2. Emphasize the importance of listening in schools.
3. Take a strong but caring stance against the code of silence.
4. Work actively to change the perception that talking to an adult about a student contemplating violence is considered “snitching”.
5. Find ways to stop bullying.
6. Empower students by involving them in planning, creating, and sustaining a school culture of safety and respect.
7. Ensure that every student feels that he or she has a trusting relationship with at least one adult at school.
8. Create mechanisms for developing and sustaining safe school climates.
9. Be aware of physical environments and their effects on creating comfort zones.
10. Emphasize an integrated systems model.
11. All climates of safety ultimately are “local”.

References

Donald Trump’s Tragic Flaw and Psychological Blind Spot
By Peter A. Olsson, MD

Donald J. Trump is difficult to love, frequently resented or despised, and often misunderstood. President Trump is disliked by many Americans including most psychiatrists, psychoanalysts, psychologists, and mental health professionals.

As a supporter of Donald Trump in 2020, I acknowledge his aggressive negative traits, cruel personal attacking of opponents, and extremely unorthodox political behavior and style. I will describe Trump’s Tragic Flaw and psychological blind spot. It led me to withdraw my support for Trump after his behavior on and around January 6, 2020.

It will take a long time for the facts to emerge about what happened at the US Capitol on Jan 6, 2021. It does seem clear that Trump’s tragic flaw of an intense obsession with winning and not being a loser was prominent that day. I think he underestimated the power of his charisma on some violent disturbed followers who had long before January 6th planned violence that began before Trump finished his powerful speech. Trump did not want physical violence in any form. I do not feel he encouraged violence at the capital. Just the opposite. He urged peaceful demonstrations that Trump saw as a strong political form of fighting.

Tragically, Trump was ignorant about the fact that any large group without effective leadership can become a crowd, even a violent mob. Trump’s expressed distain for Vice President Pence if he did not do as Trump wished about the vote count was another reflection of Trump’s tragic flaw. The obsession with not being a loser endangered vice president Mike Pence! Trump’s “Win at all Costs” became politically and legally costly.

Tragically, in fact, the Jan 6th violence prevented the last chance for effective legitimate presentation of the cases of unconstitutional election practices in Pennsylvania, Michigan, Wisconsin, Arizona, and Georgia to the congress. If such constitutional arguments had been affirmed by the supreme court and accepted by congress on January 6th, it could have changed the electoral count officiated by Vice President Pence at the Capital. The certification of the electoral votes by congress described in the constitution is not merely perfunctory and ceremonial. I recommend the reader carefully read Article II section 1 and the 12th Amendment to the constitution. Americans could helpfully educate themselves in this important civics’ education.

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In addition, Trump’s obsession about being a loser of the presidential election clouded and negatively affected the senate elections in Georgia. It seemed to cause many Trump supporters in Georgia to be discouraged about voting because of Trump’s emphasis on his own having been cheated of a victory. Trump instead should have more appropriately focused on the importance of defeating the Democrat senate candidates.

It is also clear that the Covid-19 pandemic and the resulting massive use of mailed in ballots made the 2020 election controversial as well as fraught with questionable tactics by both political parties as Mollie Hemingway describes in her book (Rigged: How the Media, Big Tech, and the Democrats Seized Our Elections), and Molly Ball in her detailed TIME magazine article (“The Secret History of the Shadow Campaign That Saved the 2020 Election”). Ball from a liberal Democrat point of view, and Hemingway from a conservative Republican point of view, both locate the dangerous domains of American political election tampering and mischief.

The tragic flaw of Donald Trump’s personality is an obsession with winning at all costs. Donald Trump’s father, Fred Trump Senior, was so consumed with his business’s success that he seemed to fuse his family’s destiny with that of the Trump building and real estate company ventures. Feeling the namesake focused pressure, Fred Trump Jr. recoiled against Trump Inc. and pushed toward his ambition to be an airline pilot. Donald Trump chose, and was chosen, to join with his father and the Trump company. Unfortunately, in the process it appears that Fred Trump Jr. felt both pressures not to follow his bliss in flying but also a sense of rejection from his father for so doing. On one occasion, Fred Trump Sr. angrily put-down Fred Jr’s ambition to be an airline pilot as like being a bus driver in the sky. Donald who was present did not defend his brother on that occasion.

Regardless, Donald Trump’s self-defining mantra became “never be a loser!” During Trump’s maturation and psychological development, the relentless drive to succeed and be a winner as his father demanded and rewarded, has dominated his life. It has led to deficits in Donald’s capacity for empathy and nurturing of less aggressive successful persons. Winning and working hard gain Trump’s respect and admiration. Trump’s favored solutions for less fortunate people is primarily to provide jobs and work, arduous work. Failures in a Trump employee apprentice means, “you’re fired;” even the initially beloved general “Mad-dog” Mattis suffered such fate from Trump, as did dedicated Americans like Rex Tillerson, Jeff Sessions, and William Barr.

A truth eludes Donald Trump… sometimes a loser who learns from the experience becomes a winner. Trump a lover of sports, should have known that even if a team gets bad calls from the umpires, even if the other team cheats and gets away with it as a team loses, they can learn from a defeat. Perhaps a comeback that Americans love will happen for Trump in 2024. If so, political high drama will again prevail in America.

The anti-Trump phenomenon is fascinating, rampant, and real in America. Anti-Trumpism is notable among many psychiatrists, psychoanalysts, as well as many psychologists and other mental health professionals. President Trump has been devalued, hated, and scorned for four years by many in the liberal Democrat mainstream media (New York Times, Washington Post, CNN, MSNBC, NBC, CBS, PBS). Likewise, American academia, especially political scientists and social scientists dislike and devalue him. Social media moguls at Facebook, Twitter, and Google/Amazon worked hard to cover-up the Hunter and Joe Biden corruption scandal during the 2020 election, which might have enlightened American voters in Trump’s favor.

Many pundits have labelled Trump’s puffery, exaggerations, hyperbole, sarcastic humor, bragging, and ad hominem attacking political speechifying as destructive “lying”. Major newspapers even kept running counts of Trump’s supposed “Lies”. Trump loves his battle with the fake news media and academia. Trump’s attacks and insults of opponents damage his message. Yet, Trump seems to embrace and enjoy the political combat. I have personally felt swept-up in powerful ambivalent feelings about Trump and changed my mind about him more than once.

Trump the Political Aggressor, Identification with the Aggressor, and Hatred of the Aggressor by the American Group Self

Sandor Ferenczi coined the phrase “identification with the aggressor”. It is a paradoxical behavior that can be described as a psychological defense mechanism involving the victim of aggression or harm acting like the aggressor. Dec 17,2016 https://exploringyourmind.com/identification-with-the-aggressor/. Group self is a parallel process by which an individual’s sense of himself as part of a group is formed in parallel with an individual’s early developmental and maturational individual experiences. In 1976, Heinz Kohut described the group self. (The Search for the Self: Selected Writings of Heinz Kohut, 1950-1978, Volume 2, Paul Ornstein, ed. Footnote #21, pp 837-838)

In individual psychology, psychoanalysts describe identification with the aggressor in their work with individuals, particularly traumatized individuals. In observing Trump operate politically, it is striking to observe what can be described as American large groups identifying with, and or hating of Trump the aggressor. At his large political rallies, Trump is cheered and adored by the crowds of supporters as he insults, demeans, and caricatures political opponents. They radiate an almost
joyful identification with their aggressor hero, Donald Trump. Many in Trump’s campaign style crowds have felt traumatized and hurt by trade and other government policies in the past that they feel took their jobs away in the coal or manufacturing industries. Trump is their aggressor savior.

Democrat, and even some Republican politicians, however, more than resent and hate Trump at subconscious and conscious levels because of his aggressive, bullying, political style, and behavior. They seem to feel victimized or traumatized emotionally and politically. Trump sometimes starts such political fights, and certainly, if attacked, will predictably escalate his aggression to win a personal fight at all costs.

Sectors of the American large group self react with a tone of narcissistic woundedness, rage, resentment, and seek political revenge at all costs. One could argue that the whole commentary and opinion staffs of some media networks constantly lead and cheerlead the hate and despise Trump cadres. The biased and slanted liberal media, is in turn, attacked by Trump as “fake news”. Beneath the surface we all react negatively when attacked, mocked, or belittled. Trump’s political enemies, and there are many, react like collective wounded political animals who did not accept Trump’s election, nor did they support and work with him politically or legislatively.

Sad news for America because Trump worked tirelessly and relentlessly to keep his campaign promises

Trump is by no means the only American president with obnoxious personality traits and obvious flaws. In a nation long divided politically before Trump, it is important to defend authentic and positive aspects of Trump’s motives, kept promises, and successful efforts to improve and help our country. Often, despite his abrasive personality and personal style.

It is important for me to clearly state that I have never examined Donald Trump nor done a formal mental status examination. I have, however, observed Trump’s political verbal and non-verbal behavior. I have read his book and my psychiatrist and psychoanalyst colleagues’ observations, opinions, and theorizing about Trump. It is interesting that Trump took and very successfully passed a mental status exam (Montreal Cognitive Assessment exam), which president Biden has not to my knowledge taken.

In my over fifty years in medicine, psychiatry, and psychoanalysis, some of my most valued discoveries have been the experience of observing people for whom the textbooks would predict pain, failure, or disaster, but who triumphed over adversity to live unusually successful lives. I think Donald Trump, a flawed but effective person, is one of them. It is sad how his tragic flaw and psychological blind spot dominated the final events of the 2020 election and his administration.

Control Cases, Out-of-Control: When a Low-Fee is no Bargain
Nathan Szajnberg, MD

Summary: I describe three consecutive referrals from a Psychoanalytic Institute’s Low-Fee clinic, in order to demonstrate the inherent organizational and possibly characterological difficulties in such cases that could interfere with successful analysis by a candidate. All three cases were discussed with at least two training analysts, both of whom recommended against accepting all three cases into treatment because of ego and superego difficulties that would have interfered with a successful psychoanalytic treatment, and in fact, might have resulted in a pseudo analysis (Winnicott, 1972). I discuss the specific challenges faced by candidates in communities with a shortage of low-fee cases and the countertransference issues specific to a middle-aged candidate hearing time’s winged-chariot beating behind. This brief reports’ intent is to open discussion of weighing advantages and disadvantages of any process for accepting low-fee analysands in a psychoanalytic training program, particularly when fewer patients come for analysis and more particularly when fewer patients come for analysis and more institutes and consequently candidates seek patients. Because of institutes’ autonomy, there are varying approaches to recruiting control cases for candidates. Further, with shifts in cultural mores, fewer people pursue analysis, even at low fees. Finally, with the rise of additional institutes, particularly following the lawsuit in the USA (Wallerstein, 2000), more candidates seek patients. These synergistic forces result in greater vicissitudes for candidates seeking patients, particularly when compared to the ethos in the US during the 1950’s and 1960’s. Other pressures include external realities of lengthy training analyses, and idiosyncratic countertransference issues of the candidate – not only countertransference of childhood origins, but also of current life circumstances.

I describe and discuss the interaction among the character traits of three prospective control cases, the Institute’s referral process, and the candidate’s countertransference issues.

First, the circumstances of the Institute. The Institute chose to shift its evaluation and referral process of the low-fee clinic, established for finding control cases for candidates. In the past decade, rather than having prospective low-fee cases see a senior analyst over several sessions, patients would be seen once, possibly twice,
then referred to a candidate. Patients were told that the fee would be negotiated with the candidate, based on the patient’s finances. But, many prospective patients told candidates that they had heard from others that the fee could be as low as $10/session. Child psychoanalytic candidates were so desperate for cases that they bantered amongst themselves about paying parents to bring children. Candidates were expected to meet several times with the prospective patient, then present the case to a supervisory analyst to decide upon accepting the case.1 The issue of “analyzability” was discussed, but with sensitivity that a patient may not be analyzable with one candidate/analyst, but may be with another. If the supervisor and candidate agreed not to accept a patient, he or she was referred back to the clinic for a referral to another candidate.

Cases

I will briefly report each case, then discuss their presentations and the difficulties for both the candidate and prospective patients.

Case One: Mr. Z, in his mid-30’s drove up to the analyst’s home office in a bright yellow, Hummer, with Burberry plaid interior. The analyst could see the details of the car, for Mr. Z had parked on the sidewalk in front of the analyst’s home and partially blocking a neighbor’s driveway. He was a handsome, lean, tan, well-groomed fellow, who entered with a sense of self-assurance. He removed his butter-soft black, tailored napa leather jacket, folded it twice, and laid it upon the couch, smoothing, then caressing the jacket before he sat down. He smiled. He had bought this Armani jacket, he began, on his last trip to Italy; brought back good memories. He had had various psychotherapies. But, he thought analysis would be good for his art; after all, he had heard, read many stories about artists of the ’50’s and ’60’s and their analyses. Look at Woody Allen. Analysis would help him get in touch with his inner self, enrich his artistic processes.

He was delighted to be training in psychotherapy. He had majored in business in college, entered the family business, but really wanted to do therapy. He was pleased to be accepted in this graduate school, since his GRE scores were too low for the local traditional Ph.D. programs. Now, he wanted to have his own analysis, since he had heard much about Freud and thought that this would make him a better therapist. He did not think that he had neuroses, but he thought that an analysis would better help him understand his patients.

He missed his second visit and called afterwards. He arrived for the third visit with a jaunty enthusiasm. They had a new baby and he looked forward to learning much about development even as he was in analysis; he had learned that the candidate was a child psychiatrist, specializing in infancy.

The candidate asked if he had missed his appointment because of the baby. No, he said. He just forgot. He had never been in therapy, relished new experiences, challenges. Periodically, he reached over to smooth an unseen wrinkle in the leather jacket lying on the couch. He looked forward to using the couch.

Finally, the candidate introduced the fee.

The patient was surprised; sat back with a jerk. What was to discuss? He had heard from fellow psychology students that the fee was ten dollars.

The candidate ventured that the Institute’s policy is that the fee would be based on his ability to pay.

The patient leaned forward angrily. Would the analyst take “food from the mouth of my baby” to charge a higher fee. He was outraged. He said that the analyst should think about this, since he knew that candidates were hungry for patients. He would return to the low-fee clinic, report the candidate, and request another referral.

Case Two: Mr. R was in his mid-fifties. He had just finished a graduate program in fine art, having taken early retirement from a dot.com, after helping found the company and bringing it public. His lover had urged him to become a conceptual artist, perhaps do performance art, his dream. He enjoyed his three years in art school and now looked forward to devoting full-time to art. He would not work, but create art all day. He had been the oldest student in his school, but hoped that by doing art full-time, unlike his fellow students who had to work during the day or wait tables on weekends and evenings, he would have one-man shows soon.

He had had various psychotherapies. But, he thought analysis would be good for his art; after all, he had heard, read many stories about artists of the ’50’s and ’60’s and their analyses. Look at Woody Allen. Analysis would help him get in touch with his inner self, enrich his artistic processes.

He was glad to hear about the low-fee clinic. Otherwise, he said, he would have to return to work at least part-time to pay for his analysis. Ten dollars a session was a good deal, he said.

The candidate, after discussing the case with two training analysts, referred the patient back to the low-fee clinic.

Case Three: Ms. W came to the first meeting, after a senior analyst, telephoned the candidate. The senior analyst really liked this patient; if the patient could afford a private fee, she would treat her herself. She was glad that they had but one meeting, otherwise the analyst would have developed too strong an attraction to the patient, an attraction – the candidate learned – which was mutual.

This training analyst had heard about the candidate; that
he was a seasoned therapist and was looking for a fourth case. She thought that this would be an excellent case for the candidate. Could the candidate call back after the evaluation? Oh, by the way, the patient was a neighbor and friend of Dr. X, a very prominent training analyst. Dr. X had referred the patient saying that he wanted her to have a more senior candidate.

Ms. W was poised, dressed in an understated but classically elegant manner. Although it was winter in San Francisco, she arrived in a skirt and nylons, and a slinky, silk beige blouse with décolletage. She had been through a terrible divorce from a very wealthy man who had “ripped her off” in the divorced because of a prenup. She had been a successful writer before the four-year marriage, her first, then was out-of-work for almost a year. Finally, she just got a job that paid $60,000 a year (1996), well below the standard of living to which she had been accustomed. They had no children, and she was relieved that she had gotten the house in a desirable village, mortgage-free.

She felt that she had issues that had contributed to her marrying late and her unsuccessful marriage. She wanted to address these in analysis so that she would not repeat them. Dr. X, a very close friend and neighbor, recommended analysis. He would treat her, but he explained that he could not because they were friends. He assured her that he would help her get a good candidate. The candidate should call him with any questions, she offered.

On the second visit, they discussed details of frequency, use of the couch and the nature of free association. The candidate raised the issue of fee. The patient drew herself upright. She was assured by Dr. X that she would be charged ten dollars a session. She drew her chair forward, until her knees leaned against the candidate’s ottoman, her décolletage offered. She spoke huskily, “I am making a commitment to this process already, offering to come four times weekly. I have a great deal to offer. Surely you’ll take this into account in accepting the ten dollar fee.”

On second thought, she felt as if the candidate was ripping her off like her former husband. She would be sure to telephone Dr. X about this. This Institute would take notice, she insisted.

Discussion

In all three cases, the candidate felt both internal and external pressures to accept the last control case, having waited two years. Externally, the director of the low-fee clinic had explained that there was a shortage of cases to refer. He gave preference to first year candidates. In one of the three cases, the director of the clinic thought that since the patient had significant narcissistic issues, the patient would do well with an experienced candidate, who had had training in Kohut’s method during his residency. The candidate also felt the peer pressures of colleagues seeking patients.

Most candidates insisted that it was better to get patients from one’s own caseload, rather than the low-fee clinic.

An internal pressure was the candidate’s approaching his fifth decade with a family to support. These countertransference issues were discussed in supervision. He discussed specific countertransference issues raised with these patients. The artist, only a few years older than the candidate, had rubbed against the grain when he said that he was pleased that he would not have to work to pay for his analysis. The candidate had worked as an ICU nurse during medical school on the graveyard shift to pay for his first analysis. It is quite possible that another candidate (or analyst) who did not have these experiences, would not have reacted adversely to the artist’s remark.

The same issues applied to graduate student/former retailer. Stepping back, one could see with greater empathy that the student’s driving a Hummer, wearing Armani leather, laying his “skin” and caressing it on the couch were manifestations of a narcissism in which external valuables might be covering a core emptiness, worthlessness. One can’t be certain from only two interviews. But the sense of entitlement and remarkable wealth, evoked feelings in this candidate that permitted only an intellectual formulation of the patient’s narcissism, without sincere empathy. One supervising training analyst, upon hearing the case, offered trepwerter, “after thoughts,” that he might have said: “I don’t blame you for trying to get away with anything. You’re welcome to try. But, do you expect me to be blind and dumb?” He recommended against accepting this as a training case.

The third case, if I described it clearly, raised additional difficulties. As this attractive woman leaned forward, the candidate felt a sense of seduction. He did not find that this was an idiosyncratic countertransference, rather one being brought in by the patient very early in the evaluation. Her case raised additional complications of the special patient, first discussed by Thomas Main (Main, 1956; Szajnberg, 1985; 1994). The ”special” patient brings along complications that are not necessarily in the patient’s best interest. The senior training analyst, Dr. X, did call after the woman’s last visit, expressing disappointment that the “experienced” candidate would not reconsider his decision and accept the patient into treatment. “Of course,” Dr. X. added, “I don’t want to interfere in the process, but wanted to let you know that she is a very fine person.”

One training analyst, who was supervising the candidate in another case, was concerned that the characterological issues in two of the cases were so severe that a several-year course of exploratory psychotherapy would be necessary from the Training Committee’s position before an analysis (one that fulfills the criteria for certification)
was feasible. Given the candidate’s age and desire to complete his training, the analyst recommended against accepting both patients. In fact, he thought that both patients would present challenges to an experienced analyst.

In each case, I want to emphasize, a different candidate or analyst might have been able to treat the patients successfully, addressing issues such as entitlement, seductiveness and certain aspects of narcissism.

Freud first wrote about entitled patients in his “Some Character Types met within Psychoanalytic Work” (1916). His paper is remarkably atheoretical, more a descriptive account of three character types — “exceptions,” wrecked by success, and criminals from a sense of guilt — in which he did not give clinical material, using references to literature. While Freud initiated our inquiry into what we now call character analysis, of the three character types, the “exceptions” present with the expectation that the analyst make special exemptions. “They say that they have renounced enough and suffered enough and have a call to be spared any further demands...” such as psychoanalytic work expects. On exploration, these patients give a history of early “suffering...of which they new themselves to be guiltless...” (1916; 312-3).

But it is Kohut’s work (1967) that brought the character disorder of narcissism to the fore. To a significant degree, such patients have become the coin of the psychoanalytic realm. While Kohut eventually developed a detailed theoretical developmental model of two lines of parallel development and a lack of parental empathy, his early work focused on revised psychoanalytic technique with such patients. Kernberg (1975), Giovacchini (2000) and Andre Green (2002), among many others, have suggested that the narcissistic character is along a continuum of character disorders. Further, Giovacchini and Kernberg in particular have articulated healthy aspects to narcissism, distinguishable from that in character pathology.

Ironically perhaps, it was a social historian, Christopher Lasch (1974), who raised our awareness of narcissism as a characteristic of American culture arising in the late twentieth century. In an encyclopedic review of changes in American society — a shift in capitalism, bureaucratization of work and government, and decrease in family power and responsibility — Lasch describes narcissistic elements in society, including a sense of entitlement, emptiness and associated pursuit of desires, trivialization of personal relations, and a pseudo-self awareness and self-absorption with a search for identifications (as opposed to identity) and various “therapeutic” modalities of self-realization or self-improvement. That is, Lasch sees the Narcissistic Personality Disorder only as an epitome of an ailment in contemporary American society. In terms of the patients who presented here, this complicates our diagnostic challenge: we need think not only in terms of specific character pathology, but also an overlay of entitlement (and underlying emptiness) in the culture.

But, in terms of these three patients, there were specific aspects of narcissism that (combined with this analytic candidate’s needs for a timely finish of training) mitigated the likelihood of successful analysis: an overarching sense of being an exception, being entitled; an unusual lack of awareness of their presumptuousness; a sense that they could appeal to higher powers to prevail on the candidate (or others); and a demeaning of both the analytic situation and the analyst/candidate. In terms of demeaning, all three prospective patients were from monied backgrounds and were prepared to pay well for what they valued. None of these aspects are insurmountable in a sufficiently lengthy analysis with an analyst aware of the countertransference issues involved — countertransference in the more recent sense of counteridentification or evoked response, rather than Freud’s thoughts of a more idiosyncratic countertransference.

In the early psychoanalytic institutes, “free” or low fee clinics brought many, many patients (Makari, 2008). When Eitigen and colleagues opened the free psychoanalytic clinic in Berlin (2), there was a press of patients, almost overwhelming the capacity of the clinic. Circumstances have changed profoundly.

What does this imply for candidates? There were at least three interacting factors here: the manner in which prospective patients were referred; societal valuation of this matter of psychoanalysis; the candidate’s need to finish particularly nearing training.

Any institutional decision about screening and referring has implications with advantages and disadvantages. The advantages of this Institute’s minimal screening — including brief patient contact with a training analyst and accepting that a patient may not be treatable by a particular candidate, but possibly by another — theoretically provides greater openness, receptivity to patients; avoiding disappointment associated with extended assessments by a training analyst before referral; and offers greater hope that lack of “fit” with one candidate does not preclude “fit” with another. The disadvantages include referring to a candidate before an experienced analyst can assess not only the patient’s formal diagnosis, but also what Winnicott (1972) or Schlesinger (2002) referred to as assessing the nature of analytic process.

My paper addresses possible complications of a more “open” screening process. This is simply a caution to training centers.

Now, as a training analyst, I have discussed these three cases with colleagues. Reactions have been complex. One suggested at first, that she would have tried to interpret their attitudes, such as seeing the analysis as a “good
deal,” a cheap treatment — but she could not think of an interpretation at the moment. Then, she described a recent referral — a graduate student in psychology — who insisted on either a lower fee or lower frequency, as she was planning to buy a new car. Another colleague recounted a more complex situation: in his Institute, one must be in analysis for one year before applying for training. An older therapist came for analysis, as she had heard he was highly regarded at the Institute and on the Education committee. But, she warned him, that if she were not accepted at the Institute, she would not continue her analysis. He was concerned that a false analysis was in process.

I write this paper as a caution, without offering solutions. I write this to open discussion among candidates and Institutes to recognize the dilemmas associated with any referral process, particularly low-fee cases.

The low-fee clinic may attract prospective patients with specific characterological constellations: entitlement, a pseudo-investment in psychoanalysis, and possibly, a not-too-subtle demeaning of the analyst/analysis. If this is the case, then it is useful for Institute clinics, training analysts and candidates to identify and address such issues in order to facilitate more successful referrals and psychoanalytic treatment, less encumbered by character traits that may require lengthier analyses.

1 I thank Drs. Robert Wallerstein, Alan Skolnikoff, and Owen Renik for supervising the intake of these cases and others.

2 This clinic and the one in Hungary were funded in large part by Eitigen’s family’s fortunes.

References:

Teletherapy: Filters in the Realm of the Senses
By David V. Forrest, MD

With a significant change in how psychodynamic psychiatry is practiced, it is important to compare the differences between in-person and teletherapy. In a case I heard recently and was a discussant on, the shift occurred with the treatment itself. So it served to document, an account that compares in-person and Zoom therapeutic experiences of doctor and patient as their own scientific controls.

Zoomed therapy, which in these Covid times I mostly use, can be compared with other arrangements that filter the most direct human contact. Observation and information theory reveal how filters work, and how they reduce, and what is lost.

The Couch and the Face
The psychoanalytic couch is one such filter. We love and revere it as our trademark instrument, comparable to our stethoscopes and sphygmomanometers. I have one in all three of my offices. All who have used or lain upon it remain in awe of its power to unearth the unconscious. But how does the couch work? As with all filters, there is a calculus of what is lost. It works by how it filters and thus deprives. It uniquely extracts deep information by sensory deprivation of the face and other visual aspects of the presence of the analyst, who by transference is a love object. Simply put, the couch is an instrument that deprives the patient’s inner infant by creating separation anxiety. This effective interrogation technique of sensory deprivation is similarly used by the CIA, as was once pictured in The New York Times Magazine (see illustration).

Through the Screen Statistically
Another filter is electronic transmission. Here we can be quantitative, by relying on information engineering. We know how many bits of information are transmitted by the telephone and by video, and these numbers may be compared with face-to-face, which is an astonishingly greater, and even then, still underestimated quantity (Forrest, et al., 1974). I’ll return to this later with the numbers. I first looked into this in the 1970s as a member of a pioneering team led by James Ryan at NYSPI exploring the then-new introduction of portable videocassettes for recording psychopathology and psychotherapy. Our Electronic Textbook of Psychiatry and Neurology, for which I co-wrote, co-edited and shared...
much of the on-camera work, was distributed to over 300 medical centers. For this work, we had professional coaching in television announcing, such as being more animated and expressive to compensate for the flattening video effect of reducing emotional intensity. This is now applicable to Zoom. Clarice Kestenbaum, MD contributed videos of mother-child relating, utilizing our own wives and children. Research was advanced by videocassettes. It was a convenient way of ‘catching the evanescent in a bottle,’ as it were, as in mother-infant research by Beatrice Beebe, Ph.D. and the rhythm-of-dialogue studies by my earliest mentor, Joseph Jaffe, MD Freezing moments on video allows teachers and researchers to view more than what quickly passes in real life, such as the dance of mimicked gestures in family therapy videos that Nathan Ackerman, MD and others demonstrated. Video filters but it also expands. Our supportive Chairman, Lawrence Kolb, MD considered video as scientifically analogous to frozen sections in pathology.

Aside from information reduction, we know from long therapeutic experience that there is enough redundancy in human communication to make teletherapy work. Like most of us, I have conducted a large proportion of care by phone, always as the patients’ choice. Perhaps I have done it more because I was trained as a radio announcer in college (WPRB, news and chamber music) and am comfortable with microphones. Some patients feel they can say things over the phone (or from the couch, for that matter) that they would feel uncomfortable saying face-to-face. This can be a resistance, and later face-to-face work may be needed to overcome shame that is avoided when not face-to-face, and to cement progress that has been made on the couch.

**Missing from Zoom**

What is lost from in vivo face-to-face? A tremendous amount of information is lost, but less than is lost on the phone. Obviously there is a reduction of bits of visual information on video, and of fidelity of sound. Does information redundancy in human communication sufficiently compensate? We operate as if it does, and a case can be made, but we instinctively feel no.

An excerpt from our 1974 paper on videocassettes (Forrest, et al., 1974) provides some numbers:

“The telephone can convey 60,000 bits of information per second, whereas television can convey 90 million bits per second (Pierce JR: Communication, Sci Am 227:31-41, 1972). The number of bits that a human can receive per second by sight and hearing is unclear, but data from the microanalysis of body language alone suggest that it is large, far beyond the thousand or so bits perceived from human speech (Birdwhistell, Schefflen, Stern, references on request). The great mathematician John Von Neumann (1958, reference on request) has estimated the brain’s capacity for input at 14 x 10^10 or 140 billion bits per second, multiplying the standard body receptor rate of 14 digital impressions per second by 10^10 nerve cells (reference on request). Television, with all its 90 million bits impinging upon us each second, still enormously reduces the information that we might derive from a live interview, all considerations of communicative redundancy aside.”

And there are other dimensions an engineer might disregard but our psychodynamic training might perceive. Physical presence comprises many things. Size is one. I am just under 6 feet and 170 pounds, not enough of an outlier to think much about my stature. But my 5' 6", 135 lb. male patient does, and prefers in-person therapy because, he claims, the fact that I don’t attack or rape him is always reassuring (I’ll unpack his case another time). Zoom conceals body information, as with the movie actor Alan Ladd, whose short stature was concealed on screen by digging holes for women to stand in to kiss him. When we eventually meet patients whom we have only seen on Zoom, revelations may happen. On Zoom we also see ourselves in real time, and can learn how we come across.

Speaking of information dropout, what about our most ancient sense of smell? We rarely mention it. I have restricted myself to Dial soap and eschewed aftershave since an experience with a female patient whose perfume was so strong it lingered in my office and was remarked upon by subsequent patients. She was having an affair, and surely her lover’s wife, whom she knew, could detect her marking him with odor. I even had to explain to my
wife in the evening after a session with her. And what about the undetectable odors of pheromones in person, lost by phone or Zoom? Susan Pinker, in her Mind and Matter column (WSJ Jan 22-23, 2022, p. C5) discussed hexadecanal, one of our 6000 pheromones, which smells like a baby’s head and increases aggression in men and attenuates it in women.

The presence of others lurking around sessions or overhearing them can occur with Zoom. In our offices, we take pains to eliminate privacy breaches by sound barriers. But on Zoom, others off camera lurk like the delusional phantom boarders of demented people, and resemble imagos, the introjected representations of family members and others that play in the imaginary theaters of our patients’ minds. But Zoom presences are often real people. They are usually unseen, but may intrude into the Zoom room, and they may overheat zoomed sessions. The session may even be a patient’s performance for them, intended to be overheard. If Zoom sessions are done from home offices, they should not be intruded (or foisted) upon our families by overhearing. This topic is complex and deserves further elaboration.

Concluding remark

The filters of video teletherapy remove physicality and perhaps some defensive need to neuter and compartmentalize. A psychiatrist may broadcast from a space that is not laid out as an office setting. The patient’s broadcast site may be diluted by the presences of his partner or his roommate as voices and phantoms, and perhaps acting as comforting chaperones diluting the intensity of sessions. A parallax problem often interferes with gaze. This can be solved by camera positioning, as our political leaders reading from teleprompters demonstrate. Nevertheless, the psychodynamic treatments are generally able to progress, absent pheromones. Our patients feel helped and satisfied for the most part with the therapy by Zoom.

References:
1. Forrest DV, Ryan JH, Glavin RJ, and Merritt HH, “Through the Viewing Tube: Videocassette Psychiatry,” American Journal of Psychiatry 131:90-94, 1974, about issues in representing patient interactions on video, as we were doing in our “The Electronic Textbook of Psychiatry,” distributed to 300 Medical Centers.
2. Forrest DV: “Elements of Dynamics III: The Face and the Couch,” Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry 32:3:551-564, 2004, in which the couch is found to extract information by the torture of sensory (facial) deprivation, and relies on the redundancy of speech.

BOOK REVIEWS

Willem de Kooning’s Women: A Psychoanalytic Exploration
By Graeme J. Taylor
Reviewed by Cornelia Foss

Cherchez La Mère

Painting is a form of communication, and in the case of Willem De Kooning, the meaning of his paintings has been the subject of many psychological theories. Being a painter and not a psychiatrist, I read Dr. Graeme J. Taylor’s book, “Willem De Kooning’s Women: A Psychoanalytic Exploration,” with its host of opinions, explanations, and suppositions by a group of distinguished psychoanalysts and art critics, with great interest.

Taylor writes, most viewers of the series of De Kooning’s paintings of Women (“The Women” series) try to find meaning in these pictures. But most do not consider de Kooning’s childhood experiences, and how these might have influenced his paintings and his life as an adult. Taylor quotes, the psychoanalyst, Steven Poser, as writing, “Psychoanalysis and modern art are nearly contemporary movements in the 20th century.”

Although this is not exactly a curl up-in-a-chair-or-a-cozy-read book, it is well-organized and full of psychanalytic information as it pertains to de Kooning’s work.

Most of the world’s great evils have been attributed to bad mothers (“If it’s not one thing it’s your mother”). This is not just psychobabble, but has some good reasons… The mother is usually the first to see the baby, and to look into its eyes and vice versa, the first to snuggle and kiss the baby, to feed the baby, and to let the baby grab her finger. However, she is also the first, usually, to say “No!” To push the baby away or to deprive the baby of her presence. All this according to the psychoanalytic world, gives rise to multiple strong emotions in the baby which can later be repeated as the baby becomes an adult (compulsive repetition). “Psychobabble” is babble because it accounts for all sorts of behavioral quirks with one reason which is applied to everything, whereas the real world of psychoanalysis has myriad explanations that
help us understand ourselves.

I had long ago come to the conclusion that the terrifying images of de Kooning’s intense, grinning, toothy (vagina dentate), mad and huge-breasted women were Bill’s mother -- or rather Bill’s feelings about his mother. I knew Bill well, and we were very good friends. At one point, I was sitting next to him at a dinner. He suddenly looked at me with those large, blue eyes, and exclaimed, “I wish your name weren’t Cornelia.” Surprised, I answered, “Why? It’s an old Roman name, and I love it!” His face suddenly became suffused with rage, and he spat out “It was my mother’s name and I hated her!” It was that same evening that he threatened to throw John Ashbery, the poet, out of a window, and probably would have done so if several of the men hadn’t stopped him. He was drunk of course. When sober, de Kooning was not just handsome – he was beautiful. This did not mean that there was a feminine aspect about him. On the contrary, he was very masculine. He once said, “I am both male and female. These women are self-portraits. I have no opinion of women--I don’t particularly stress the masculine or the feminine. I am concerned only with human values.” Women irritated him, he also said to Seldman Rodman. I painted the irritation in the ‘Women’ Series, that’s all. And later to the critic, David Sylvester, about hilariousness--the idea of the idol, the oracle, and above all the hilariousness. If I don’t look at life that way, I won’t know how to keep on being around.” He also referred to the women like the ladies of Gertrude Stein. Perhaps he was thinking of the Picasso’s portrait of Gertrude Stein -- certainly her spread legs remind one of the DeKooning “Women,” or rather the vice versa.

Dr. Graeme Taylor also gives us a clear overview of de Kooning’s life. He was shuttled to different family members when quite young, and his mother seems not to have been very loving. She did have large, dark eyes which may account for the frightening, big black orbs which his women had for eyes.

Born in Holland, he came to America as a stowaway in 1962, and also became an American citizen at that time. By then he was already recognized as an important painter. The question of course was, what kind of painter? Abstract painting had become all the rage. Even though de Kooning was considered an abstract expressionist, many critics and fellow artists thought of him as a figurative painter, and oddly it infuriated them. David Sylvester quotes him when asked about this, saying “I feel it was their problem.” In any event, de Kooning refused to be either an “abstract artist” or a “figurative artist”, but something in between. This annoyed and exasperated the well-known Clement Greenberg and many other critics of the day.

Throughout his life, de Kooning had many girlfriends (again “repetition compulsion,” according to Judith Zilczer). Most of these relationships did not end well. “I can’t get away from the woman,” he complained. “Wherever I look I find her.” Carol Duncan, the art critic, described ‘Woman 1’ as a “Big, bad, vulgar and dangerous mama.”

De Kooning’s painting ‘Women 1’ is considered one of the most controversial paintings of a woman in the history of art, Taylor writes. It was exhibited along with works by Jackson Pollack and Arshile Gorky in the Venice Biennale and a few years later, all seven of the women paintings were exhibited at the Charles Egan Gallery in New York. Clement Greenberg dubbed the paintings “magnificent,” and De Kooning as one of the four or five most important artists in the country.

Eventually, de Kooning left New York and moved to Springs, a small village near East Hampton, Long Island. Quite a few painters, including Jackson Pollack and wife Lee Krasner had houses there. It appealed to them, as it was rural, inexpensive, and a working-class neighborhood.

Local lore has it that one summer a “flasher” appeared in the Springs and was frightened women and children. One day, Bill was sitting at a bar there when the flasher came in and sat down next to him. A friendly conversation ensued, and the flasher asked Bill if he could come to his studio to see his paintings. “Sure!” was Bill’s reply, and he added, “Come by tomorrow.” The flasher was delighted and left soon after. As soon as he was out the door, one of Bill’s pals came up to him, shouting, “Are you crazy, Bill? That was The Flasher! --And you just asked him to your studio?” Bill answered in his laconic way, “Yeah, I know. I’m going to scare him with my paintings.” I think that answers the question as to whether De Kooning knew that his “women paintings” were terrifying.

Also, Dr. Taylor writes, “Applying psychoanalytic knowledge to artists and their work, however, is a risky enterprise as it is prone to many errors.” Taylor also quotes the psychoanalyst, Aaron H. Esman, “There is danger that the analytic investigator may, unimpeded, impose his biases on the data, or that he will lack an adequate understanding of the terrain in which he is working.”

Indeed, Freud’s interpretation of works by Michelangelo and Leonardo Da Vinci has been harshly criticized for mistranslations, slender evidence, and failure to consider non-psychoanalytic factors… Freud probably anticipated making some errors. In a letter to Ernest Jones in 1921, Freud remarked, “Yet it is evident there is much slippery ground in many of our applications to biography and literature. The difference between trying to understand clinical situations and artistic creations is that in the latter, the person is absent as well as his or her free associations.”

Another quote in Taylor’s book, which is anonymous,
is that “De Kooning was not consciously aware of the aggression that went into his Women Paintings.” I would say the opposite. He was very well aware of what he was doing. Also, he told David Sylvester that certain artists and critics had attacked him for painting something figurative, but he answered, “I felt it was their problem.” Bill never said or did anything without meaning it, but then, a dumb, great painter is something that has never existed.

When Titian was painting a model, with whom he was in love, she was dying of breast cancer. In the several paintings, which he painted of her, her right breast became smaller with each painting and finally became quite shriveled. The combination of cold observation and the depiction of heartbreaking beauty and innocence makes the viewer stop. Not every viewer knows or understands her circumstance, but one’s emotions are aroused. That is great painting.

De Kooning’s particular combination of abstract and figurative painting was unique. Oddly, this infuriated some critics for curious reasons of their own. Dr. Taylor writes that “Clement Greenberg at one point told the artist that, given the direction that serious art was taking, it was folly to return to the figure.” Not only did it confuse people, but his paintings evoked strong feelings. No matter how beastly his women were, the paintings were beautiful. He admired the ‘Venus of Willendorf,’ and it showed. His women were mythical. Also, his colors were the most refined combination of pastel pink, yellow, green, and light blue. When surrounded by stern black, they were not only beautiful but arresting. It was also thought that de Kooning had difficulty drawing hands, and therefore left them out, calling the painting unfinished. As de Kooning was a consummate draftsman, the idea that he would leave out the hands out of exasperation, was silly. MeyMeyer Schapiro, the distinguished art historian, told me of going to Bill’s studio and seeing a painting de Kooning was working on, and telling him to stop and consider the painting finished. Meyer added, “modernism should have something fundamentally broken in the painting.” Bill listened to him, and the painting has been greatly praised. Meyer was quite right. In some of the other Women Paintings, bill painted the hands of the women as long claws. Again, he knew what he was doing.

Sadly, towards the end of his life, Bill de Kooning no longer did; he fell prey to a form of senility. He no longer recognized people, places, and his memories shifted. Around that time, a friend and I gave a party on the beach. A young girl joined us. She looked at Bill and asked, “How do you like my haircut?” He smiled at her in his sweet and polite way and exclaimed, “It’s beautiful, darling.” After she left, he turned to me and asked, “Who was that girl?”.. I had to tell him: “Bill, that was your daughter, Lisa.”

A few months later, Lisa called me and told me her new house, which she had built next to her father’s, was finished, and she asked me to come and see it that evening. When I drove up the small road to Lisa’s new house, trying not to run over any of the animals that Lisa collected — miniature donkeys, rabbits, hens and such– I saw Bill sitting on the steps of the new house, looking doleful. I sat down next to him, and, trying to cheer him up, I asked “Aren’t you pleased? Lisa has had this house built next to yours, and it’s beautiful.” To my great sadness, his answer was: “Yeah, it’s nice, but who’s Lisa?”

His wife, Elaine, from whom Bill had been separated, decided to rejoin him in those years. She became his de facto studio manager and helped him mix the different colors that he liked, that he would then apply to his canvases, with wild strokes. The assistants would then cover various large areas with white paint - and these were called his “Ribbon Paintings,” and were exhibited to great acclaim at MOMA. Robert Hughes, the art historian and critic, however, wrote in 1977, described these ribbon paintings as “among the saddest paintings ever made by a once major artist.” I agree with him and see them as desperate clawings. He tried to hold on to his mind – that superb mind that was leaving him to all the devils and monsters he feared. Willem De Kooning showed us human travails, and he showed it to us with kindness and silly humor -- And the possibilities of interpreting him are endless.

As Dr. Graeme J. Taylor reports in his fine book, “When David Sylvester, the distinguished art critic, asked De Kooning whether his work “was making a comment about our age,” De Kooning answered, “It maybe turned out that way, and maybe subconsciously when I’m doing it, but I couldn’t be that corny.”

And finally, there is a wonderful line by Jasper Johns, quoted by Dr. Taylor. “I don’t know if the search for understanding art in any final way is possible, but it opens our eyes instead of closing them.”
In “Talking to Strangers,” Malcolm Gladwell challenges our perception of the world today. We all believe that we know how to read someone and are able to recognize when we are being deceived. However, Gladwell elucidates that as a society, we are incapable of understanding and communicating with people we do not know. The book displays the annals of failed interactions between strangers and why humans are so inept at interpreting others because of two prominent issues: the Truth-Default Theory and Transparency. So in a sense, this book is about the art of understanding people we don’t know.

As humans, we are wired to believe that people are always telling the truth. According to Gladwell, the fact that we can’t differentiate liars is based in the psychologist Dr. Timothy Levine’s theory of the default to truth. Until there are enough doubts triggered to convince ourselves that someone is lying, it is part of our nature to always trust someone.

To describe an example, in the case of Ana Montes, a Defense Intelligence Agency senior analyst, she misled everyone who knew her, including her siblings and boyfriend, who all worked in intelligence fields. It was established that Montes was highly knowledgeable about Fidel Castro, hence her nickname, the Queen of Cuba. In part, because she was so high-up in the DIA, so no one suspected that she was a Cuban spy. In 1996 the Cuban military shot down U.S. planes because they were flying over Cuban airspace. In a meeting set up by Montes, it became known that Cuba warned the United States about the likelihood of an attack, which in turn made the U.S. government look incompetent. It is that there is something wrong with us. How could Carmichael believe that the Queen of Cuba was a spy?

Ana Montes was not some evil genius or super spy. She didn’t have to be. We assume that someone is always telling the truth even if we have suspicions. There were many signs that Ana Montes was a spy, but it is common for people like Carmichael to subconsciously ignore them or automatically rationalize them. Gladwell states, “The issue with spies is not that there is something brilliant about them. It is that there is something wrong with us (p. 68).” Montes did not need to be creative or even that secretive because no one besides Brown had the slightest idea that she was sharing U.S. secrets with Cuba. For instance, Montes even requested a paid sabbatical trip to Havana and then, when she came back, she wrote a paper that emphasized her bias towards Cuba. Why did no one realize that she was a Cuban spy when she so clearly supported Cuba’s ideals? From a Gladwellian perspective, everyone in society functions in the same manner of defaulting to the truth, where we aren’t questioning everyone’s actions. It is an easier and more simple way of living. If we abandon our innate nature of trusting people, then we won’t believe a word anyone says, which would be much more complicated to live with than being lied to.

When we interact with strangers or even people we know, we believe that the way they portray themselves represents how they are feeling. This idea is called transparency, which according to Gladwell, is a fallacy. Humans believe that we can read people’s emotions by just looking at them and their mannerisms. This is an erroneous way to understand someone and will ultimately create confusion and even chaos. In our minds, we paint a picture of what each emotion looks like. For instance, we associate anger with people who have furrowed eyebrows, clenched fists, and flared nostrils. So, when that person is exhibiting any of these expressions, we believe that they are angry, but we learn from Gladwell that peoples’ expressions don’t exactly match their emotions. In particular, the phenomenon of transparency allows judges to be blindly fooled by the defendants. If a computer were to judge the defendants they would use only the evidence provided to deem if they are guilty. It has been proven that a computer is more successful at making bail decisions. The world, nonetheless, can’t just ignore the personal connections and interactions between humans as they are “socially necessary.” Judges believe that it is vital to observe the people they are judging because it will provide further insight into the defendant’s intentions. However, this ideology is not effective and in turn, judges let more people free who then commit more crimes.
Guilty people don’t always look guilty, which is where the issue of transparency begins.

Since we believe that all emotions are universal, we tend to conclude that people’s honesty directly correlates to their demeanor. We stereotype that truthful people are always calm and confident, and people who are lying are regarded as fidgety and nervous. What happens if we encounter someone who embodies the characteristics of a liar but is telling the truth? The Amanda Knox story is a quintessential example of a mismatched person, someone who does not conform to our expectations of an honest person. In 2007 Meredith Kercher, Knox’s roommate, was murdered. All focus was on Knox even though Rudy Guede, the confirmed murderer, had intent to kill. Amanda Knox’s reaction to the murder was not the most common response, which was why the police thought she was the killer. All of her friends mourned Kercher’s death while Knox was emotionless and acted as if she wasn’t concerned. However, this was Amanda’s genuine reaction to her roommate’s murder. If it wasn’t a stranger who investigated her, they would know that this was a normal response for Amanda. “We have built a world that systematically discriminates against a class of people, who through no fault of their own, violate our ridiculous ideas about transparency (p. 186).” The police were convinced that Knox was guilty because of the way she acted, but there was zero evidence that she was even at the scene of the crime. We are proficient in detecting lies in matched people, but when faced with a mismatched person we are inadequate at determining if they are telling the truth. In our interactions with strangers, we are unable to truly understand them because we default to the stereotypical mannerisms that we believe represent specific emotions.

“Talking to Strangers” is not exactly a self-help guide with a simple answer of how we can be better when conversing with strangers. It is an intricate and illuminating book that creates awareness in understanding strangers. Gladwell does not provide specific tips on how to discover who the next Montes could be. He instead explains why we are so inept at detecting lies and deceit. We are left wondering who has fooled us in our lifetime and how we can really prevent this from happening again. We learn that the truth is not something that we as humans can discover or even understand so easily. Our world is built on the notions of believing in the truth, which is why our interactions with strangers go awry. It is part of our nature to be biased toward the truth and automatically make assumptions based on a stranger’s demeanor. The cases Gladwell explains are insightful and compelling about how negligent we are in reading strangers. The implications are important for psychiatrists, psychologist and other mental health professions. It makes us really think about our future conversations with the people we do not know, and those we’re getting to know. Readers, including me, will never look at strangers in the same way again.
IN MEMORIAM

Harold Eist, MD

President of the American Psychiatric Association
(1996-1997)
President of the Washington Psychiatric Society

(Previously published in Capital Psychiatry: the e-Magazine of the Washington Psychiatric Society, Gerald P. Perman, MD, Editor)

IN MEMORIAM BY GERALD P. PERMAN, M.D.

Harold Eist, M.D. died on December 16, 2021 following complications from hip surgery. Child and adolescent psychiatrist and psychoanalyst, Harold Eist was President of the American Psychiatric Association 1996-1997 and President of the Washington Psychiatric Society three times (1981-82, 1990-1991 and 2008-2009). I briefly served on a WPS committee that Harold chaired, with Henry Work and two or three others, that met in the basement office of Harold’s home. In addition to his analytic couch, his office had a whimsical elephant motif. The superb dry white wines he served helped lubricate our discussions. I no longer remember what committee it was, but the excellent white wines and friendly good feelings are unforgettable.

Harold attended the University of Alberta that published a tribute to him in 2015 after he received the alumni association’s Distinguished Alumni Award, it’s highest award, that recognized “living graduates whose outstanding achievements have earned them national or international prominence.” What follows is mostly taken from the 2015 issue of the “New Trail” University of Alberta Journal.

Harold Eist, M.D., 50 Years a Champion: he has devoted his career to protecting and serving the mentally ill disadvantaged. Colleagues have called him the Winston Churchill of American psychiatry. As a forceful eloquent advocate for the mentally ill during 50 years of practice, he has been a leader and an agent of change in the medical community. Eist was the director of a mental health clinic in Washington, D.C. (3000 Connecticut Avenue, N.W. across from the National Zoo) where for 25 years he treated the most deprived communities in D.C. including seriously ill and dangerous patients, both adults and children. The clinic received the APA’s Gold Award. Dr. Eist said that he was “motivated by the unfairness of life … we have to try to make it more. My patients inspired me to work hard, to learn and to constantly challenge myself to find more creative ways to help.”

His drive to help the less fortunate was sparked by a visit as a young university student to the Caribbean nation of St. Kitt’s and Nevis with the World University Service of Canada. Nevis had no doctor and Harold planned to return to help the people there, but he realized that there
were severely disadvantaged people in the Nation’s Capital, so he ended up staying there.

He was credited with protecting the confidentiality of his patient’s records and he endured a lengthy public court battle in which he ultimately prevailed and for which he received a courage award from the APA.

In addition to his presidency of the APA, Eist was the North American representative to the World Psychiatric Association, and he wrote hundreds of journal articles, newspaper columns and book chapters. He testified before Senate and congressional panels and provided commentary for the Washington Post, New York Times, 60 Minutes, and CBS Evening News. At the University of Alberta, he was a columnist for The Gateway and he founded the Student Philosophical Society. His best memory was meeting his wife Ann of whom he said: I don’t know how a wonderful woman like that has put up with me all these years.”

I encourage you to read Harold’s response to receiving the Distinguished Alumni award at:

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Brian Crowley, MD
Psychiatric Fellow
American Academy of Psychodynamic Psychiatry and Psychoanalysis

Brian Crowley, MD, a prominent member of the academy, died on July 17, 2022. Dr. Crowley was born on January 29, 1933. He graduated from Washington and Lee University after three years and from Yale Medical School in 1957. He returned to Washington, DC for residency at St. Elizabeth’s Hospital and later graduated from the Washington Psychoanalytic Institute. He served as a staff psychiatrist for the US Naval Hospitals in Philadelphia and Bethesda and was a Lieutenant Commander in the Navy Reserve.

Among his many accomplishments, he was twice chair of the department of psychiatry at Suburban Hospital in Maryland, president of the Washington Psychiatric Society and taught at Uniformed Services University School of Medicine, George Washington University School of Medicine. He also taught at the law schools of the University of Maryland and Catholic University. He had a national reputation for his work in forensic psychiatry, psychoanalysis and post traumatic stress disorder. He was an expert witness in numerous criminal and civil jury trials.

Barry Fisher, MD
NEW MEMBERS

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