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Psychoanalysis and the Exploration of Racism in our Midst

Bonnie Kaufman

At the intersection of the Covid pandemic, the Trump administration's incompetent response to it, and the brutal murders of George Floyd, Breonna Taylor and others, the psychoanalytic community has had to confront its own positions on these issues, both historically and in our current institutions and procedures. The pandemic has uncovered the deep divisions in our society, in particular the ways in which people of color have suffered disproportionately from illness and death from the virus, as well as greater economic hardship. As a community committed to looking below the surface of our experience, in order to understand how unconscious phenomena may influence our conscious lives, both with our patients, and as individuals, it is fitting that we lead the way, wherever we can. Here are some of the projects that have been initiated, and some issues that have arisen in the process.

Earlier in the year, Hillery Bosworth invited colleagues to join a reading project, which she called "Conscious and Unconscious Experiences of Blackness and Whiteness in Clinical Psychoanalytic Work." As she observed: " …regardless of one's own race, ethnicity, self or family year of immigration/forced transfer to America, we are all saturated in a society that has been organized around a Black/White ideology for over 400 years, and thus racial ideas inform our perceptions and actions whether we are aware of them or not." Her aims were to achieve a better understanding of the conscious and unconscious experience of being Black in America, as well as of being White in America, and thereby recognize unconscious/disavowed racism in ourselves and in our patients. She offered a preliminary reading list, encouraging others to join in and to suggest other relevant literature.

Our Director, Susan Vaughan, has also prioritized the examination of these issues at the Center. In Executive Committee meetings the discussion has centered around similar projects, such as promoting self-examination by the white majority about white privilege;

and encouraging reading groups on topics like whiteness, racism and the Black experience, as well as the psychodynamics of otherness. Given that systemic racism, by definition, affects all aspects of our functioning, she asked the chairs of each committee and division on the EC to engage their members in discussion and development of strategies towards greater awareness and inclusiveness in their work. She also strongly advocated establishing a scholarship for candidates of color in the name of Margaret Lawrence, the first African American woman to become a psychoanalyst in the United States. Lawrence was a distinguished graduate of the Columbia Center but it is regrettable, and telling, that few of us have been aware of her existence or achievements.[1]

As a starting point, Vaughan had initially suggested a summer reading list relating specifically to white privilege, but others seemed to think that this was putting the cart before the horse. Clearly, as Susan Coates pointed out, any reading list should also include racism and the Black experience, starting with a major article by our own Dionne Powell, "Race, African Americans, and Psychoanalysis: Collective Silence in the Therapeutic Conversation," which received the *JAPA* prize, and appeared in *JAPA* in 2018. Powell thanked Vaughan for her efforts to address racism in psychoanalysis and at the Center, although she was surprised that she had not heard of Margaret Lawrence until recently, and wondered if that, and the omission of her own paper from the initial reading list, were perhaps symptoms of the kinds of problems that we confront. This was an illuminating interchange between two people who are both sincerely committed to meaningful progress on issues of race and minority inclusivity, as individuals and as psychoanalysts.

Others then added to the conversation. There was input in particular from members who work with people from minority communities, and who pointed out that psychoanalysis in general, and Columbia's Psychoanalytic Center in particular, have been seen as a "city on a hill," where minorities were not welcomed for training even if they could afford the costs. Clearly, recruitment, and how to do it effectively and sensitively, must be major priorities. Finally, it is important that we not deal with these issues primarily from a

[1] Following her death at the age of 105, Lawrence received a lengthy obituary in the *New York Times*, Dec. 8, 2019.

professional perspective, thereby insulating ourselves from honest self-examination, and awareness of the pervasiveness of racism in our everyday lives, well beyond our consulting rooms.

Clearly, we have much to do. The next issue of the *Bulletin* will follow up with a report on progress made, and where our work has led us. Meanwhile we are pleased to reprint (from the *Bulletin*, Spring 2008) an in-person interview that Wynn Jackson conducted with Margaret Lawrence herself, very much in the tradition of those carried out by the Center's Bluma Swerdloff for the celebrated Columbia Oral History Project.

We also hope that you will re-read a more recent *Bulletin* item (Fall 2016, pp. 41–48). This is the report of the APM Scientific Meeting of January 2016, where Dionne Powell used her *JAPA* paper (referenced above), as the basis of a discussion with Anton Hart, exploring the deeply disturbing state of race relations and prejudices, both unexamined and rationalized, within the psychoanalytic community. It could not be more pertinent to our current concerns.

Margaret Morgan Lawrence: The Center's First Black Graduate

Wynn Jackson

When Dr. Margaret Morgan Lawrence received her Certificate in Psychoanalysis in 1951, she became the first black graduate of the Columbia University Center for Psychoanalytic Training and Research. All of us who are candidates or graduates of the Center know how long and arduous analytic training is and how difficult it is to combine that training with family life. Imagine how much harder it was for the first black candidate who was also the mother of three young children when she began her training. The resilience and vitality that saw Dr. Lawrence through the rigors of medical and analytic training in a segregated world are still evident today. At age 93, Dr. Lawrence follows news about psychoanalysis from her study and retains her life membership in the Association for Psychoanalytic Medicine. In fact, until three years ago, she was seeing patients in her home office in Rockland County.

This is the second article about Dr. Lawrence published in the *Bulletin*. The first article recounted an interview with Dr. Lawrence conducted by Joanna Chapin exactly 20 years ago, at the time of publication of *Balm in Gilead: Journey of a Healer* (1988). This was a well-received biography of Dr. Lawrence written by her daughter, Harvard Professor Sara Lawrence Lightfoot, as part of the Radcliffe Biography Series of "lives of extraordinary women."

I visited Dr. Lawrence at her home in Pomona, Rockland County, New York, on March 28, 2008. She greeted me with a warm smile at the front door of her one-story house in a forested cooperative community. She then ushered me into her living room, which was comfortably furnished and filled with plants, African sculpture, a grand piano, and an antique organ. Her white hair, with a few lingering strands of dark brown, was wound around her head and clasped with a turquoise-encrusted clip. Still slim, she was dressed in a subtly patterned green jacket which matched her blouse and slacks. Sometimes she walked with the aid of a cane, but her movements were quick and her step sure. Although she has some help with housekeeping and shopping, she has lived alone in her

house since her husband, a sociology professor, died twenty years ago.

Apologizing for her slight hearing loss, Dr. Lawrence invited me to sit down and chat. "This is an historic year," she remarked. "A black man and a woman running for President!" Dr. Lawrence's own life has been punctuated by historic firsts and by overcoming racial and sexual discrimination. It was striking that in my interview with her, Dr. Lawrence minimized the discrimination she had faced. Her daughter's book was more informative about the hurdles she had cleared in order to develop her medical career. Raised by an Episcopal priest father and teacher mother in segregated Vicksburg, Mississippi, she came to Harlem in 1928 to attend Wadleigh High School, a public girls' school. She recalled: "I fit in. It was a classical high school." She was mentored by the Dean, who gave her private Greek lessons and expected her to perform at a high level academically. Upon graduation with multiple academic honors, she was accepted with a full-tuition scholarship at Cornell University, where she was the first black (termed "negro" in that era) student to matriculate. At that time, black students were not allowed to board in the dorm, so she worked as a live-in servant for two families in Ithaca. Although she did well as a pre-medical student and on the medical school admissions test (the precursor of the MCAT) she was denied admission to Cornell Medical School. The Dean told her that a "negro" man had been admitted twenty years before but had developed tuberculosis and quit. Stunned by this statement, she called her father, who contacted the National Council of the Episcopal Church; with their help she was admitted to the Columbia College of Physicians and Surgeons, where she was the only black student and one of ten women in her class. Graduating in 1940, she was denied a pediatrics residency at Babies' Hospital because the supervisor of nurses refused to let her live in the nurses' residence. Instead, she became a house officer at Harlem Hospital. I asked her what in her background or temperament allowed her to persist despite these difficulties. She replied: "I can't say what made me persist. I guess I wouldn't know that, would I? But I can tell you that it never occurred to me not to work, not to keep going. I just went on. I liked what I did, and I just kept going." After completing her pediatrics residency, she served as the only woman on the faculty of Meharry Medical School in Nashville. She had just had her first child when she joined the faculty, and she had two more babies in quick succession. She returned

to work after short maternity leaves and attracted attention, both positive and critical, for combining motherhood with her career so gracefully.

In the course of her clinical work and teaching, Dr. Lawrence became interested in the "whole child" and in the family interactions of her young patients. She commented: "The students would often ask me questions related to child psychiatry, which I was not trained to answer." Attending a course taught by Benjamin Spock at Cornell Medical School in New York increased her interest in this behavioral aspect of pediatrics. In *Balm in Gilead*, Dr. Lightfoot speculates that Dr. Lawrence's interest in emotional illness stemmed from her growing up with an intermittently depressed mother. Dr. Lawrence's mother was a dedicated teacher who came from the North to teach in the South, where she met and married her husband, Dr. Lawrence's father. The young couple's firstborn son died in infancy and the young parents were, of course, distraught. Dr. Lawrence commented: "My father would say to me, 'If the boy had lived, he would have been a priest of the church.' In my days, I have heard that psychoanalysts often have priest fathers." Dr. Lawrence, born less than two years after her deceased brother, grew up with her mother's suffering two episodes of what we would likely call depression, during which she spent much of her time in bed. At the end of these episodes, she would rise from bed and resume her teaching with vigor. Dr. Lawrence commented that the resumption of teaching was her mother's "ego strength." Several times during my interview with her, Dr. Lawrence commented that understanding the inner life of each child was integral to her work as a child psychiatrist and analyst. One might hypothesize that her wish to understand her mother's inner life and connect with her might have sparked that drive to understand and connect with others.

Having decided to train in psychiatry, Dr. Lawrence was introduced by a mutual friend to Dr. Viola Bernard, who was serving on a committee working to attract a "negro" student to the Columbia Center. Dr. Lawrence recalled that she and Dr. Bernard "stayed up all night talking about psychiatry. She wanted to convince me that if I went into psychiatry I should go into psychoanalysis." In keeping with her history of developing longstanding relationships with mentors, Dr. Lawrence remained friends with Dr. Bernard during her residency and analytic training. Later, she moved to Rockland County,

where Dr. Bernard owned a second home, and the two analysts remained "lifelong friends."

After her all-night discussion with Dr. Bernard, Dr. Lawrence met with Dr. Nolan D. C. Lewis, the director of the Psychiatric Institute. She recalls, "I put out my hand, and he opened the window." I asked: "He didn't shake your hand?" She answered: "No, but we did talk. I discovered that a newspaper reporter for *P.M.* had been traveling by train and found himself sitting next to Dr. Lewis. He knew who Lewis was, but Lewis didn't know he was a reporter. He said to Dr. Lewis: 'I understand you don't have any negro doctors or patients at New York State Psychiatric Institute.' Lewis said: 'I don't think the faculty would like that.' The next day, the newspaper carried (an account of) that conversation." Dr. Lawrence added: "When the newspaper reported that conversation, Dr. Bernard went to see Dr. Lewis …She said: 'Wasn't that a terrible thing that was in the paper about the Institute?' She said: 'I happen to have somebody who could fill this need.' And she called my name. He said: 'It is too late for this year.' She said: 'I'm sure she will be willing to wait.'" After her interview with Dr. Lewis, Dr. Lawrence was accepted for psychiatric residency at Columbia. During the intervening year she worked as a fellow at Babies' Hospital and became board certified in pediatrics. She was the first black woman to earn board certification in that specialty and in fact, she said, she may have been the first black person of either sex to win pediatric board specialization.

After Dr. Lawrence talked with me for a while in her living room, she enthusiastically led me on a tour of her house and office, where she has lived and worked since the 1950s. Her home was filled with pictures of her late husband, her two daughters and her son, and her grandchildren and her new great-granddaughter. The daughter who wrote her biography is a Harvard education professor; her other daughter, Paula Lawrence Wehmiller, is an artist, teacher, and former principal who became an Episcopal priest; and her son, Charles Lawrence III, is a law professor at Georgetown whose interest in his mother's field is demonstrated by his article "The Ego and the Id and Equal Protection: Reckoning with Unconscious Racism." Dr. Lawrence's children attended Quaker colleges (Swarthmore and Haverford). In fact, Swarthmore played a key part in the genesis of this article. A few years ago, Dr. Lawrence was the commencement speaker at Swarthmore, the year Dr. Lila Kalinich's son graduated. Dr. Kalinich was so impressed with the speech and with

Dr. Lawrence's accomplishments that she suggested that I interview Dr. Lawrence for the *Bulletin*. Each of Dr. Lawrence's children is married to an equally successful spouse. She commented that her children had seen her work and raise a family at the same time, so melding family and work seemed natural to them. I asked her how she had managed to raise three children and pursue demanding medical training and employment. She looked sharply at me and asked: "Do you have children? Do you have a husband?" When I answered "Yes," she said: "It was my husband. He did so much for the children. He was there when I couldn't be …He was as much a part of the children's life as I."

Dr. Lawrence commented that she admired her children's close friendships with their peers. "I didn't have that, and I wish I had." I replied: "I would imagine you didn't have much time for friendship during those years." She agreed. She did tell me that, in addition to her very close family relationships and strong collegial relationships, she had cordial relations with the other members of her cooperative and with fellow members of her church, where her husband was a leader and traveled internationally in the service of that work.

I asked Dr. Lawrence whether raising her children had aided her in her work as a child analyst. She looked at me piercingly and said: "I would say it was the other way around — that being an analyst helped me to understand my children, to be able to interpret their inner worlds." She told me that her psychoanalytic training at Columbia was very helpful, and that an especially valuable aspect of that training was her supervision with child analyst David Levy, who taught her how to "make plays," which she distinguished from play therapy. She explained that she would give her young patients parent dolls and child dolls and a play house. The children would then, with the aid of the dolls, enact the conflicts they were consumed with. Recalling Dr. Levy, she said, "He taught me to let the child tell the story …He was very active in the play room …You learned to listen to the child's feeling life." I remarked on the art supplies she had in her playroom and the figure drawings by her daughter and granddaughter in her waiting room. She said that her patients gravitated towards the art supplies, and she found these tools helpful in their therapies. I asked: "So the art and play were like free association?" She replied, "Yes, and the play therapy helped in my work with adults …I don't find it that different, working with adults and children."

Although Dr. Lawrence's analytic training was tremendously helpful to her, she had a difficult time exiting from it, an episode recounted in *Balm in Gilead*. During her training, Abram Kardiner, a prominent faculty member, was writing a book on the "negro psyche," a book later published as *Mark of Oppression*. He asked Dr. Lawrence to travel to the South with him for several months as his research assistant to help him interview "negroes." She refused, citing her obligations as a wife and mother as well as her reluctance to interrupt her analytic training. Dr. Lightfoot wrote in her book: "She was also suspicious of his perspective and his methods, and worried that in his research negroes might be portrayed as powerless and inarticulate. But she did not mention these apprehensions." Dr. Lightfoot added: "Kardiner was furious that this black trainee — the only one available to him — would dare to refuse his offer. He needed her to make his work legitimate, and she had the nerve to decline the chance to work with him. From that moment on, he stopped talking to her." At the end of her training she "took the oral examinations required for the final certificate of graduation," wrote Dr. Lightfoot. Afterwards, the director of the Center, Dr. Sandor Rado, called her into his office and told her that the committee had decided that she "should have a consultation with Dr. Abram Kardiner to see if you need further analysis." Dr. Lawrence asked why this consultation was necessary, and Dr. Rado said he would not tell her. Dr. Lawrence refused to meet with Dr. Kardiner but offered to consult with her analyst Dr. Eugene Milch and her supervisor Dr. Levy. Dr. Rado accepted this compromise but said that if Dr. Levy and Dr. Milch weren't satisfied, she would have to meet with Dr. Kardiner. During the agreed-upon appointment, Dr. Levy said to her: "'Someone told Rado that you had said that you didn't want to work with Negro patients …Is that true?' …She shot back: 'Absolutely not!' Levy's reply was both relieving and deeply troubling. Almost casually, he said: 'Well, just forget it then. I'll take care of it.'" (Lightfoot p.183) Once again, Dr. Lawrence's strong relationship with her mentor helped her negotiate a difficult situation. This time, her steadfastness in refusing the interview with Dr. Kardiner may have been crucial. She later learned that Dr. Kardiner was her analyst's analyst.

After graduating from analytic training, Dr. Lawrence combined hospital psychiatry with a growing private practice in Rockland County. She worked at Harlem Hospital for 25 years, until she retired at age 70, the mandatory age at that time, and continued to

see private patients until she was 90 years old. When I asked her what she thought of as her greatest achievement, she said it was starting the therapeutic nursery at Rockland County Mental Health Center, a facility she and two psychoanalytic colleagues founded. She added that she felt that the nursery contributed much to the community and that she was glad that she was able to train social workers and nurses who contributed to the welfare of patients.

Dr. Lawrence ended our visit by serving me a delicious green salad topped with avocadoes and peppers and coated with her homemade olive oil dressing. She spoke animatedly with me as she prepared the salad in her kitchen, whose windows overlook a tree-filled yard with no houses in sight. She had brewed a pot of green tea, which she favors for its health benefits. She said a short grace before we ate. As we lunched, she chatted with me about her travels through five countries in Africa and about the people she has met during her life, including Archbishop Desmond Tutu. She noticed my Southern accent and commented that blacks and white Southerners have a strong kinship.

Dr. Lightfoot's biography of her mother noted that Dr. Lawrence considered the concept of ego strength central to her psychoanalytic thinking. I would say that Dr. Lawrence epitomizes ego strength. Overcoming tremendous odds, she obtained stellar medical training and credentials and developed a successful career in psychiatry while raising three successful, solid children with her beloved husband. We should all strive to accomplish as much as she and to remain as vital and charming at age 93.

REFERENCES

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Movie Night 2020
Ida

It was a coincidence, but a timely one, that just four days before this Movie Night presentation, world leaders met to commemorate the seventy-fifth anniversary of the liberation of the Auschwitz-Birkenau death camp. Standing out from the many excellent and haunting films about the Holocaust, *Ida* demonstrates the reach of this traumatic period of our history beyond the camps themselves, as it echoes down the generations, and contaminates subsequent history throughout Europe and the modern world.

The papers that follow represent responses to this and other films that explore these painful issues.

Ida: A film by Pawel Pawlikowski

Bonnie Kaufman

When *Ida* came out in 2014 it was reviewed in numerous magazines and journals. *The New Yorker,* unusually, published two separate reviews, two weeks apart: the first by Richard Brody, and the second by David Denby. These two critics had markedly different reactions to the film.

Brody's review, titled "The distasteful vagueness of *Ida*," was rather negative about the ways the film was constructed — particularly what he thought was its absence of specificity. He saw the characters not as individual people but as ciphers, standing for the different elements of Polish society during and in the immediate aftermath of World War II. In his view, this diminished the value of the story each character told, and the human relationships between them.

Denby, on the other hand, while also seeing the representational aspects of the characters, focused more on the painful interactions between them as individuals. In his view, post-war Poland was the sum total of thousands of such painful individual stories. For him, the difference between film as documentary and a film like *Ida* was the haunting experience of the characters that the spectator takes away from the viewing.

This demonstrates that there can never be a single "right way" to experience a film like *Ida*. Each individual story that comes out of this agonizing period of history is framed by historical trauma, and that trauma is the summation of millions of lives destroyed — sometimes one by one, more often thousands at a time — all people, with families, friends — all lives, brutally extinguished. If *Ida* has a meaning, it is as both a documentary of an era and a society gone mad, and as a tribute to individuals, the choices they made, and that were made for them, and their ultimate deaths. These perspectives cannot be separated; and this, for me, is the great strength and beauty of the film.

There is a complex category of cinema that is grouped under the heading of "Holocaust films." Some, such as *Schindler's List*, tell stories of individual people, while others, which intentionally do not tell a character-driven story, are more clearly documentaries. Alain

Resnais' stunning film, *Night and Fog (Nuit et Brouillard)* is one of these. It was created in 1955, ten years after the liberation of the camp at Auschwitz-Birkenau, and released in 1956. This film documents what took place in this horrific concentration camp with what might be characterized as a cold distance — at odds with the pain and anguish of the thousands of individuals who suffered and perished there. Yet, there is also a sense in which this very objectified cataloging of the horror (rooms piled high with bones, skulls, human hair, valuables confiscated from the inmates, while the viewer, like the camera itself, looks in from the outside) intensifies the viewer's experience of helplessness to an almost intolerable degree. As much as we care, as much as we want to understand, we can never comprehend what it was like actually to live the experiences that those many inmates suffered.

It is significant that Resnais chose to use both color and black-and-white to film this documentary. When the story is historical, we see film that looks like the world outside, in normal color. It is when the camera enters the tomb-like chambers filled with human remains that the film is shot in black-and-white. The agony of the trauma stops time. A sense is created that these rooms cannot possibly be reality — and yet they are. The non-color seems unreal — but it is real. These bones could not possibly be human beings — neighbors, friends, children — and yet they are.

Pawlikowski has chosen to film *Ida* entirely in black and white, pushing us forcefully out of the beauty and grounding of the color in the world back into that stark agony. The film begins with Anna, the novice who is soon to take her vows; living with other nuns and going about her daily life of poverty and service, a life of relative silence, which is part of the discipline of her order. Before Anna is permitted to take her vows, the mother superior insists that she go to Warsaw to find her only living relative, her aunt. She does so, and so learns for the first time about her past. Her aunt, a boorish, hard drinking, promiscuous, former Communist functionary called "Red Wanda," who was responsible for the murder of Polish resistance fighters, tells Anna who she really is — Ida, a Jewish child sent to the convent for survival. She never chose life in the convent but was left there as a baby by the Polish Christians who killed her parents and her young cousin, in order to save themselves.

The nuns have chosen this life, but seeing Anna/Ida in this colorless environment foreshadows what she, and we, as spectators,

will see. She escaped the fate of her parents, but she too, is part of the black-and-white unreal world to which her aunt will introduce her, and which they both will struggle to comprehend, each in her own way. There was, and is, no choice.

The "road movie" is often used as a device to explore the past, with the possibility of achieving either a degree of satisfaction and resolution (as in *Wild Strawberries*), or a result that ends in despair (as in *La Strada*). Contemporary filmmakers take advantage of our familiarity with other films in which such conceits are used. For Pawlikowski, a Pole who was taken as an adolescent by his mother to England and became a celebrated British film-maker, this film was also a journey down the road of his own past. For me, the beginning of Ida and Wanda's journey posed the question of whether they will find peace, or simply a concretization of their pain, especially Wanda's.

Regardless of Pawlikowski's own conscious intentions, the theme of this pair, going down this road together, can conjure up the idea of an analytic dyad. In this vein, we might see Wanda as the analyst, who progressively takes her young niece into their shared past. The film begins this way, but over time Ida, with her quiet, non-intervening ways, seems to become the source of stability for Wanda, who shares more and more of her pain as she resurrects the unspeakable memories of her final days with her sister, and her own little boy. When they at last get to the site of their childhood home, and learn about the murder of the family, they are taken to the graves, dig up the remains and re-inter them in a Jewish cemetery.

The two then separate, for the last time. Ida returns to the convent, and Wanda to her apartment, where, unable to bear what she has been forced to remember, she kills herself by jumping from the window. Her encounter with her niece has brought back all the pain of losing her sister, and, especially poignantly, the little son she had to leave behind, who was murdered by the Pole. She had forced herself to make the killer describe how he killed the child, and, for me, at least, this seems to be the knowledge with which she can no longer live.

Ida returns to the city for her aunt's memorial, and there meets up again with the young musician, Lis, to whom she and Wanda had given a ride when they were first heading to the family home. He had been taken with Ida, and Wanda had wanted her niece to experience the pleasures of normal life before taking her vows, but Ida was not

willing. Now, she puts on her aunt's sexy dress and high-heeled shoes, and goes out to listen to music with Lis. During the night they spend together Lis says he cares deeply for her and would like to marry her, but in the morning Ida gets up without waking him and returns to the convent, where the film ends.

In some ways, it seems that Ida's decision to return to the convent represents a refusal to internalize what she has learned about herself, and that her unwillingness to stay with Lis is about her refusal to grow and change. Yet it might also be seen another way. The film takes place in the early 1960s when the world is undergoing profound changes, politically and culturally. Lis's music is all about American jazz, and it seems, watching his performance gigs in cafés and night clubs, that it is the dawn of a new era, in which the Holocaust may become merely a painful remnant of an all-but-forgotten past.

What is the right way to "Never Forget?" Perhaps for Ida, who has internalized the memory of the past she never lived, a return to the convent is the only way to remember.

Toxic Secrets[1]

Ellen Handler Spitz

Set in postwar Norway, a little-known, semi-autobiographical film of 1997, called *Mendel*, by Alexander Rossler, a Jew born in 1947 Dachau, may be of special interest to psychoanalysts and other mental health practitioners, for it traces the effects of noxious secrets kept within families. Set in the immediate aftermath of World War II, the film's eponymous character is nine-year-old Mendel Rosler, a German-Jewish boy born too late to know what happened during the Shoah. The Shoah, however, radically contorts his everyday life. His parents and an older brother David, all traumatized, recall it vividly. They live daily and nightly within the horrors of concentration camp scenes they suffered but which Mendel was spared. With regard to this recent past, they maintain an impregnable wall of silence. Unable to talk about what happened just before Mendel's birth and during his infancy, they betray their grief and intense anxiety by behaviors, often involuntary, that are unintelligible to Mendel. These behaviors include sudden outbursts, mood swings, violent nightmares, incomprehensible jokes, the sequestering of photographs, and, most blatantly, repeated refusals to answer Mendel's questions. He, in confusion and ignorance, acts out in defiance. He is disobedient; he breaks rules, and he dares fate in a variety of dangerous experiments, both in reaction to what makes no sense to him and in order to find out something that may help him understand what is being kept hidden from him.

As is not uncommon in the genre of fictionalized autobiography, the film poses overarching implied questions. It asks, perhaps above all, whether protecting children from the knowledge of a destructive and terrifying past may prove more even damaging than affording them some access to it. Furthermore, to complicate this question, it reveals that parents and siblings who have endured trauma

[1] I would like to dedicate this essay to Dr. Bonnie Kaufman, who co-chairs Movie Night with Dr. Edith Cooper, and who has graciously invited me to contribute this essay, which is adapted from my book, *Illuminating Childhood*: Portraits in Fiction, Film, and Drama, 2011 (Ann Arbor: University of Michigan Press).

may impose silence not only to protect others, which is the ostensible reason, but in order to protect themselves and to maintain their sanity in the present; thus, they may be incapable of revisiting the past even for the sake of others.[2] What happens then?

Mendel tells its story almost exclusively from the point of view of one character — its child protagonist. There is no effort to explore, on camera, the choices made, or the exigencies borne, by Bella and Aron, Mendel's parents. Their trials and sacrifices are left to the imagination of viewers.

Lilting klezmer music fills our ears as the film begins, and we see a tangle of gnarled, broken, sprawling roots, the partially destroyed foundations of a huge unseen tree. In a valley below, blurred by distance, a tiny car speeds along, a Volkswagen. Next, we see a crucified roadside Christ, its carved wooden feet pierced by nails. The first words we hear are those of Mendel Trotzig. He says, in German: "I didn't have any bad memories from Germany." This little boy has nothing to remember. His words are spoken as his family, in the company of other refugees, are sped out of Germany to be resettled in Norway during the early 1950s, whence a quota of Jews, left homeless by the ravages of the war, were deported. Mendel's older brother David, who *does* know what happened in Germany, aggressively slams down the shaded window of their compartment, blocking out what is still (and may forever be) to him a terrifying country.

Mendel cannot understand. His father Aron, who nervously chain-smokes and compulsively repeats self-mocking jokes at which others laugh uneasily, survived the camps at the cost of his religious faith; he now scorns all Jewish ritual practice. At night, he wakes up soaked in his pajamas after terrifying dreams. In one recurring oneiric episode, his shoes are stolen. "You can't trust anyone," he tells Mendel.

Bella, Mendel's mother, hides photographs. Whenever Mendel appears curious about them, she shoos him away. She sings sorrowfully at bedtime to David in Yiddish, and David softly weeps. Mendel is bewildered by all this and poses a barrage of questions, to which

[2] For parents of the second generation, silence was not a choice. Among the distinguished authors who have written on this phenomenon are Dori Laub, Cathy Caruth, Saul Friedlander, and Marianne Hirsch.

he hears only the weary refrain: Be quiet. Go back to bed. You are too young to understand. This is not for children.

Little by little, Mendel's family tries to adapt to its altered surroundings in Lutheran Norway. However, as can be deduced from the image of the crucified Christ at the start of the film, their kindly hosts have welcomed them not only to dispense charity but also to proselytize and convert them to Christianity. We hear pious Norwegians make tactless speeches to this ragged remnant of exiled Jews. We watch as they ply the immigrant children of Mendel's cohort with songs, symbols, and signs that seem harmless enough to the naïve youth but which provoke bitter resentment on the part of their survivor parents.

At a Christmas party, gifts are offered to the Jewish children, and Mendel is admonished by his parents not to accept his. For the parents, these gifts are a brazen form of seduction by the Lutherans, but Mendel, naturally, does not understand. During the scene, a religious Jew, the father of Mendel's friend Marcus, points out that, although the goyim sing tenderly about their infant Jesus, they murdered Jewish infants in cold blood. Later in the film, the wife of Marcus asks the pious Lutherans whether Jesus can bring back her dead children. Mendel looks on. These words baffle him. Yet, when he asks what they mean, he is rebuffed and told he is too young to understand.

Unlike David, Mendel is not sent immediately to school in Norway; nor, at first, does he learn Norwegian. He feels trapped in the cramped quarters of the decrepit building where the Jews have been lodged. Scandinavian wintertime proves too severe for outdoor play. Lonely and bored, Mendel bounces his ball on the stairwell, but an angry German-hating custodian reproves him. Ironically, because Mendel and his family are German-speakers, she assumes they are the enemy and materializes like a tarantula to spook, menace, and threaten him. We can only imagine what she herself must have suffered before the Jews' arrival. Cast into this gloom of claustrophobia, paranoia, and chronic anxiety, Mendel longs for his fantasy of the benign Germany he left behind. Plagued by an ignorance maintained by parental silence, he can only look backward. To what was never there.

One day, Mendel climbs the stairs to the very top of the building. He threads his way past exposed wires and hanging laundry until he reaches the level just under the eaves. To his surprise, the space

is not empty. He comes upon a solitary frail old man, a Norwegian, seated on a humble pallet surrounded by a few rudimentary supplies. The apparition seems uncanny to Mendel, who, from a safe distance in the half light of the attic, stares at him with wonder. The old man is carving a small wooden horse. Mendel edges closer to watch. Neither one speaks. Finally, the old man reaches out and hands the boy a block of wood and a piece of sandpaper. In so doing, he performs something marvelous: in Winnicott's words, he "meets and matches the moment of hope" — he gives Mendel exactly what the child lacks: a manageable task to perform, a way to feel useful instead of superfluous. Moreover, he includes Mendel in his activity rather than shunting him aside. After this initial encounter, Mendel climbs the stairs regularly and, unbeknownst to his parents, spends lots of time in the attic.

Shortly, Mendel learns that a young woman with a baby, presumably the old man's daughter and grandchild, come to visit and bring food. Observing their pleasure as they greet each other and embrace and how tenderly the grandfather fondles the baby, Mendel wonders about his own unknown grandfather. The Norwegians offer him portions of herring and potatoes, which the immigrant child accepts with relish. Eventually, Mendel poses a burning question to his parents, who have no idea where he has been spending his time: Where is his own grandfather, he wants to know. Why do grandfathers still exist here in Norway? Failing to get an answer, he persists in his questioning until his mother finally blurts out: "Our old ones were the first to die." This sentence, without context, makes no sense to Mendel, who already knows there was war in Norway as well as in Germany.

At length, the old man finishes his wooden horse and unexpectedly reaches out to offer it to Mendel. The spontaneity of this gesture, allied with the fact that the child has patiently witnessed creation of the object, renders the gift exquisitely precious, and Mendel, jumping into the old man's arms, embraces him with the joy of a truly happy child. Carrying it gingerly downstairs to his apartment, Mendel plays with it, and, when his parents ask where he got it, he turns tables on them: he tells them that *this* is *his* secret. Suspicious and mistrustful, his survivor parents are incapable of connecting that answer to their own concealments. They badger him until, finally, he reveals the presence of the Norwegian grandfather in the attic. Mendel's parents erupt with exclamations of horror

and chastise him for his clandestine friendship with a sinister foreigner, a goy. They forbid him to visit the old man and they tell him he must never accept gifts from anyone unknown to the family. As in the Christmas party scene, a gift to a Jewish child is seen as a seduction, a lure away from the gnarled roots of tradition.

When Mendel objects to the prohibition, his father grabs the wooden horse and hurls it to the floor where one leg breaks off. The boy cringes. Once again, his parents' behavior makes no sense to him. This time that behavior seems genuinely cruel. Yet viewers of the film, privy to the invisible terror that grips these traumatized, exiled parents, can empathize with them and sense the wellsprings of fear that motivate them as well as feel deeply sympathetic to the child's sense of loss.

The film progresses powerfully, scene after scene, to portray a range of effects produced by secrecy. Wishing to keep their son innocent of the Shoah and emotionally incapable of revisiting it themselves, Mendel's parents do not see that being kept in the dark can exacerbate anxiety rather than allay it. The incomprehensibility of his parents' words and acts makes it difficult for Mendel to adapt to the new world in which they all find themselves, and eventually, he begins to have frightening fantasies and exhibit symptoms of his own. Like his father, he starts to awaken at night with bad dreams and he loses bladder control — disturbances which seem symbolic of his chronic failure to exert cognitive control over his environment. He snoops one day among his mother's private objects as he searches for a photo album so as to find a picture of his missing grandfather.

Eventually, Mendel's family is relocated in the countryside, and Mendel is sent to school. There, he learns Norwegian and plays rough after school games with a group of boys who swap tales and boast proudly of their fathers' courage against the Germans during the war. Mendel is exposed to photographs of emaciated Jews in prison garb with hostile German guards standing by. He knows by now that none of his grandparents is alive. He knows too, of course, that he is a Jew, but he does not know exactly what that means nor what happened to Jews during the war. He wonders why *they* did not have guns, like the Germans. Why did *they* not fight back, like the Norwegians?

In a heart-rending scene, which I am about to describe, Mendel is made to face some of the unbearable truth of the Shoah. That learning, however, comes not from his parents but from his older

brother David, and I want to emphasize that it is the absence of parental guidance that prompts this bone-chilling scene of sibling intervention. Absent from the scene, the parents are implicit in what happens. Their incapacity to teach Mendel and to help him, little by little, to learn what he needs to know, creates a vacuum. It is into that vacuum that a drastic confrontation between the brothers erupts.

One afternoon, while David is bent over studying at his desk, Mendel barges in. Interrupting his older brother, he bombards him with his usual litany of unanswered questions. "Why don't you tell me about the war?" Why weren't the Jews brave? Why didn't the Jews resist? Why didn't the Jews snatch guns out of their enemies' hands and fight back? Why? Nobody is ever going to do that to me! Why did they stand around like sheep? Why? All they did was pray.

David tries to ignore all this and continue studying. And we, listening to Mendel's questions, clearly motivated by his new friends' stories and his own ignorance of the Shoah, may suspect that filmmaker Rosler also puts into his child character 's mouth some of the ideology of the Israeli Zionists, whose cry was "Never again!" Even so, it makes psychological sense, and Mendel plagues his brother by repeating his questions and mimicking a davening Jew at prayer while insolently whining baa-baa. "Why didn't they do something?" he challenges. He, Mendel, would have grabbed a gun from the firing squad and died resisting.

David squirms at his desk. He tries gallantly to shoo his little brother away. In an effort to deflect Mendel's onslaught, he says: "You haven't experienced anything. You were born too late to die." Mendel keeps davening and imitating sheep. Finally, it proves too much for David. Exasperated beyond his adolescent, far from perfect self-control, he rises from his chair. Infuriated by Mendel's taunts, he attacks his brother. He pins the much smaller Mendel to the ground. Holding him down while breathing heavily from exertion and emotion, David demands an apology. Mendel, however, who still understands nothing about the Shoah, insolently repeats his "Baaa-baa."

At this point, David loses his composure entirely and picks Mendel up. With a flash of sadistic inspiration, he commences a brutal act of instruction. He carries the struggling younger child to the open window of the apartment, several stories high, with the ground far below. Holding him by his ankles so that he is upside down outside the high window, David demands: "Say you're sorry or I'll let

you go." Mendel shakes his head. In horrid fascination, we watch as David shakes him by his feet over the window ledge and warns: "This is no game, you little Satan."

Finally, Mendel murmurs "Mercy," and David pulls him back inside. Standing him up on his feet, David looks down at him contemptuously and says he had his chance but his pride ran out. Both boys notice that Mendel has wet his pants from fear.

After this lesson — that no one has the right to predict his own courage in the face of death — Mendel is chastened and momentarily subdued, but he is still just as ignorant about what happened in Germany as he was before. Suddenly, he makes a break and dashes away from his brother; he locks himself defiantly in the bathroom.

A split-frame screen shows us both brothers' faces on either side of the door. Mendel opens it a crack. In that instant, David grabs him and forces him into a headlock. Mendel winces, and, slowly, this time, the aggression melts into an embrace. The brothers hug one another, and David admits, with genuine affection: "You're awfully irritating, but you're brave." "Then," begs Mendel, "Tell me …"

Only now, only after this life and limb lesson that no one can stand in the place of another, can the boys begin to talk. For the first time, truths about the war are spoken. Secrets are unconcealed. The Shoah and the mother's hidden photographs are discussed. David reveals to Mendel that his own beloved birth father died in Germany while resisting the Nazis and that Aron, therefore, is Mendel's father but not his. With this momentous revelation, past and present begin slowly to clarify; blurred shapes drift into sharper focus. Puzzle pieces slide over to fit together. Images that were superimposed slowly separate and therefore become more intelligible.

In the aftermath of the Shoah, "good-enough" parenting shifts invariably in meaning. *Mendel* is a film that explores both the blatant and the nuanced effects of toxic secrets on one young boy. It never addresses the psyches of his loving yet damaged parents, one of them a step-parent, and to have done so might well have been to disrupt as well as augment its narrative arc. Yet viewers' imaginations are primed. We are encouraged to consider the sequelae when parents are so wounded that they cannot visit the past and cannot satisfy the innate curiosity of their children. In the absence of words, Freud taught, we have acts — primitive, often, and inconclusive.

Lessons in Suffering: Challenges in Learning to Analyze Masochistic Patients

Presenters: Robert Glick, Jay Crosby, Aaron Reliford, Eric Marcus

October 1, 2019

Reporter: Bonnie Kaufman

Robert Glick began by noting that the title of the presentation, "Lessons in Suffering," refers to psychoanalytic education and the experiences of both candidates and their analytic supervisors in the treatment of masochistic patients. The issue, and the approach, evolved out of work he has done with other senior faculty members at the Center in the creation and refinement of CAPE — the innovative post-graduation education program for Training and Supervising Analysts, and didactic teachers. The process described tells us what it is like to work with masochistic patients, but masochism becomes more broadly a concept to think with, and to understand the psychoanalytic process as it unfolds during training.

THE TASK OF THE ANALYST

Analysts try to understand what drives their patients' suffering, to help them liberate themselves from neurotic inhibitions and restore healthy self-regard. The analyst is both a witness to, and companion in, this emotional growth. The goal is to enable them to open their minds to themselves through revealing themselves to us. This work can be slow and humbling, so we often try to find "tools of the trade" to help us through it. One such tool is theory, used as a kind of stencil through which we may frame something meaningful.

Pain and suffering are inescapable in life, but they differ from the torment of masochism. The pursuit of misery and the pain of unconsciously motivated suffering require a more complex understanding of mental life, and will be reflected in suffering and learning on

the part of both analyst/candidate and supervisor in psychoanalytic education.

MASOCHISM

Masochism reveals the ultimate power of psychic reality over external reality. It can also torment us into questioning the value of what we do, which often ends with our being resigned to "fail better," as Samuel Beckett put it, realizing that it is often fruitless to strive for perfection.

The psychoanalytic story of masochism begins with Freud's description of moral masochism, with its basis in unconscious punishment, and moves conceptually through changing theories of ego psychology, object relations theory, and child development, which stressed the often critical role of early developmental trauma. This pathology is determined from different developmental levels, with pain unconsciously considered the necessary condition for need satisfaction or pleasure, and therefore inextricably associated with it. Arnold Cooper's contribution was the need to distinguish between healthy narcissism and pathological narcissistic development, which he related to the developing infant's increasing experience of powerlessness, associated with unmet needs. The infant turns to unconscious, infantile omnipotent control as a central self-preservative defense. Masochism, then, may be forged in the crucible of severe developmental trauma, and be the consequence of fearful dependence on abusive, inconsistent, unpredictable, cruel and exploitative caregivers. As a primitive form of omnipotent control, the infant directs rage on itself, an adaptive survival response. Sharone Ornstein suggests the infant develops a "tracker" mindset, becoming a "vigilante" of omnipotent control which affords the child a sense of self-protection. Better to punish yourself than to allow damage from outside.

SUFFERING AS AN ASPECT OF CANDIDACY

Glick then gave brief vignettes of his own early work with masochistic patients during his candidacy. First, he described a patient who repeatedly entered into liaisons with powerful, narcissistic

men (like her father) and then would provoke sado-masochistic abuse. In his countertransference Glick felt less like the abuser than the abused, who had to become her powerless, devalued self. As the work went on, he resolved to "fail better."

Next, was a young man whose divorced, alcoholic mother wanted him to be "fixed" so he could support her grandiosity. At one point he described his dilemma in terms of a scene from the original film version of *The Manchurian Candidate*. Angela Lansbury takes control of her son, Lawrence Harvey, the assassin, saying: "Why don't we play a little solitaire?" The patient's submissiveness served as a way to keep his mother alive, protecting her from his rage. In both these cases, consultation with others was helpful as time went on.

The demands of training itself may evoke various masochistic and defensive reactions, leading often to countertransference struggles with patients. Glick admitted that he often saw his supervisors as intimidating and irritating, and struggled to balance the need for their knowledge and support with a wish not to be controlled by their requirements. He had to analyze his own passivity, as well as his anger.

Some types of countertransference issues are common in students who work with masochistic patients. Often, there is a "honeymoon" phase, a period of early improvement. The candidate/analyst dares to hope that "I will succeed where others have failed!" That fantasy quickly evaporates. The candidate often comes to fear their own anger at everyone — patient, supervisor, their own analyst, and themselves.

THE SUPERVISORY PROCESS

When working with such difficult psychopathology, supervisees may be prone to enactments, detachment, advice to the patient when they should just listen, "mistakes" that feel painful and punishing. Supervisors, too, succumb to the pull of the pathology and the student's anger and distress, reacting with boredom, frustration, advice, and ill-timed theorizing, among others.

There was a time when it was assumed that training analysts would also be excellent supervisors, but that is quite often not the case. A supervisor may wonder why something that is clear to him

or her is not also evident to the supervisee. Too often we assume that that we are right, and the student is wrong. There are many different supervisory styles. We want to teach how we work and what we know, while also finding ways to encourage the formation of the trainee's own psychoanalytic identity. But we are also vulnerable to our own needs and wishes, that is, to be idealized as an analytic "parent," sending our progeny into the world to do themselves (and us) proud. We may want them to meet our needs by being worshipful acolytes. Ultimately, we must tolerate their differences, errors, and competitive feelings, as well as their need to symbolically kill us off as they become the analyst they need to be.

Glick then introduced the two supervisees, the first of whom had worked with him, and the second with Eric Marcus. He asked us to try to listen, both for the supervisor's methods and how the candidate learns from them.

Jay Crosby began with a quotation from a well-known paper by Betty Joseph: "The pull toward death and despair [in many masochistic patients] is not a longing for peace and freedom from effort. Indeed, just to die, although attractive, would be no good. There is a felt need to know and have the satisfaction of seeing oneself being destroyed." The awareness of the depth of this suffering is compounded for the trainee and for the supervisor, by the work they do together to deal with it.

Crosby began analytic training with two goals: both to study and to learn from the experts with whom he felt privileged to work, while at the same time developing his own psychoanalytic identity. He felt cautious around institutional authority and was concerned about the possible iatrogenic effect of power over candidates. This was his first case, and his need to find his voice created internal pressures and fantasies from the start.

Crosby's patient, a creative, gay man in his thirties, had a history of traumatic relationships and anonymous sexual encounters, and had great difficulty moving forward professionally. This would have been a taxing case for any analyst, let alone as a first case for a candidate. The situation was further complicated by the fact that the patient had recently ended a ten-year psychotherapy with a respected local analyst well known to Crosby. Nonetheless, after discussions with his supervisor, Crosby decided to accept the case.

Early transference developed around the patient's provocative accounts of doctors and therapists whom he met up with for

anonymous sex. Crosby found himself intervening actively, by interpreting the material as it related to the new treatment. It seemed the patient needed to excite his analyst with his despair. Glick cautioned that the interpretations were heavy-handed, and probably designed to help the analyst cope with his anxiety. He urged Crosby to slow down and listen more. Crosby reacted by feeling they were spending too much time on him and not enough on the patient, and he became doubtful about the value of the supervision.

Crosby moved to a significant moment in the treatment, when his patient talked about an upcoming trip with many men whom he described as "sordid," and with whom there would be drug and alcohol use and anonymous sex. Glick urged him to get the patient to wonder why this made him so anxious, but after the trip the patient announced that it had been disappointing, without going into detail about the "sordid" men. Crosby felt as if he'd been left on a cliff-edge, and told the patient that his disavowal of disturbing material showed him to be "stuck in the perpetual present tense." This made the patient extremely anxious.

Crosby went to the next supervisory session feeling guilty that he had chastised the patient, and for using the intervention to relieve his own frustration. Yet it also seemed that they had reached some new level, in spite and perhaps because of this countertransference "error." Glick agreed that the patient had been chastised and urged Crosby to explore his own sadism towards the patient, which left Crosby in a crisis of confidence

Next day, the patient for the first time reported a dream, in which the analyst was present with one of the analyst's own friends, with whom there were hints of an erotic connection. There was to be an analytic session, in a space like the patient's home. The patient wanted to water his plants before the session began, so that they wouldn't die. Crosby and Crosby's friend had an erotic history, and Crosby was naked and wearing a leather harness. In this context, of loss, deprivation and failure, and the erotization of shame and destructiveness, Crosby was transformed from the authority into the gazed-upon, submissive object. This material decreased the tension between analyst and supervisor, and reassured both of them that the work was on the right track.

Crosby emphasized how important it has been to discuss the intensity of the countertransference demands that this patient has placed on him. He has come to see masochism, at least in this

case, as a kind of love affair, not with suffering itself, but with pleasure in staging dramas that recur again and again, leading to the same frustrating result. Using the symbolism of the patient's dream, Crosby ended up seeing himself as a supervisee who insisted on watering his own plants, and who resisted Glick's suggestions out of a fear of masochistic submission, thereby clinging to a premature sense of his own identity as an analyst. Perhaps too, the friendly duo in the dream alluded to the supervisory dyad, suggesting that the friendly and perhaps even erotically tinged relationship could mask more difficult power dynamics that can play out in the parallel process.

Crosby ended by noting the biggest challenge he faces in treating this patient, namely, his own anxiety over being the witness, in fantasy, to a slow-motion tragedy. As the witness, he participates in a form of voyeuristic torture, and simultaneously, he is tortured himself. It is a drama that will likely continue to be remarkably resistant to change.

The work of Aaron Reliford and Eric Marcus followed. Reliford's patient seemingly found innumerable ways to sabotage her treatment: such as becoming involved in crises which made her "need" to decrease the frequency of sessions; or traveling out of the country on very short notice and requiring remote sessions using FaceTime. All the while she kept moving from one damaging relationship to another, while rejecting any men who seemed genuinely to care about her. She avoided the transference, was unable or unwilling to work with any sexual fantasies, and rarely reported dreams. The sessions seemed often to be about "soap-opera" psychodynamic issues. It was thus very difficult for Reliford to find deeper issues to work through, as any progress the patient experienced was defended against, so as to keep the treatment on the same shallow level. Reliford's ountertransference guilt, and fear of seeming aggressive, frequently led him to avoid possibly useful confrontations, and he often experienced mid-phase boredom.

For Reliford it seemed that confrontation and interpretation would violate an unspoken, masochistic "contract," that is, to be an empathic witness in the experience of mutual suffering. Whereas Crosby had tended to intervene prematurely to cope with his patient's pathology, and then suffered for his "ineptitude," Reliford was apt to hang back in unconscious collusion with his patient's failure to engage.

Both analyst and supervisor had to tolerate the complexities of the countertransference. Marcus often found himself bored and impatient, even feeling sadistic towards the analyst, who seemed humiliated by the treatment's failures and difficulties; at times Marcus even felt reduced to a kind of pseudo-stupidity. The extreme difficulty of caring for this frustrating, often enraging patient, was reflected in that of maintaining a relationship of tender, loving care between analyst and supervisor. In the longer term, the analyst has to learn to understand his own guilty inhibition of necessary assertion and intervention, as a manifestation of the underlying organized masochistic attitude. This unconscious masochistic story must be gradually put into words, making use of sexual and fantasy material in the process.

Marcus saw Reliford as devoted to his patient and their work; his steadiness and reliability made him a constant object for her. He was determined to learn, and be open to supervision, despite its complexities. Masochistic patients try our patience, and our suffering for them is noble, which may be what Freud meant by moral masochism. What should be positive reinforcement for a masochistic patient is experienced as negative, and vice versa — an apt description of the masochistic repetition compulsion. As the patient starts to improve, she will resist any progress and the transference will become stormy, as she attacks the analyst and incites him to attack her.

Marcus concluded by noting what a pleasure it had been to work with Reliford, and to accompany him on the journey to insight and growing competence in theory and practice.

One of the questions from the audience, was whether masochistic patients actually enjoy their suffering. Marcus thought that the difference between the moral masochist and the sexual masochist is that the former feels that suffering is noble, so that it becomes a fundamental aspect of their self-esteem. It is not actually pleasurable, but it is strangely satisfying.

Psychotherapy Affiliates' Event
Relevance and Applications of Psychoanalysis to the Psychotherapeutic frame

Presenters: Seth Aronson, Eve Caligor

Moderator: Talia Hatzor

November 19, 2019

Reporter: Bonnie Kaufman

This program, which was targeted to clinicians practicing psychodynamic psychotherapy, offered an overview of each presenter's ideas about how and when to apply theories, developed by and for psychoanalysis, to lesser-frequency forms of psychodynamic treatment.

After welcoming the participants, Dr. Hatzor referred to Freud's 1919 paper "Lines of Advance in Psycho-Analytic Therapy," in which he makes two salient points. First, he denounces the dangers of ethical violations and cautions all analysts against clinical grandiosity; we cannot force our own ideals upon the patient. Second, he makes a prophetic statement — that psychoanalysis, in order to make a far-reaching contribution to alleviating the misery and suffering of the most deprived, will need vastly to increase the number of its clinicians, and create free clinics to effect change in "the conscience of society." If we are to bring this about, Freud states, we will "then be faced by the task of adapting our technique to the new conditions."

The Columbia Psychoanalytic Center has created programs that embody these goals, beginning in 1992 with the Adult Psychodynamic Psychotherapy Program, which was followed by the Psychoanalytic Parent-Infant Psychotherapy Training Program; the Child and Adolescent Psychodynamic Psychotherapy Training Program; the Transference-Focused Psychotherapy Program; and Columbia Psychology in the Schools. Led by eminent senior members of the Columbia faculty, these programs have attracted, educated, and graduated, dozens of clinicians from many areas of the country and abroad. They are dedicated to fulfilling Freud's mission to help

non-psychoanalysts use analytic theory and techniques to enrich their therapeutic work.

The first presenter was Eve Caligor, M.D., Clinical Professor of Psychiatry at the Columbia University College of Physicians and Surgeons, and Training and Supervising Analyst at the Center. She is also vice-president of the International Society for Transference-Focused Psychotherapy (TFP). Dr. Caligor felt that empirical developments in the understanding of psychopathology and psychotherapy outcomes — evidence-based principles and psychotherapy research — inform the creation of contemporary models which can be valuable to psychodynamic clinicians. Central elements include a comprehensive assessment, with a careful exploration of both character pathology and the level of ego functioning. This is crucial to the development of an appropriate treatment program, which must be tailored to the severity of the patient's pathology. Before beginning treatment it is important to share a diagnostic impression with the patient, as well as discuss treatment goals and the frame. With all such patients, the exploratory process focuses on the here-and-now, and the goal is to promote reflective capacities within the patient.

Randomized Clinical Trials carefully select patients with a shared diagnosis or problem, and assign them randomly to active treatments, which are delivered "by the book." The average outcome is then compared. The question then remains: "what works for whom, and how?" In response, there has been a move away from thinking in terms of diagnostic categories, to developing more general treatment models that function across diagnoses, as well as models that can be more flexibly applied. The presenting problem is always embedded in personality, which must always be assessed as part of the clinical evaluation. Love relationships, work, and leisure interests are important. Experts tend to agree, however, that the dimensions of a personality disorder, rather than the category, are usually the best predictors of prognosis. Classification, according to the nature and severity of impairment in self- and interpersonal functioning, is complemented by description of dominant traits. This has been adopted in the DSM5 Alternative Model of Personality Disorders and is compatible with Kernberg's object relations theory-based model of personality organization. The levels of impairment range from normal, through mild, moderate, and severe, to extreme, and are major determinants both of outcome, and the types of therapeutic relationships that can succeed.

Contemporary Psychodynamic Psychotherapy focuses on alliance-building, through establishing shared goals, agreeing on the tasks of both patient and therapist, and forming a positive bond. Also important are the expectation of positive change, and the use of specific interventions to remediate specific psychological deficits as they emerge in the treatment. Whereas psychoanalytic psychotherapy, like its parent treatment, tends to be unstructured, focused on transference and rooted in exploring development, Contemporary Psychodynamic Psychotherapy uses evidence-based principles and models of pathology, as described above, to create a structured, goal-oriented procedure. This is tailored to the level of personality organization, but focuses on affective dominance and the therapeutic alliance, and on issues in the here-and-now

Dr. Caligor gave the example of Mr. H., 35 years old, whose wife urged him to seek treatment after losing yet another job. Although competent, he persisted in belittling those he worked with and for, and showed little understanding of his behavior. He was also somewhat dismissive of his wife, yet felt he loved her.

Description: Interpersonal problems in the workplace, and with self-esteem.

Diagnosis: Mixed personality disorder, with prominent narcissistic, obsessional and sadomasochistic features.

Structural assessment:

Identity: Somewhat unstable sense of self and others.

Object relations: Stable marital relationship; some capacity for mutual, dependent interactions.

Defenses: Splitting-based/ dissociative, and higher level.

Moral functioning: Intact.

Aggression: Somewhat poorly integrated

Conclusion: High borderline level of personality organization/LPFS2

The therapist starts by sharing the diagnostic impression with the patient, focusing on his subjective experience and functional impairment, as well as the specific personality disorder, if relevant, and discussion of differential therapeutic approaches. For this patient it might involve noting his repeated tendency to lash out because he feels disrespected, even though he knows it is not in his best interests; and explaining it as a kind of rigidity in his personality. In addition, he has trouble maintaining a stable sense of himself, or of other people at work. Treatment can help him modify and curtail

these repetitive and self-damaging behaviors. Such treatment goals create an anchor; support the developing alliance; and organize the therapist's listening. Working on these behaviors and traits will benefit the patient's here-and-now functioning.

Next, we heard from Seth Aronson, M.D., Director of Training, Training and Supervising Analyst, and Fellow, at the William Alanson White Institute. He teaches childhood psychopathology and child/adolescent psychotherapy at Long Island University. His whimsy and creativity are reflected in the titles of some of his papers, which include "Balancing the fiddlers on my roof: on wearing a yarmulke and working as a psychoanalyst," and "Only connect: the mutuality of attachment," taking us from Anatevka to Howards End in his intrapsychic world. His talk to our group was titled: "Psychoanalysis: the APP Every Smart Clinician Should Have."

The discussion began on a personal note, when Aronson talked about his tonsillectomy at age six, and how his pediatrician took him the night before to the empty operating room where the procedure would take place, and "walked" him through everything that would happen, which greatly mitigated the young patient's anxiety. The pediatrician clearly had a deep understanding of the young child's emotional experience, despite that not being his area of expertise. Years later, Aronson read an article written by that pediatrician in the *Psychoanalytic Study of the Child*, learning that he had been trained in part by disciples and trainees of Anna Freud. We might say that the pediatrician had the above-mentioned App before they existed.

Aronson described his training at Jacobi Medical Center, Albert Einstein College of Medicine, where he worked in the therapeutic nursery program and adolescent day treatment program, as well as being involved with the pediatric consultation-liaison service; a program for youth affected by substance abuse; and a pioneering program providing mental health services to children and families affected by AIDS. He then presented two clinical vignettes, which illustrate the value of teaching psychoanalytic principles to clinicians working in these vital fields.

In the therapeutic nursery program, he worked with three-and-a-half-year-old Noah, who was on the autistic spectrum. The multidisciplinary staff of the program learned much from each other, and also learned how to complement the work of other members of the team. Noah was frightened, with flat affect, and his capacity for interaction with others and his experience of the world were extremely

constricted. He also had sudden tantrums, which had caused him to be expelled from several pre-schools. Aronson suspected the child was terrified of his aggression and his object world's reaction to it, both in reality and in his own fantasy.

Aronson described the slow, often painful work of helping the child to interact, using some play therapy, and also toys. He first tossed a nerf ball at various objects in the office, using it to help Noah separate inner from outer (were things the ball hit alive or not?). A pivotal moment occurred when Noah was playing with a toy cat with a long, fluffy tail, and Aronson pretended to sneeze, so violently that his yarmulke flew off his head. The child was terrified at his own sadistic aggression and sadism towards his therapist, but in the next session, Noah chose to play with the cat again, and was able to repeat more calmly the frightening behaviors of the previous session. Over time, the play became mutual, as when the therapist would put the cap on Noah's head and pretend to knock it off with the tail of the toy cat. Aronson described this psychoanalytically, as being about returning projected material to the child. Noah's receptivity evidenced a new perception of himself as a person who was allowed to be aggressive, and of his therapist as someone who could tolerate and contain his aggression, and return this projected, dissociated material to him in a form which he could allow himself to possess.

Aronson added that the treatment included sessions with Noah's parents, and concluded the case by again stressing that this work took place in a municipal hospital setting, where a psychoanalytically oriented approach, integral to understanding this child's world, was encouraged.

Aronson next described the group program for older children, which drew upon many psychoanalytic concepts, such as that of the "mother-group," from the work of Saul Scheidlinger. Could such an idea, that group members often longed unconsciously to return to a need-gratifying relationship with a primary caregiver, be implemented in a group experience, and how could such feelings be discussed and interpreted in the group setting? Putting the groups together involved drawing on the ideas of analysts like Bion and Guntrip. Setting up the groups and choosing the leaders was helped by the work of the Viennese analyst, August Aichhorn. AIDS groups benefited from studies done at Jacobi by Martha Wolfenstein on childhood bereavement, and from Erna Furman's understanding of

the developmental level of the child at the time of the loss. Other thinkers provided useful ideas about continuity. After the traumatic loss of a parent, a child could not be expected to detach in a normal way from earlier parental imagoes and representations. Rather, the child was helped to take an active role in creating a Winnicottian set of transitional phenomena, separate yet connected, affording them tools to mourn through memory, language and activity, rather than helpless passivity.

The adolescent day treatment program served fifteen hard-to-reach adolescents with conduct disorders, who were out of school for psychiatric and other reasons. Here, Aronson was the primary therapist for fourteen-year-old P, who had a history of serious neglect, abuse, time in foster care, and violent behavior. Initially very verbally abusive, threatening and insolent, P. spent some time in Rikers, and on his release, sought Aronson out to resume their work together.

Once again, a key moment related to Aronson's visible Jewish identity, his yarmulke. P., who was smoking as they walked together outside the hospital grounds, took out a matchbook with an image of Sabbath candles and Hebrew script. He noted off-handedly that he probably got it from some little Jewish store near his father's house. Aronson suspected that it might relate to his own consistent refusal to react with retaliation to P's many provocative efforts to anger him into ending the relationship. Aronson saw this as evidence of the truth of Roy Schafer's idea that the parental figure must "even in their punishing activities, provide needed expressions of parental care, contact, and love." Rather than focusing solely on P.'s pathology, Aronson tried to experience him as a person abused and suffering horrific loss, that is, in Philip Bromberg's words, to "stand in the spaces." Aronson contrasted this work, and its positive outcome, to what might have been P.'s fate in a behaviorally oriented program for potential offenders with conduct disorders.

Aronson ended with a plea: that we must take seriously the risks of ceding the public sector, and the populations it serves, to those who are antagonistic to psychoanalytic ideas and principles. From transference-focused psychotherapy, mentalization-based approaches, to, the understanding of attachment styles, we have much to offer. What should be taught are, in Freud's words "the applications of psychoanalysis …without which no analytic training is complete."

Visiting Scholar Lecture
The Early Shapes of Psychic Life as Forerunners of (Bi)sexuality

Presenter: Patrick Miller

Discussant: Rosemary H. Balsam

February 11, 2020

Reporter: Bonnie Kaufman

Patrick Miller is a psychiatrist and psychoanalyst who practices in Paris. He is also an IPA training analyst, and in 2005 co-founded the *Société Psychanalytique de Recherche et de Formation*. His scholarship revolves around themes of sexuality, the body, the psyche-soma dynamic, and early trauma, and how these affect the analyst's "psychical reality." He is the author of numerous papers and two books.

Miller began by noting that, in recent years, sexuality has featured less often in analytic work, and theory, than was the case when Freudian drive theory was dominant. Even when patients repress or avoid sexual details, analysts often seem to feel that this material is less important; that the "heart of the matter" lies in more primitive stages of psychic life. Miller, however, sees no need to split the early stages of psychic life from the later manifestations of infantile and adult sexuality, since the former contribute significantly to the structuring of the individual's later sexual identity. Oedipal development and adult sexual functioning are both deeply affected by the nature of the communications that affect the earliest development of the bodily ego.

Miller seeks to complement Freudian drive theory with the work of Wilfred Bion, who looked at the earliest psychic growth through the interaction of container and contained. Parents' own unconscious Oedipal conflicts are active from the very beginning of their interactions with the infant, and hence play a major role (especially on the mother's side) in determining the child's capacity for penetrability, permeability and receptivity. Therefore, this early situation is, in effect, always triangular.

Miller further noted that, in psychoanalytic work, the processes of inter-penetrability in early psychic growth, and the ensuing developmental stalemates, may be reenacted through the dynamics of both the analysand's and the analyst's psychic dispositions; that is, in the complex unfolding of transference and counter-transference. The analyst, over time, learns to hear the earliest manifestations of the struggle in new ways, thus enabling the dyad to unlock and work through conflicts which were previously unclear or unavailable. The earliest forms of interplay contribute not only to the construction of the psychical apparatus, but also to the development of the body ego. Their modalities relate to many different forms of interpenetration of the infant's and the mother's psychical spaces, shaped by bodily sensations and proprioception, and experienced as pleasurable or non-pleasurable.

Miller presented several illustrative clinical vignettes. The first was of a patient whose seemingly perverse pathology emerged rather differently in the course of the analytic work, ultimately leading to a more positive therapeutic outcome. Jean-Marie was described, in the first session, as an uptight, conventional, slightly boring 30-year-old man, the only child of very controlling parents who decided virtually everything that he would be and do. They saw their son as an extension of themselves, treating him as a phallic-narcissistic object, through which to satisfy their needs at his expense.

In the second session, however, the patient unexpectedly started telling the analyst about his humiliating sadomasochistic sexual adventures, such as group sex, and encounters with professional female dominatrixes. The patient, paradoxically, saw this part of his life as a self-chosen "bubble of protection" within which he could win freedom from his parents' lethal grip. He described his mother, who had never held him or expressed tenderness, as hard, cold, and devoid of emotions. His father spent most of his time at home naked, except for a T-shirt, and with his genitals constantly exposed. He was totally uninterested in his son.

Miller thought — borrowing a term from Melanie Klein — that Jean-Marie was a "toilet child," that is, a receptacle for his parents' hateful, destructive projections, which he was forced to contain. His mother was herself an impermeable container, completely closed to the needs of her child. As the patient described his sado-masochistic play with men and women, who used sex toys to penetrate him, he created for himself an environment of pheromone-like smells, and

the sense of being filled by the other that in some way afforded him a safe and inviting maternal space.

In the staging of his sexual scenario, Jean-Marie seemed to re-enact the primal trauma of the impossibility of entering the maternal psyche, as well as the experience of being intrusively penetrated by his parents' pathological projective identifications. But the re-enactment represented his determination to create a change in the outcome, by using sexual and anal libidinal forces to bind the destructive aspect of the initial trauma. He thereby created an enveloping, libidinal, maternal object, and the ability to penetrate that object by going into the "bubble of protection." What appeared from the outside to be a perversion, (and which could develop in that direction with time), at this point seemed designed to repair the primitive bodily experience both of being denied access, and of being intrusively penetrated. As this idea emerged in the analysis, and the analyst explored it with the patient, this process itself became yet another envelope to contain, transform, and care for him.

In the earliest period of psychic life, representations of sexual difference are not meaningful as such for the infant, but are very present in the lives of his/her parents, and in the infant's complex bodily sensations. For the analyst, they are represented by the various transference positions they assume. Miller said he had drawn on Klein and Bion in constructing much of his own theory. Bion developed the concept of projective identification, not as a pathological mechanism but as something central to psychic development. To become human, that is, to develop a mind, the infant needs to propel the raw elements of somatic experience into another human mind, which can transform them into mental contents. At the origins of mental life lies an encounter, a kind of primal scene that is both intrapsychic and intersubjective. It is simultaneously an encounter between body and mind, and between subject and object. As for the concepts of container and contained, Bion designated the female sign as representing the container, and the male sign as representing the contained. But each symbol represents much more than the list of ideas normally subsumed under them, for example, "feminine, woman, vagina," or "masculine, man, penis." For Miller, Bion was getting to something experienced at the dawn of psychical activity, which relates to femininity and masculinity, rather than to the sexual attributes of man and woman. Bion saw the dynamic circulation between male and female as "commensal," in that each depends on

the other for mutual benefit. In early development, both mother and infant derive benefit. The infant's fears are projected into the mother and metabolized by her active receptivity. If this process is successful, the infant will re-introject a part of itself which has become more tolerable, thereby enabling growth. If the process fails, the infant's projected fears are re-internalized as a nameless dread, a kind of helplessness. This failure then becomes the new "norm" between mother and child, leading in the latter to a punitive superego and a sense of futility.

Miller then discussed the mid-twentieth century *oeuvre* of Henry Miller, whose frankly sexual writing in such "perverse" novels as *Tropic of Cancer* led to their being banned. Giving diverse examples, he noted how the work actually conveys a remarkable love of sexuality, especially in the ways in which the sexual encounter allows two people each to penetrate and be penetrated by the other. They start from clearly differentiated, exciting, gendered positions but progressively lose their sense of gender identity as they reach the climax of orgasm.

Patrick Miller then described another patient, a young man who had been hospitalized with a probable psychosis and was frequently suicidal and self-destructive. Over the years of treatment, this man evidenced great joy in love-making, seen in his sexually poetic descriptions of the bodies of his female partners and the ways in which he pleasured them, all of which the analyst came to see as valuable parts of his psyche. Miller also realized that he himself had found a new kind of creativity in the ways he was able to hear and respond to the patient, thereby modifying the analyst's containing function. Thus, he no longer needed to understand the patient's stories as a defensive avoidance, but rather as the projection of a creative part of himself into his analyst. In one such story, the patient acted out his blind rage when forced to attend a party celebrating one of his father's business accomplishments, by overturning all the buffet tables laden with food. His furious father insisted on meeting with the analyst and told him he wished his son were dead. When Miller told the father that he often felt that his son was haunted, the father broke down and revealed something he had never told anyone, not even his wife; that his own father was a violent alcoholic who savagely beat him and his mother, and committed suicide by hanging. The "haunted" son had unconsciously been assigned by his father to reincarnate the much-hated grandfather, whom the

father could never mourn but kept alive in this way in order to keep destroying him.

Another patient was a young woman who appeared for her first session dressed like a character in an Almodóvar film. She looked cold and hard and came across as alternately aggressive and remote. After Miller commented on how closed she appeared, she relaxed and admitted that she was scared. During the treatment, her cold, hard demeanor softened, as she revealed her desire for a relationship with a man who might provide her with exciting sex, as well as a caring partner. In a dream, she had sex with a woman with a penis, who penetrated her deeply, giving her an intensely satisfying experience. While the dream pointed to issues of homosexual desire and penis envy, Miller felt that this imagery, in the context of the maternal transference, was used to give shape and meaning to the evolving psychical intercourse between infant and mother, as enacted between analysand and analyst.

The evacuation of raw bodily and psychical elements into the container (the mother's psyche) is part of the process of projective identification for both male and female infants. Does one aspect of a little girl's femininity include a capacity to inject her own psychic fears into a receptive maternal space, which can help her to metabolize them? Does the baby boy need to construct an inner space where he can experience and access his feminine and maternal yearnings?

As Miller noted, the second phase of projective identification involves the re-introjection of elements metabolized by the maternal psyche, and the successful development of this capacity, in both male and female infant, will determine that individual's ability to achieve true pleasure in sexuality as an adult. If the mechanisms of pathological projective identification are too prominent in the psyche of the primary object, the ability to achieve passive sexual pleasure — which is, in fact, always *actively* passive — may be lost.

Miller ended by reiterating that the analytic process should foster change and growth in both partners, through furthering penetrability and permeability. If we can describe the analytic pair as a couple, we must try to understand the kind of copulation that is taking place, and what determines whether it ends up being sterile or fruitful.

Response by Rosemary H. Balsam

Rosemary H. Balsam is Associate Clinical Professor of Psychiatry at the Yale Medical School, and a training and supervising analyst at the Western New England Institute for Psychoanalysis. She is the author of books and papers dealing with gender, sexuality and body issues, especially as they relate to female development.

Balsam largely agreed with Miller that adults who seek psychoanalytic treatment these days are less likely to focus on problematic sexual practices than in the past, and that even psychoanalysts do not always perceive the ways in which primitive psychic integrations are present in adult sexual behavior. But if sexuality as a major shaper of life has been left behind along with Freudian drive theory, then what accounts for this shift? It may have many explanations, such as postmodern criticism, object-relations theory, and competition with sex therapy. And many practitioners are fascinated by the influence of the fearsome mother in the earliest period of life. Balsam, however, pointed out that this avoidance is also part of a long-standing repudiation and erasure of the female body, especially as regards its role in pregnancy and birth. Femaleness is often still subject to a system of inadvertent phallocentric theory-building.

Balsam noted that, while Freud focused mainly on what he saw as the woman's need to bury and obscure her earliest, pre-Oedipal history, in fact men do the same thing when it comes to the powerful, pre-Oedipal mother. It is this early experience that links drive theory to object relations theories of ego development. Balsam cited work by Hans Loewald, Melanie Klein and Julia Kristeva, all of whom highlight the erotic aspects of the earliest relations between mother and infant. She also mentioned Chris Lovett, a fellow Bionian who not that long before had presented a paper on "The Erotics of the Container," in which he pointed out that seeing the maternal object too narrowly as a container and metabolizer overlooks the erotic aspects of the mother-child relationship, and the ways in which they may present in the analytic setting. Balsam underlined several other features of Miller's presentation with which she agreed, although she questioned the phallo-centrism of requiring an actual penis in dealing with issues of penetration and containment, when a nipple could also be experienced in this way.

Balsam went on to explore some of her own associations to the material in each of Miller's case vignettes. She noted that Jean-Marie's yearning for closeness to his father suggests that he might want orifices through which his father could enter him, and that his cloacal anus, with its associated smells, could perhaps be enlarged for that purpose. This idea could also represent his being connected to his mother *in utero*, where she *had* to take care of him. Balsam, further mentioned an entry in one of Leonardo's notebooks, where he refers to nature creating the body which forms the child: "…the soul of the mother first constructs within the womb the shape of man, and in due time awakens the soul that is to be its inhabitant."

Here the presenter's earlier remarks on the literary productions of Henry Miller were apposite. Far from finding this work pornographic, Balsam saw it as an honest explication of some of the theses advanced by Patrick Miller in his talk. She was reminded of Marcel Proust's exquisite description of memories evoked by the madeleines of his childhood: "No sooner had the warm liquid, and the crumbs with it, touched my palette, than a shudder ran through my whole body…An exquisite pleasure had invaded my senses…this new sensation having had on me the effect which love has, filling me with a precious essence; or rather this essence was not in me, it was myself…Whence could it have come to me, this all-powerful joy?" Balsam associated this passage to what Jean-Marie said about his dominatrix: "I am in search of a smell, and that smell is something enveloping, that can carry me away in my sexuality. I am in search of an odor…reminiscent of a fusion." Jean-Marie too was in search of lost time. If only his mother had been in touch with the joys of skin to skin and spirit to spirit, the contact her son so desperately craved…

Balsam concluded with brief mentions of Miller's other vignettes. First, how he was able to tell his sometimes-psychotic patient's father about his intuition that the boy seemed haunted, which released in the father the agonizing admission about his own father's violence to himself and his mother, and ultimate suicide by hanging; also how the patient's father kept his own father alive in his son, as a substitute victim for his own rage. Then she considered Miller's description of his female patient, the frozen, brittle woman whose façade protected her from her fears of those around her, and from her damaged, frightened self. Balsam associated the patient's later

dream, of having intercourse with a woman with a penis, to the umbilical joining of mother and infant as a forerunner of the fantasized female penis. Then, as the patient began to consider marriage and children, was she in effect reuniting with her mother — the mother of procreation?

The Levy-Goldfarb Lecture
Play, Free-association and Enactment

Eugene Mahon

March 3, 2020

Reporter: Bonnie Kaufman

The 2020 Levy-Goldfarb Lecture was given by Eugene Mahon, Training and Supervising Analyst at the Columbia University Center for Psychoanalytic Training and Research, and a child and adult psychoanalyst in New York City.

Mahon defines childhood symbolic play, and free association, as discrete entities, albeit psychologically related. Freud describes symbolic play as fantasy which requires props and playthings for actualization, to which Mahon adds the component of action. Free association becomes possible through the achievement of formal Piagetian cognitive operations in early adolescence, when props are no longer needed, since words and ideas themselves generate the flow of free associations. In adult analyses, there are times when the abstract, exclusively verbal free associative process fails to express the whole affective analytic communication. Enactment in such situations represents a creative regression to the play mode of props, playthings and action, to express what words alone cannot.

Mahon illustrated these ideas with three vignettes. The first was from the analysis of a child between the ages of four and six. When the four-year-old walks into the analyst's office and steals his chair, what is going on? The same child, again in analysis from between the ages of twelve and fourteen, is able to free-associate creatively and productively, and to analyze his parapraxes. What has made such a transformation possible? Finally, Mahon presented excerpts from the analysis of a different person — an older adult for whom the free associative process failed to carry the full burden of affective meanings. Enactment was enlisted to facilitate the full expression of affective communication. What made it necessary?

Play, for Freud, was psychoanalytically equivalent to fantasy, but whereas fantasy is private, play is publicly enacted with props

and playthings, not unlike the way a director sets up the *mise-en-scène* of a staged drama. Action affords an important way into the unconscious life of the small child. This aim-inhibited acting through play experiments with and tests out reality before accepting it and adapting to it. It does not seek immediate gratification of desire or an obvious solution to a problem, but rather explores various possibilities of experience. Mahon noted that Peter Neubauer used a sartorial analogy: the child tries on various solutions, looking for the best fit. This resonates with Piaget's idea that in play, assimilation is ascendant, while imitation prioritizes accommodation. Both are approaches to understanding the complexities of reality for the small child.

The child analyst is primarily interested in the ways the mind tests out fantasy, using dramatic action with props and playthings to experiment with nascent psychological reality. If early defensive strategies are dealt with through repression, play tries to displace them onto the dramatis personae of symbolic theater in order to deal with the inevitable return of the repressed. Childhood can be understood as a constant tug of war between the instinct repressed, and the instinct evoked again and again in fantasy and displaced into the theater of play. Mahon reminded us that it was Charles Sarnoff who showed that it is the capacity to repress, established in the third year of life, that makes secondary or psychoanalytic symbolism possible.

The capacity to free associate, made possible through the achievement of Piagetian formal cognition in adolescence, is in effect play, but using thoughts instead of concrete objects. This differs from its use in the analytic setting, where the fundamental rule subjects the analysand's associations to the laws of psychoanalytic process and conflict. Enactment, on the other hand, represents a retreat from the exclusivity of the adult free associative process; the activity mode inherent in play is again enlisted to represent fantasy that could not be adequately accessed through the free associative process alone.

Mahon then presented clinical material, starting with the case of Adam, a little boy who came to treatment after having apparently unprovoked outbursts of aggression toward peers at school. There had been one unfortunate episode at home with a housekeeper, but otherwise the concerned, mature and intelligent parents could not think of any explanation. He began with a session several months into the analysis, when the child ran in and sat in the analyst's chair,

indicating his wish/need to be in charge. He told the analyst a "joke:" *Why did the chicken steal the bagpipes? Because he wanted to have a perfect house*. This turned out to come from a dream that the child was playing with in a waking state. Using clay, Adam created bagpipes that looked like a scrotum and phallus. This material and the child's subsequent behavior (tearing the bagpipes and later a clay elephant apart), demonstrated his wish to take over his father's power and authority, while reassuring himself that his mother would still love him. The wish to castrate, and the anxious wish to undo it, took center stage. As these issues were gradually dealt with, Adam's behavior improved, and he made many friends. As Mahon put it, he became "a reformed larcenist," on entering latency, when this phase of his treatment ended.

The next phase of Adam's analysis began with the death of his grandfather. Adam had written to the analyst a few times in the interim, telling him how he missed their interactions, and his grief over the loss of his grandfather prompted even more communications. His parents then encouraged him to resume the analysis, even though Adam had felt he should work things out on his own. He described a kind of "academic ennui," which covered deeper feelings of shattered self-esteem. His sense that his teacher favored the work of other classmates, resulting in his academic slump, seemed to be a projection of his own need to be self-critical. When this was pointed out, Adam described the interior of his mind as "a kind of Supreme Court ruled by a triumvirate — one severe and unrelenting, the second empathic and fair, and the third, instead of being cruel to himself like Boss One, was cruel to others. He noted ruefully that One and Three usually worked together, but he wished that he could be rid of both of them and be guided by Boss Two alone. Mahon marveled at Adam's ability to describe a superego system of such complexity, and at his seemingly endless enjoyment of the process. Adam worked with language as he previously had with props and toys, and he watched the unfolding of his unconscious mind in the analysis with excitement and delight.

One dream stood out: "I am in a grungy room, with peeling paint, in a motel called the Sands of Time. There is a centipede in the bedclothes. I try to smash it." His associations were to seeing a centipede on the wall when he was five, and calling his father to help him. Then he moved to current associations: a friend teasing him with a rubber snake, like a centipede with jaws. Perhaps Boss

One wanted Adam to feel that it was his own temper and cockiness that brought down wrath on his head.

Later dreams related to a nuclear power plant, and Hitler and Mussolini dividing up the spoils of Italy, these two being obvious stand-ins for Boss One. Another dream had him being chased around by a large number six, which he connected with the word "sex," and described his recoiling at the idea of the bloody mess of childbirth, and his misunderstanding of menstruation as "peeing blood." (He was greatly relieved when his father explained the processes accurately to him.) Here Adam also revisited the dream about the chicken and the bagpipes: If Boss One insisted that dirty sexual stuff has no place in an American mind (a perfect house), then he would have to hire a chicken to steal the dirty stuff (bagpipes) and make off with it in order to keep the house picture perfect.

As the analytic process proceeded, Adam continually demonstrated his capacity to play with the language of his dreams and free associations. He would even banter with his analyst, at times calling him on what Mahon admitted might his own philosophical pedantry: "Oh, so you mean it could be a dream within a dream, and what's happening right now might not be happening at all?"Adam was hereby demonstrating his newfound comfort with aggression, which he could express with humor and a sublimated level of pleasure. He is a fine example of the ways in which a young adolescent is capable of developing his Piagetian formal cognition.

The final section of the presentation was composed of moments from the analysis of Etienne, an adult in his fifties. He was a man of many talents — an artist, accomplished violinist, and a physicist, who had received many honors but became depressed whenever another was bestowed upon him. He had noticed this pattern — becoming depressed instead of feeling elated and satisfied. His mother was a successful, highly esteemed librarian in Paris; his father had been a heroic resistance fighter during the Vichy regime, but became seriously depressed and dysfunctional soon after the war ended. His beloved father's transformation into an empty shell of his former self was emotionally devastating for Etienne. As a small boy, he was very anxious about his aggressive feelings towards his father, as well as guilty when he enjoyed having his mother to himself. He could not allow himself to show any interest in the analyst, let alone curiosity about his life, as this aroused enormous anxiety. Mahon thought that Etienne needed to keep his analyst as unresponsive as his

father became after his emotional collapse. It was in this context that a significant enactment emerged.

When Etienne was offered a significant academic post at a major American university, he took it, despite his profound attachment to France, but decided with his wife to buy a cottage in the south of France so as to maintain a foothold in their homeland. This was the outcome of much analytic work around mourning the father he had loved, and accepting the empty shell he had become, while acknowledging that uncovering these sorrows did not undo them.

Etienne had a recurring fantasy related to *The Count of Monte-Cristo*, which he had read and loved as an adolescent, both the novel, and the numerous film renditions that followed. He focused especially on the old priest, who laboriously digs himself out of his cell only to find himself in that of Edmond Dantès, rather than on his way to freedom. But the two man become friends and work together to escape the Chateau d'If. The priest teaches Dantès swordplay and educates him in philosophy. Before his death, he tells Dantès where the treasure of Monte-Cristo is located, and Dantès takes the place of the abbé in the body bag that was to hold his corpse. Etienne imagined himself as occupying the dead body of his father, now restored to health and accompanying him over the years as he grew up.

Even after long periods of intense analytic work, Etienne began to feel that he would never get to the core of his problems, which seemed almost beyond words. Buying the cottage in France had seemed like it might help in this regard, and this in turn evoked a significant memory. As a young boy in Paris, Etienne and his schoolmates daily passed by a famous bronze statue of Montaigne. They superstitiously believed that rubbing the right shoe of the statue would bring them luck in their examinations. When Etienne did this, he would imagine that the statue was actually alive. In his new cottage, he suddenly realized that he could make a terra cotta replica of the Montaigne statue for his living room. On its completion, he affixed to its base the quotation: "I portray the passage." [1] He also remembered another saying from Montaigne that he felt described the analysis: "The world always looks straight ahead; as for me, I

[1] The quotation continues: "not a passing from one age to another […] but from day to day, from minute to minute."

turn my gaze inward …I take stock of myself, I taste myself …I roll about in myself." He used the term "enactment" (without realizing its current significance in psychoanalytic theory) to describe his sense that it was designed to fill in the space in his psyche left by his father's catastrophic depression and decline. The house and statue now represented, in fantasy, his father not only restored to health, but also able to absorb and even cherish his son's necessary Oedipal aggression.

Later in the treatment, when asked about connections between the Monte-Cristo fantasy and the Montaigne enactment, Etienne said: "I suppose they are the same. I did not know how to grieve my father when he died because he did not die biologically. He had died emotionally, and I did not know how to conceptualize such a death …I wanted my father to overcome the emotional disability that took him away from me as a child …It remained an unknown fantasy until I sculpted a statue of Montaigne and placed it in my home. I was bringing my errant father home without realizing it."

Later, after the treatment ended, the analyst heard from Etienne that the uncanny significance of the statue seemed to be receding. His fantasy of the resurrected healthy father now had to coexist with the knowledge and acceptance of his father's chronic disability.

In his summing up, Mahon was struck by the pre-adolescent Adam's newfound capacity to free associate, and how it enabled him to build upon his earlier progress. Mahon described it as a "marvel of introspective verbal gymnastics," compared to his earlier play. It is his capacity to let thoughts play with each other, exposing the depths of unconscious fantasies. Little Adam's dream and his joke about the larcenous chicken represents the unconscious fantasy of stealing the equipment of his father or analyst; eventually, the older boy can explore these issues in language, once the work of analysis has enabled him to be more comfortable with transgressive wishes. Psychoanalysis can itself be seen as a long period of trial thought expressed in free associations, eventually facilitating mature self-enhancing action, while repudiating self-destructive behaviors. Adam moved from displacement in play to displacement in the transference, where he was able to work through issues in language.

Freud saw play as a bearer of fantasy; Mahon sees it, in addition, as the tester of fantasy. Play puts fantasy through its paces and enables the player to critique its meaning and its outcome.

Etienne's work in analysis was almost exclusively a free associative process, during which he unearthed his pathological identification with his seriously depressed father, as a result of which he was unable to celebrate his own successes rather than sabotage them. Something always seemed to be missing, as if "the words had not gotten to the roots." By identifying with his defeated father, Etienne had resolved his Oedipus complex in a neurotic way that did not allow him to embrace his accomplishments without being punished by his sadistic superego. An enactment emerged in a form akin to play, in which the props (the house, the statue) became essential elements. As a small child Etienne had shown considerable technical, artistic and intellectual abilities (manifested in his skillful and elaborate building with blocks), autonomous ego functions that were soon interfered with by his neurosis. But now these abilities could be brought into the service of the enactment to resolve the remaining analytic stalemate.

After the enactment had dredged up the depths that could not be reached in any other way, the content of that enactment now became the property of an insightful, free associative, playful process, which thereby further enlightened his mind. Thus, enactments can enrich psychoanalytic process when their unconscious urgencies are understood, so that they can enter the conscious mainstream and momentum of free associative working through.

BOOK REVIEW

Different Patients, Different Therapies: Optimizing Treatment using Differential Psychotherapeutics. Deborah L. Cabaniss and Yael Holoshitz. London and New York: Norton, 2019.

This book performs a valuable function by bringing together many modalities of psychotherapy from a continuously evolving field. It is a kind of "super glue" for the various psychotherapeutic frameworks, serving as a potential guide for both beginning students and seasoned practitioners, when faced with the bewildering array of choices in the field. These choices vary along multiple dimensions, which include: the training and inclination of the therapist; the preferences of the patient; the patient's needs as self-assessed and assessed by the clinician; and research-derived evidence. "Differential Psychotherapeutics" (DP) is the term the authors coined to describe a systematic way of thinking about what patients need. It entails a four-step process: learning, thinking, matching, and discussing. The DP rubric enables the clinician to compare multiple ways to think about and treat patients, starting with the question, "What kinds of treatments might help this patient?" rather than, "Is this patient right for such-and-such kind of psychotherapy?"

In the first part of the book, the authors point out that a learning process occurs from the outset of a consultation right through the last session of treatment. They observe how different therapists learn about their patients through the lenses of the various frameworks within which they think and work. The reader is guided through the essential information to be gathered, as well as how to think about setting the frame, inquiring about current issues and life events, and identifying patients' internal and external resources. The authors go on to describe the process of "thinking" during the initial sessions, with respect to what is wrong from the patient's point of view, why it is happening, and what needs to change. In short, they underscore that it is essential to engage patients by focusing on problems the patients themselves recognize. Next comes "matching," a two-step process whereby the therapist pairs what they think is wrong and what needs to change with possible treatments, in an ongoing conversation with the patient. The aim is to prioritize options by considering the overriding importance of safety, patient goals, and internal and external resources. The final step of the DP process is "discussing,"

which entails co-constructing a treatment plan with the patient. The DP rubric can be applied at various points throughout the treatment.

In Part II, the authors describe twenty-three types of psychotherapies, using the DP rubric. These include: cognitive and behavioral therapies; psychodynamic and supportive therapies; interpersonal therapies; family therapies; and value-based and strength-based therapies. The authors provide glimpses into how therapists who practice within these frameworks think, in terms of the DP rubric. For example, the chapter on "Psychodynamic and Supportive Therapies" begins with key concepts, followed by some brief background. They describe how a psychodynamic therapist learns about a patient, thinks about what might be wrong, why it is happening, what needs to change, and what resources are available. In the matching stage they delineate reasons why a therapist may recommend this treatment and how it might be helpful for particular issues, as well as a good match for a particular type of person. This section of the book is both wide-ranging and well-organized, in a framework that can accommodate high levels of complexity without overwhelming the reader.

I particularly valued Part III: "Differential Psychotherapeutics in Practice." It is rich with lively clinical vignettes, written by residents and recent graduates taught by the authors. Each vignette illustrates an overarching issue, which is then discussed by three experts who practice in different modalities, using the DP rubric. The topics include: substance abuse; depression; obsessions and compulsions; parenting; psychosis; depression and medical illness; trauma; panic; late life depression and grief; affect dysregulation; postpartum depression; and low self-esteem. The authors walk the reader through the whole DP process, providing a platform from which to dive into various treatment options. For example, in a case of postpartum depression, Ruth Graver applies a psychodynamic framework, using the rubric to discuss what she learns from the vignette, what appears to be wrong, why she thinks it is happening, what needs to change, and what resources are or are not available. She then discusses her thinking about what treatments she would recommend ("matching") and concludes with a verbatim example of how she would discuss her thoughts with the patient. The section ends with Graver's estimation of how the treatment might go. There are two further discussions of this same case of postpartum depression, by experts in CBT and in Interpersonal Psychotherapy respectively, who in turn recommend

different treatment matches. The reader learns that there is never a single right answer; rather, they are taught *how* to think instead of *what* to think about the treatment approach.

By encouraging dialogue among differently trained practitioners, this book should have an integrative effect on the field. It also makes treatment choice more accessible, in ways that may increase the confidence of newer therapists by demystifying the expertise of their more seasoned colleagues. In my first year of psychology training, my cohort watched the classic 1965 film, *Three Approaches to Psychotherapy* (which became famous as the "Gloria" films). We saw a real patient, Gloria, meeting for a first session with three therapists who had founded three different therapy models: Carl Rogers (Person-Centered) was unwaveringly supportive; Fritz Perls (Gestalt) was unwaveringly confrontational; and Albert Ellis (Rational-Emotive Behavior Therapy) was unwaveringly rational. The road clearly forked in three different directions. In the end, Gloria chose Fritz Perls, the one who seemed to be giving her the hardest time. Some of us would have made the same choice, others would have had different preferences. The exercise was thought-provoking, but the process was not systematically spelled out. This book fills in that gap.

Different Patients, Different Therapies: Optimizing Treatment Using Different Psychotherapeutics is noteworthy for its comprehensive scope and up to date perspective, buttressed by systematic research. The authors also manifest a striking respect for the patient, whom they call the "therapist's best supervisor." For both confused beginners and experienced practitioners, undertaking the demanding task set out in this volume will prove richly rewarding. It is a valuable therapeutic resource. As for myself, it will be ready on hand in my office, and will find its way into the syllabuses of the courses that I teach.

Jillian Stile

IN MEMORIAM

Richard C. Friedman

With great sadness, the Association for Psychoanalytic Medicine mourns the passing of one of our most admired members, Richard Friedman. Richard was a graduate analyst of the Center and an internationally recognized contributor to psychiatry and psychoanalysis in the field of sexuality.

A respected teacher and beloved colleague at the Center and the APM, and a leader in the American Academy of Psychoanalysis and Dynamic Psychotherapy, Richard shared his sparkle and creativity with us over many years, and he will be sorely missed. We reprint below the announcement sent out on behalf of the Center by its director, Dr. Susan Vaughan.

I am sad to report that Richard C. Friedman died on Tuesday, March 31, in New York City, from complications related to on-going health issues (not COVID-19 related).

An academic psychiatrist, professor, and researcher, Rick first studied at Bard Colleg,e and received his MD from the University of Rochester in 1966. He completed his psychiatric residency at Columbia University, and then spent two years with the US Army Medical Corps in the psychiatric department of William Beaumont Army Medical Center in El Paso, Texas. Rick held three appointments: as a Clinical Professor of Psychiatry at Cornell; as a faculty member of the Columbia University Center for Psychoanalytic Training and Research; and as a Research Professor at the Derner School at Adelphi University.

Rick was always interested in academic medicine and psychiatry, beginning with his early paper on sleep deprivation in interns and its consequences for performance (written with J T Bigger and Don Kornfeld and published in 1971). However, Rick went on to make sexuality, homosexuality and gender his primary areas of academic interest and productivity. He was the lead Editor of *Sex Differences in Behavior* (Wiley, 1974) just when the field was beginning. He served as a member of the Psychosexual Disorders DSM-III Advisory Committee (DSM-III, 1980), which helped

him expand his interests in sexual behavior, endocrinology, and neurobiology. He also published on behavior and the menstrual cycle (1982) and served as an editor for a volume on new perspectives on sexuality (1985), in which he addressed sex roles and sexual disorders in women.

In 1988, Rick published his ground-breaking volume *Male Homosexuality: A Contemporary Psychoanalytic Perspective*. He was the first to combine recent findings in psychobiology, gender identity, and family studies with psychoanalytic theory, challenging the Freudian theory of the Oedipus complex. He noted that erotic desire for the opposite-sex parent was not universal and that homosexuality was not a symptomatic response to unconscious fears of heterosexuality. Friedman concluded that homosexuality was not pathological, and therefore should not be treated as a condition to be cured. The book had a major impact on the field and led to significant changes in the way psychoanalysts and psychotherapists understand and treat gay patients.

Rick often talked and wrote about wanting to inform the psychoanalytic community about "non-analytic" research, as a way of getting people to rethink many issues. There were, of course, some in the LGBTQ community who found his approach to be biologically reductive, but it was still a much-needed corrective to traditional psychoanalytic explanations. Part of his aim was to look at ways of updating psychoanalytic theory using neighboring disciplines. Arguing that sexual desire begins somewhere between the ages of 5 and 10, later than Freud believed, Friedman reasoned that it is not primarily directed at either parent.

Rick frequently collaborated with Jennifer I. Downey, also a Center faculty member, on papers and books such as: *Masculinity and Sexuality: Selected Topics in the Psychology of Men* (1999), and *Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice* (2002); its second edition was published in 2008, and titled *Sexual Orientation and Psychodynamic Psychotherapy: Sexual Science and Clinical Practice*. Friedman and Downey were both deeply involved with the American Academy of Psychoanalysis and Dynamic Psychiatry, with Rick serving as editor of its journal, *Psychodynamic Psychiatry*, up to the time of his death. In addition, Rick was a member of the International Academy of Sex Research and on the editorial board of the *Archives*, its journal.

A psychiatrist and psychoanalyst who practiced for decades on the Upper West Side of Manhattan, Rick will be missed by his many patients, students, research colleagues, and the psychiatric and psychoanalytic community.

He is survived by his wife, Sue Matorin, LCSW, a social worker at Weill-Cornell, and their son, Jeremiah Friedman.

Susan C. Vaughan, M.D.
Director, Columbia University Center for Psychoanalytic Training and Research

Our Tribute to Richard

Sue Matorin and Jeremiah S. Friedman

Our family is deeply appreciative of this opportunity to celebrate Richard's work and his contributions to the field he loved. Because we have been unable to gather for a traditional memorial during the on-going public health crisis, we have cherished the many heartfelt notes and messages we have received, as well as the postings on the various listservs and academic bulletins that Richard followed throughout his professional life. This tribute, however, is especially meaningful, given Richard's long association with Columbia, an institution he supported and held in deep regard until his death.

Richard was private by nature, especially as regards the many health challenges he faced since his triple-bypass surgery at the age of forty-seven. Through it all, he soldiered on with grace and courage, maintaining a demanding clinical practice dedicated to the care of complex patients, and pursuing his scholarly work with diligence and intensity. Briefly hospitalized in early March, he had returned home and was once again preparing to head back to work at the time of his death. Especially when so many were dying alone in hospitals, we are so thankful that he passed away quickly and peacefully in his own home, secure with family love.

In recent years, Richard had planned for me to inform his patients "in the event" (in part because I am a clinician myself, but also intuiting that I could serve as a link to him as they processed the content of my call). However, I was rather unprepared for the extraordinary nature of these conversations. In call after call, patients poured out their stories of what brought them to his consulting room and how his treatment had transformed — and in many cases saved — their lives. There were narratives of career upheavals, personal tragedies, painful marriages and divorces, devastating illnesses — illnesses Richard had often been the first to diagnose. (Though whole-heartedly committed to psychoanalysis, Richard always identified first and foremost as a physician). Confidentiality precludes my expanding here, but Andrew Soloman's riveting portrayal of their therapy for the *New Yorker* (available online) educated the public about the intricacies of dynamic treatment and the richness of

a long-term therapeutic relationship. In detailing his own experience, Andrew captured Richard's acute diagnostic skill, his gems of wisdom, his capacity to challenge and push a patient through crippling symptoms, and most of all, his unfailing humanity. For a visit to Richard's office might also include a discussion of classical music, or growing up in the Bronx, or, more likely than not, the flailing New York Knicks. While of course well versed in the analytic tradition, Richard was unafraid to break with it when clinically appropriate — by bring pizza to one anxious young patient's college dorm; attending another's wedding; or joyfully becoming godfather to a former patient's son. It was this insistence on relating to patients as multidimensional human beings that was truly the foundation of his practice. This capacity to transform a life was repeated to me by many others, as patients expressed grief that they could no longer ask him questions or turn to him for advice, and insisted that he was "more than a psychiatrist" but also a "mentor," or in one case, "part of my family." Richard always maintained boundaries, and only shared a personal item by design when clinically appropriate, but I believe patients could intuit a life that was textured and complex.

Richard loved taking care of patients, but his identity was that of a scholar. His office, with its floor-to-ceiling bookcases, and journals and drafts of papers on the desk, reflected that. No one has captured that identity more eloquently than his frequent collaborator, Dr. Jennifer Downey. Their intellectual partnership produced ground-breaking contributions to the field of sex and gender, all well known to this community. Since his death, Jennifer has written eloquently, beautifully, and meticulously about Richard's scholarly work. She has traced the full arc of his career from his early, seminal work on sleep deprivation to his maverick scholarship revising psychoanalytic views about homosexuality. As editor-in-chief of the Academy's journal, *Psychodynamic Psychiatry*, Richard was a staunch advocate for the richness of the biopsychosocial frame, and a champion of psychodynamic psychiatry as model of practice for this generation of clinicians. He leaves the journal in the very capable hands of Drs. Downey and Cesar Alfonso. He was a gifted teacher, and in addition to the many colleagues who benefitted from his writings, I have heard from scores of former students who treasure his teaching and mentorship.

Richard possessed an intimidating intellect and a sometimes aloof self-presentation, as he himself acknowledged, but when he

let his guard down he was warm, loyal and generous, nurturing lifelong friendships from his days at the Bronx High School of Science, and displaying a sharp sense of humor best shared with his brother, Daniel, and our son, Jeremiah. He was an accomplished pianist, performing concertos on a day's notice in high school and he also played the accordion at weddings to earn money in medical school. He was a student of history who loved the Constitution, and this past winter predicted the civil violence consuming our nation. Richard often reminisced that he started his first book when Jeremiah was a baby by his feet, and that he was his first writing partner. He chuckled that our son too married a "licensed clinical social worker," just as he had. He was only able to travel to California and meet his grandson, Theo Dylan, once before his death, but he took immense joy in the close bond he formed with his four-year-old granddaughter, Tess. He had the highest respect for our son's choice of screenwriting as a career, and was irritated at any suggestion that he had hoped to be followed into medicine.

It is no surprise that one patient, who had been struggling in a horribly conflicted marriage and, with enormous guilt, was thinking about pursuing a healthier relationship, noted that at a session's end, Richard had advised: "Always make room for love in your life." It is a piece of clinical insight that might well serve us all, particularly in these challenging times. And a fitting motto for the remarkable analyst, husband and father who transformed us with his love and support.

Editorial: Contributions to Psychoanalysis and Psychodynamic Psychiatry by Richard C. Friedman (1941–2020)

Jennifer I. Downey

As Interim Editor of *Psychodynamic Psychiatry*, I have the honor to comment on Richard C. Friedman's extraordinary career. At the time of his death in late March of this year, Richard C. Friedman (RCF) had been Editor of the *Journal of the American Academy of Psychodynamic Psychiatry and Psychoanalysis* for eight years. During that time, the journal was renamed *Psychodynamic Psychiatry* and became the first English-language journal in the world about psychodynamic psychiatry. At the time of his death, Dr. Friedman was Clinical Professor of Psychiatry at Weill-Cornell School of Medicine and Lecturer in Psychiatry at the Columbia University College of Physicians & Surgeons. He was also on the faculty of the Columbia Center for Psychoanalytic Training and Research and Research Professor at the Derner School of Adelphi University.

RCF was a curious, vigorously intellectual man, filled with ideas for new projects, new questions to answer in psychiatry, always on the lookout for new work that would be of importance to the *Psychodynamic Psychiatry* community. He was a gifted clinician, whose clinical work is vividly described by a patient with whom he worked for 25 years in a recent *New Yorker* article, "Obituary for the Analyst: Richard C. Friedman and the Quelling of My Depression" (Solomon, 2020).

RCF was also a charismatic teacher who could explain psychodynamic concepts with clarity and simplicity. I hope that at the panel on RCF's work that the Academy will hold at a future annual meeting, we'll have a chance to discuss his teaching about human sexual behavior and pathology, which was extraordinary.

During his professional career, RCF published two authored books, six edited books, and over 117 papers and chapters. The exact number is unknown since he had not revised his CV for a couple of years. He

Jennifer I. Downey, MD, Interim Editor

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was an internationally renowned researcher in sex and gender and a member of the DSM-III Advisory Committee for Psychosexual Disorders. In 2009, he received the coveted Mary S. Sigourney Award in recognition of distinguished contributions to psychoanalysis.

My goal here is not to describe RCF in all his facets, but to discuss the *arc of his thought*. In order to do this, I'm going to select some of what I judge to be his most important contributions.

In 1976, RCF and I met for the first time when he interviewed me for a position in the Psychiatric Residency Training Program at Columbia University. In medical school, I had done independent research on sex and gender in children with congenital adrenal hyperplasia. He was the first person I had ever met who understood my work. By the end of this interview, I saw that we shared the same preoccupation: What makes people heterosexual? Or homosexual? And what determines the many different ways people feel and act sexually? Neither of us favored the question of what makes people homosexual, a question that had its day in the 1990s most recently when neuroscientists tackled it (psychoanalysts had argued the etiology of homosexuality over many previous decades). To us, it didn't seem obvious what determined *any* kind of sexual orientation.

When I came to Columbia as a resident, I was eager to see RCF again, but he had moved away. We next met in 1990 when he invited me to join the Academy's Research Committee. In 1993, we published our first paper together, "Neurobiology and Sexual Orientation: Current Relationships." Together, we wrote about sex and gender for 24 years.

That said, I think RCF made two huge contributions to psychiatry before I ever knew him. Newly graduated from the psychiatric residency at Columbia and a Major in the US Army, while medical director of a 100-bed psychiatric facility for soldiers in El Paso, Texas, RCF published "The Intern and Sleep Loss" in the *New England Journal of Medicine* (Friedman, Bigger, & Kornfeld, 1971). This was the first paper ever published on the effects of sleep deprivation on physicians' performance. Friedman and colleagues studied the performance of interns in sleep-deprived and rested states performing the task of reading a long and varied electrocardiogram. Sleep-deprived interns made significantly more errors, took a longer time to perform the task, and reported more dysphoric feelings and cognitive, perceptual, and physiological symptoms. This unique study lent powerful support when residency programs years later reconsidered trainees' hours and reconfigured schedules for resident physicians. It is almost always the first reference in any article about effects of sleep deprivation on physicians' performance.

Although this study has nothing specifically psychodynamic about it, it demonstrates many qualities that would characterize RCF's later work. The study was focused. The findings were dramatic. The report was succinct. Perhaps most striking was his ability to look beyond establishment thinking ("interns should work long hours because they will learn more" and residents could be on call in those days for 60 hours without sleep), and ask a new question: What results from the sleep deprivation physicians experience during training? His thinking was unconventional. He was willing to challenge established practice. Lastly, he did this with facts. He performed a scientific experiment.

Although RCF was quite radical in his thinking and would confront authority, I never thought of him as an activist. An activist argues with passionate reasoning. Rick always argued from the available facts. He deeply researched the background of every question he took up. Then he made his best, rational argument. He also stated what information was missing and what questions the field still had to answer.

Because he used the scientific method, a tool of the medical establishment, people heard him differently. He had a chance to speak and convince where others might not have been heard. While not an activist in the usual sense, RCF was an idealist. He chose the issues he took on not just because they interested him but because he felt that they were important for the field and for patients. He believed that medicine and psychiatry needed to operate using the best information currently available. He believed that there was a human cost when doctors had incorrect information, and that patients suffered. He was horrified by the harm organized psychoanalysis had done to homosexual individuals by attempting vainly to convert them to heterosexuality. The way psychoanalytic thinkers had layered their ideas over Freud's, rarely criticizing or "taking off the table" his incorrect theories, was anathema to him. He felt trainees in psychoanalysis were taught the "archeological approach," in which layers of theory had to be deciphered and nothing was deemed to be incorrect. He wanted to fix that.

In the 1970s, RCF was lead editor of the volume *Sex Differences in Behavior* (Friedman, Richart, & Van de Wiele, 1974) just as the field began to take off. As a young faculty member at Columbia, he researched male identical twins who were discordant for sexual orientation and reported on hormone levels in gay and straight men. With others in the 1970s and 1980s, he wrote a series of papers about depression, suicide, and the menstrual cycle.

In 1988 came another major milestone. RCF published the groundbreaking *Male Homosexuality: A Contemporary Psychoanalytic Perspective*. The late 1980s were the time when important scholarship about

gay men was first published—RCF's book in 1988, Richard Isay's *Being Homosexual: Gay Men and Their Development* (1989), and Kenneth Lewes's *The Psychoanalytic Theory of Male Homosexuality* (1988). RCF did not have access to Isay's or Lewes's work for reference. No matter. RCF's *Male Homosexuality* was strikingly original.

The book began with a section on biopsychosocial research and male homosexuality. Noting that there was no accepted definition of homosexuality (and none of heterosexuality), RCF observed that there are four elements of sexual orientation—sexual fantasy, sexual behavior, self-identity, and social role (the public presentation of oneself as gay). In this working definition, sexual fantasies are conceptualized as *conscious*.

RCF brought the area of sexual orientation up to date by reviewing the research on gender, observing that the concept of gender had not been distinguished from sex in Freud's day and that as a result, Freud's writing conflated the two. Here also was a review of Freud's work, especially the *Three Essays* (1905).

RCF discussed the major psychological studies on large groups of homosexual individuals that had been published to date. He also reviewed the only psychoanalytic research study ever done on male homosexuality (Bieber et al., 1962), which concluded that family dynamics set the stage for the development of a young boy's homosexual orientation. RCF disagreed with that study and noted that a contemporary re-evaluation of psychoanalytic models and mechanisms in male homosexuality was needed, as was an overall update of psychoanalytic theory. Nonetheless, he considered Irving Bieber a personal friend and gave a eulogy at his funeral.

Part II of *Male Homosexuality* addressed psychopathology and sexual orientation in men. RCF argued that degree of heterosexual versus homosexual orientation (as described by the Kinsey scale presenting sexual orientation on a spectrum from 0 "completely heterosexual" to 6 "completely homosexual") varied *independently* from level of character organization (Kernberg, 1984) and degree of psychopathology. Chapters contrasted the meticulously described cases of men with the same levels of character pathology but who differed in sexual orientation. RCF was saying that psychopathology is on a different developmental track from sexual orientation. He took the position that *male homosexuality was not the result of psychopathology.* The field of psychoanalysis had not given up this idea, despite changes by psychiatrists in the DSM-III (American Psychiatric Association, 1980) when ego-syntonic homosexuality was removed from the manual (ego-dystonic homosexuality was retained). RCF said that healthy men both gay and straight could be found and that these men were not in the purview of mental

health professionals because such men had never had reason to seek treatment.

RCF was a careful reader of Freud and the work of subsequent psychoanalytic theorists. He devoted a chapter to discussing the Schreber case (Freud, 1911) and why it dd not effectively make the case that paranoid psychodynamics are at the root of homosexuality in men. At the end, he wrote,

> The contemporary clinician no longer need consider why homosexual men are paranoid, since there is no evidence that they generally are. It now must be asked why homosexual males are not more often paranoid, Homosexuality begins in childhood, and many gay people grow up in environments that are virulently homophobic and sexist. One might expect that as a result of exposure to hostile, severely stressful interpersonal environments, homosexual males would tend to develop paranoid psychopathology. Since this does not occur with unusual frequency, we must ask whether unusually adept coping mechanisms coexist with homosexuality in many individuals. (p. 179)

This section of the book contained a number of radical departures from traditional psychoanalytic thinking. RCF 1) discarded the notion of paranoid psychopathology or any psychopathology as a common cause of homosexual sexual orientation; 2) discarded the notion that "constitutional bisexuality" is present in all individuals; and 3) argued that bisexuality is not a symptom of identity diffusion and borderline syndromes but rather ordinarily occurs independently from other character traits.

RCF always noted that each individual case had to be considered on its own merits. One could find individual instances, for instance, where borderline men experienced identity diffusion in the sexual sphere, but these instances did not prove to be a pattern that explained the behavior of the many. More than once in the book he said, areas of thought had not been thoroughly researched and that the psychoanalytic community needed to pay attention to the people who did not fit into the theory and try to understand them better (e.g., p. 257).

In Part III, RCF discussed development—both in childhood and adolescence—of the sexuality of boys. He noted that in most boys, sexual fantasies are in place by early puberty and in the large majority, these fantasies are fixed for life. The sexual fantasies take on autonomy and are a fixed part of the personality, "irreducible." Thus, he argued that the concept of "sexual preference" does not apply to the majority of males, though some men, mostly bisexual, may have more behavioral options.

RCF also noted the frequency of what he called "gender disturbance" in the development of some pre-gay boys. By this, he was not referring to effeminacy or to any kind of disorder but rather to the feeling of being *inadequately masculine* in childhood. He noted that while the feeling of being inadequately masculine was often observed in gay youth, adult gay men usually consolidated a secure sense of masculinity. They solved the problem developmentally. RCF said that gay men *remember* feeling unmasculine as boys. He was not saying that they were.

In the last part of the book, RCF discussed theoretical issues. What did it mean that nearly always individuals form a definite sense of gender before differentiation of their sexual fantasies takes place? If these fantasies become settled and the rest of the personality can continue to grow and develop no matter what the gender of the fantasied object, then the psychoanalyst could conceptualize a developmental track that is healthy for homosexual men. RCF reviewed the reports that a few men had changed their sexual orientation from homosexual to heterosexual while in psychotherapy. He noted that nearly always the individuals who could do this had some pre-existing bisexual predisposition, and that frequently homosexual fantasies persisted.

Male Homosexuality had been a book about the development of homosexual orientation and sought to put contemporary psychodynamic theory about it on a strong scientific foundation. In the early 1990s RCF and I started to present these ideas more widely. Sometimes when we spoke at ordinarily sedate events, psychoanalysts screamed from the audience. In 1994 when we published "Homosexuality," an invited review in the *New England Journal of Medicine*, we subsequently received a large packet of letters from the Journal with the cryptic note, "We didn't think these needed a reply." Much to our surprise, the letters were predominantly hate mail from academic professors of medicine. At the same time, trainees were telling us it was obvious and inarguable that sexual orientation was biologically caused. They didn't see why this needed to be taught! The field was divided on this point, depending partly on the era when training had been received. The psychoanalytic community and some of the older medical community had not caught up.

Later in the decade, RCF and I wrote more about the *treatment* of homosexual individuals. To this day, one of our most referenced articles is his first-authored article, "Internalized Homophobia and the Negative Therapeutic Reaction in Homosexual Men" (1995), which appeared in the *Journal of the American Academy of Psychoanalysis*. A. K. Malyon in 1982 had discussed "internalized homophobia" in gay men, noting that children who will become gay adults are raised ordinarily in heterosexist and homophobic settings. We reasoned that this experience could be

traumatic and lead to *internalization of negative attitudes* affecting identity formation, self-esteem, the elaboration of defenses, patterns of cognition, psychological integrity, and object relations.

The first paper we wrote on this phenomenon, mentioned above, discussed the onset of internalized homophobia not only in early but also in late childhood. Internalized homophobia could occur in individuals whose earlier developmental tracks were quite healthy as well as in individuals who had suffered abuse and neglect in early childhood and suffered from lifelong self-hatred. We said the treatment of these two groups needed to be different. In general, individuals with symptoms of internalized homophobia need careful diagnostic assessment to identify any Axis I and Axis II disorders that require treatment. Supportive psychotherapy, such as what is called "gay-affirmative" psychotherapy, helps many patients. In that paper, we discussed the assessment and treatment of individuals who *get worse* from gay-affirmative psychotherapy, that is, develop the "negative therapeutic reaction" Freud talked about. The paper discussed the assessment and treatment of these individuals. That article may be found in the book of our collected papers, *Sexual Orientation and Psychoanalysis: Sexual Science and Clinical Practice*, Columbia, 2002 (reissued in 2008 as *Sexual Orientation and Psychodynamic Psychotherapy*). There are many more chapters in the book on the treatment of internalized homophobia.

In the 2000s, the volume mentioned above was published. The first half of the book addressed theoretical and developmental issues in sexual orientation. The second half discussed clinical work, all with non-heterosexual men and women. To this day, of all our papers, the one that is the most read and referenced is "Psychoanalysis and Sexual Fantasies," which was first published in the *Archives of Sexual Behavior* (2000) and appeared as the first chapter in the book. In that paper, RCF and I started by discussing the ways in which psychoanalysis failed to explain the differences in sexual experiences between genders. Take a concept as basic as erotic fantasy. Psychoanalysis had no definition of this because of Freud's tendency to blur the distinction between sexual and other "libidinal" experiences. We made the distinction between unconscious sexual fantasy and conscious sexual fantasy and said that sexual fantasies, the conscious kind that are embedded in sexual feelings, depend in both sexes on adequate androgen levels. We made a distinction between men's and women's sexual fantasies and said that sexual fantasies are best understood by considering them as gender-specific. Thus, males' sexual fantasies differ considerably from those of females.

The paper summarized a number of errors in Freud's ideas about sexuality. He never considered prenatal hormonal effects, only pubertal

ones. He reasoned that the Oedipus complex universally organizes sexual behavior, while we wrote that the Oedipus complex is not universally found in individuals and does not necessarily organize their behavior. We also wrote that we do not believe that constitutional bisexuality is present in all people.

We then briefly wrote about the two dimensions of men's sexual fantasy—1) orienting sexual fantasy (that is, what gender of object arouses the individual); and 2) what specific situations arouse the individual male. This "sex script" tends to be stable for the individual male from puberty on.

We discussed female sexual fantasy in much more detail. Generally, sexual fantasy in women is more complex. Men always know when they are aroused—they feel excited, have an erection, feel the urgent need for orgasm. Women, on the other hand, may show objective signs of sexual arousal while subjectively not feeling sexually excited. RCF and I concluded that sexual arousal in women should be defined *subjectively*—a woman must *feel* aroused no matter what the laboratory measurements of arousal show.

We discussed the *cyclicity* of sexual fantasies in many women of reproductive age. A carefully done study by a psychoanalyst, T. Benedek, and a gynecologist, B. B. Rubenstein, had reported that women's dreams varied according to the phase of their menstrual cycle (1942). Early in the cycle, the women reported dreams of sexual stimulation, whereas after ovulation their reported dreams turned more to procreational aspects of sexuality. We speculated that erotic fantasy is much more closely linked to procreative fantasies in women than men. Thus, women probably find fantasies of becoming pregnant more exciting than men do.

We also noted that women's sexual fantasies seem to be more "plastic" than men's. There is a subset of women who develop homosexual fantasies while in female-dominated environments (such as women's schools) or later in life when they encounter a particularly rewarding intimate relationship with another woman. We wrote that in our clinical work we had not experienced or seen reports of sexual fantasy changes of this kind appearing in men.

Beginning in the 2000s, RCF as well as many others in the Academy became increasingly concerned that psychodynamic principles were falling out of psychiatric residency training partly because of the difficulty residencies were having finding supervisors and partly because of economic pressures from insurance companies, which had started rationing psychiatric treatment to brief questionnaires and med-check visits. The fact that organized psychoanalysis had founded separately

run institutes rather than joining the academic enterprise in universities also contributed to waning interest in psychoanalytic thinking from organized psychiatry. It was at this time and because of this need, for instance, that the Academy initiated the Teichner Program to fund visits of psychoanalytic scholars to residency programs across the United States that were struggling to teach a psychodynamic approach to patients.

By 2012, RCF had concluded that it would be beneficial to establish psychodynamic psychiatry as a new discipline, based on three bodies of knowledge—psychoanalysis, neurobiology, and academic psychiatry and the behavioral sciences. Many of us thought had that, but RCF articulated it. When he became Editor of the Journal in 2012, the name was changed to *Psychodynamic Psychiatry*. He and I (then Deputy Editor) wrote the first editorial for the newly named journal about why psychodynamic psychiatry was distinct from psychoanalysis. RCF felt that the contemporary psychiatrist should be able to do more than practice "symptom removal." Rather, the clinician should be able to use a bio-psychosocial model of psychological function that would enable him or her to understand any patient. A psychodynamic assessment was helpful for any patient since it was based on the patient's individual developmental history and included a consideration of trauma as well as any psychiatric illnesses present. Thus, a psychodynamic assessment could be made for any individual whether or not he or she needed medication and would ever undergo psychotherapy. It was beneficial to help understand every patient.

RCF's passion for this cause—furthering new information and research in the field of psychodynamic psychiatry and putting it on an increasingly solid scientific foundation—was key to his devotion to *Psychodynamic Psychiatry*. He had always believed that psychoanalysts had unique opportunities to understand the human mind, and he sought articles from them as well as from behavioral science researchers. He also wanted to publish case reports and clinical articles in *Psychodynamic Psychiatry* in order to help readers apply psychodynamic principles in their daily work.

This was an interdisciplinary enterprise. While RCF always did interdisciplinary work and published in countless journals, his career was embedded in the Academy. Even in the 1950s when the Academy was formed, the founders did so with the expectation that the Academy would support a broad range of ideas about psychoanalytic thought. Dr. Janet Rioch, the first President of the Academy, wrote in a 1957 Academy newsletter (quoted in the first volume of the Academy's journal, then called *Science and Psychoanalysis*, 1958):

> It is our obligation as scientific observers to examine the validity of the data, hypotheses, and theories presented, to raise pertinent questions, and to actively challenge or to actively confirm. . . . The result . . . will inevitably lead to . . . a more vital coming together of psychoanalysts with each other and with their colleagues in other fields of science.

The Academy was always a "big tent." RCF found his place with us and contributed enormously to the field of human behavior and psychodynamic psychiatry.

Years ago, someone said to me, "In science you never want to have to 'eat your hat.'" RCF did more than scientific research and was interested in more than sex and gender. He was interested in the human mind and the depth psychology to understand it. He was a clinician, teacher, scholar, and editor of *Psychodynamic Psychiatry*. Painstakingly, against considerable odds, he built his body of work. He was meticulous in his thinking, and each idea built on the earlier ones. He never had to "eat his hat." On the contrary, he lent scholarship, integrity, and inspiration to our discipline and our daily work. Psychiatry and psychoanalysis changed because of him.

The Academy appreciates that this idealistic, productive, and brilliant scholar found his intellectual home with us.

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Retirement of Judy Mars

On January 9, 2020, a party was held at the home of our Director, Susan Vaughn, to celebrate Judy Mars's twenty-five years of service to the Columbia Psychoanalytic Center. The tributes that follow, from Susan and from Judy's long-time colleague, Joan Jackson, will illustrate how much we owe to her. Much as we miss both Judy and Joan, we are happy that the administration of the Center now rests in the capable hands of the admirable Madrid Poultney.

Joan Jackson Celebrates Judy Mars

Twenty-five years is a long time. When you work with someone that long, it means there are going to be lots of memories and lots of stories. These days, I have trouble recalling what I had for breakfast, but I've had a chance to prepare for tonight's dinner so I thought I'd just touch on a few of the things I'll remember most about Judy.

Judy and I first met through a friend of my family whom we have known for over fifty years. She worked in the Music Arts Division of the Brooklyn Public Library at Grand Army Plaza, so when I was asked by Ethel Person to look for a new librarian following the retirement of Doris Parker, Judy said she was willing to make the trek over to Washington Heights. Judy worked for all the following directors: Ethel Person, Roger MacKinnon, Bob Glick, Eric Marcus and, finally, Susan Vaughan.

There was a lot to learn about technology in those early days of computers, and I can honestly say that Judy taught me everything I know. Her patience is legendary, and her skills saved us, time and again. More than just being knowledgeable, Judy is genuinely kind, and went out of her way to be helpful. You couldn't ask for more in a co-worker and in a friend.

We shared with each other her beautiful wedding, the births of her children, and the sad passing of her mother and father.

Of course, we're all going to miss Judy, but I know that she'll be moving on to bigger and better things. So, let's raise our glasses and say it one more time: Thanks for everything, Judy!

Postscript from Joan Jackson

Arriving early at Susan Vaughan's apartment, I sat on the couch and watched as more and more faculty members arrived. I think it was a great tribute to Judy that so many of them made it to the party, many after seeing their patients, and some who I knew lived far away and would be very late getting home. Many people sat beside me on the couch to tell me their memories of Judy. She indeed had a great impact on people. What I remember most is the way she was with the candidates, first when they were new, and later as they went on to become faculty. She was friendly and sunny, and always eased their worries about classes and the dreaded Progression Committee.

I gather that all that has changed now. Judy's time at the Center came to an end when things at the Center changed. Candidates no longer congregated in the Center office/library for coffee before class, instead going straight to their classrooms. She missed the human contact and began to feel isolated in her office, often going all day without seeing another person.

Judy was great at her job, and great at helping me. She never once seemed annoyed when I asked for computer help — which I did constantly. With me, she had the patience of Job.

Before the COVID-19 pandemic we met for coffee every month, and some day, after this is all over, I hope we will resume the practice. She is, indeed, a very good friend.

Thank you, Judy!

Last night we celebrated Judy Mars' retirement after (nearly) 30 years of holding us all together so beautifully. The place was packed and humming and the tributes to Judy left us all wondering what we will do without her. As the inscription on her crystal bowl read, Judy's "smile is a curve that set everything straight." Here are a few images to remember the event by.

Consequences of Covid Claustrophobia

Bonnie Kaufman

The Columbia Psychoanalytic Center/APM listserv (CUPP), is a valuable tool that enables members to solicit and provide referrals, as well as to seek and share useful theoretical and clinical information. It has been especially valuable during the Covid-19 pandemic, enabling us to stay connected despite the lockdown and enforced social isolation. But over time, as New York City's medical disaster was gradually brought under control, some glimmers of lightheartedness (and even stir-craziness) were seen everywhere, CUPP being no exception. See discussion below.

BAGEL NERVE STIMULATOR?

— Dear All: I recently received a printout of a dictated consultation report from an eminent physician, who referred to the patient having been treated with a bagel nerve stimulator. Was this another fabulous Siri malapropism, or is there a new technology out there I haven't heard of?

— That's interesting. I wonder if it was being used to augment Loxitane?

— Few things can stimulate me like an everything bagel with a schmear.

— I'm guessing they used the bagel nerve stimulator to avoid any problems with the Medicare donut hole.

— I've heard bagel nerve stimulation was especially helpful for Obsessive Consumption Disorder.

— Carbi-dopa?

No one objected when we asked to use these *bageltelles* in the next issue of the *Bulletin*, so here they are — here in New York City, the bagel capital of the world! Perhaps Andrew Cuomo's secret to getting New York State's pandemic under such good control is also bagel-related — chicken soup?

ARTICLES