PINE PSYCHOANALYTIC CENTER, INC. NEWSLETTER

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EDITOR'S NOTE:

SPEAKING OF CONVERSATIONS

The decision to accept the position of Editor of this Newsletter came as a surprise to me! I had not been aware of any wish to take on such a role, and I had very strong feelings about the Newsletter, dating back to the year in which I made the decision to attend PINE. Back then, Jessie Miller was the Editor of the Newsletter, and (perhaps because I attended some of the scientific meetings at PINE?) I received the Newsletters before I'd even submitted my applications. Jessie's articles—often short and playful readings of films or poems or areas of interest in clinical practice (like the role of erotic love) made me want to learn what Jessie had learned. The Newsletter nurtured a promise of a way of seeing the world that psychoanalytic training, at its best, could offer: an unpretentious, deeply thoughtful, and illuminating relationship to our surroundings, and to each other. In no small way, it made PINE an enticing place to train to become a psychoanalyst.

Six years ago, when Frances Lang took on the role of Editor, I recall wondering how she could have the confidence to do such a thing. I soon saw that Frances' Newsletter redefined itself, matching Frances' broad and insatiable curiosity about everything, from politics, to reflections on global issues, to dialogues with academics from very different perspectives, and on to all reaches of the PINE community. Again, I found the Newsletter to be a source of inspiration.

Frances was the right person for this endeavor. And when Frances offered the role to me, I was pretty sure that I wasn't. I loved the Newsletter, but I didn't see myself as someone who could produce it. As I mulled it over, however, I found that my mind was racing with a sense of possibility. Thoughts and ideas poured in about topics to take up, members of PINE and beyond to call upon, "conversations" to be had. I began to envision the PINE Newsletter as a forum for pursuing questions and topics that analysts engage with privately, and to more formally bring these questions from one discussant to another. My sincere hope is that every reader of our Newsletter will feel invited, and ideally, at some point even compelled, to join in these virtual conversations, and that together, we can use the Newsletter as a space in which to explore questions and ideas that arise within our community.

Together with my new editorial board, Dr. Ayelet Barkai and Dr. Kimberlyn Leary, we have dreamt up a number of potential conversations. This volume of the Newsletter introduces two of these developing topics. Dr. Axel Hoffer generously accepted our invitation to pursue questions regarding small-scale ethical conflicts in the consulting room. The question we posed to him was to address fleeting moments of ethical tension in psychoanalytic work—the places where we are not confronted with overt ethical conflict, such as the realization that a patient is abusing another person, or our own mistreatment of a patient—but rather the places where our ability to hear our patients is disrupted by feelings that emerge from our own strongly held values or priorities. A typical example would be a passionate Democrat analyst trying to listen

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evenly to a devoted Republican analysand in the middle of a contentious election season. Given Dr. Hoffer's longstanding interest in psychoanalytic neutrality and the changing role of free association in contemporary psychoanalysis, he seemed an ideal introductory interlocutor on this topic. Dr. Hoffer is a Training and Supervising Analyst at PINE, an Associate Clinical Professor of Psychiatry at the Harvard Medical School, and was a member of the editorial board of the *Journal of the American Psychoanalytic Association*. He is also an expert on the relationship between Ferenzi and Freud. Dr. Hoffer's response provides a thoughtful and original musing on his long-standing interest, "Passionate Neutrality." In future volumes of the Newsletter, we hope to invite responses to and developments of the themes that Dr. Hoffer raises.

We also present accounts of structural changes, locally and nationally, in the approach to psychoanalytic training and organization. Dr. Michael Dvorkin has summarized the historic organizational re-structuring that culminated in our new by-laws and our new name, "PINE Psychoanalytic Center." As well, I have drawn on the expertise of Dr. Myrna Weiss, Co-Chair of the American Psychoanalytic Association's Board on Professional Standards, to report on the remarkable ongoing changes to our national educational standards.

Finally, we include a report of the November 7, 2009 scientific meeting with Ira Brenner. Dr. Rodrigo Barahona graciously accepted my invitation to try a new format of reporting, interweaving his reflections on the day's discussion with his report. Dr. Barahona does an outstanding job of connecting the three presenters' talks so that they engage with each other, while also raising further questions that emerged from that dialogue. In addition, this report is an opportunity to become acquainted with Dr. Barahona, our newest candidate, whose introduction to our community is somewhat overdue.

We hope to dedicate our next edition of the Newsletter to the multiplicity of perspectives on PINE as an Institute and PINE as a community. Please start associating, reflecting, dreaming, remembering, and reminiscing, as everyone will be invited to take up the question: "What is This Thing Called PINE?"

PASSIONATE NEUTRALITY

Axel Hoffer, M.D.

"You must be kidding, Axel. How can you be passionate about neutrality? Neutrality is the opposite of passion." Such responses from colleagues are very familiar to me, ever since some thirty years ago I thought I was the only one who didn't understand the concept of neutrality. Was I neutral? Should I be neutral? Did I want to be neutral? What does it mean for an analyst to be neutral? I was so eager for my patients to freely tell me what was on their minds. I soon realized that shame and embarrassment was an important impediment to their telling me anything, let alone their free associations. And I was learning in my analytic training that I needed to hear their free associations to gain access to their unconscious. What to do? They assumed I was judging their secrets harshly and I wouldn't like them if I knew their shameful secrets. What did I need to do or be for them to trust me enough to tell me what mattered to them? They were concerned about being judged. Was neutrality the answer? I became increasingly curious about what the concept of neutrality was really about. OK, I admit it to you. What was initially an interest and curiosity about the concept has become a passion with me.

It was at that time I learned that the German word Freud used was **"Indifferenz,"** a cognate of indifference in English, and translated by Strachey as "neutrality." (Joan Riviere translated it as indifference.) It appeared in Freud's paper (1915): "On Transference Love" in the sentence: "Besides, the experiment of letting oneself go a little way in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality **(Indifferenz**) towards the patient, which we have acquired through keeping the countertransference in check." "Keeping the countertransference in check" meant, as I understood it, recognizing a leaning away from neutrality as a danger to the analytic enterprise and therefore a signal for countertransference analysis by the analyst. Giving up the neutrality towards the patient is not only a danger in relation to an erotic transference but a danger in a more general sense. Freud meant by indifference, in my view, a scientific concept. **I believe he meant neutral with respect to outcome, as in a scientific experiment, in which the scientist does not know in advance, nor does he or she try to influence, the outcome of the experiment.** My thesis is simply that the analyst's task is to fully explore the patient's conflicts in order to find his or her resolution to them, not the analyst's preferred solution. Much of the controversy about neutrality and indifference is a consequence of the confusing and unengaged sound of the everyday usage of these terms. A better word than scientific indifference, something that conveys intense engagement, is

called for. Unfortunately, I have not yet been able to come up with a better word.

There are many papers about neutrality, each with its own definition and attitude regarding this technical concept. As mentioned above, my perhaps idiosyncratic view of neutrality, understood as scientific indifference to the conflict, not to the person, refers to how the analysand resolves relevant choices and conflicts. Unexpectedly, as bland and boring as the term "neutrality" appears, it has given rise to intense debates. For example, Owen Renik, after hearing one of my presentations on neutrality, perhaps just by chance, published his paper entitled: "The Perils of Neutrality" (Renik, 1996). One of Owen's points is that the analyst should own up to and openly acknowledge – "put his cards on the table," as he says – personal biases. I argue that the analyst, rather, should do the painstaking emotional and intellectual work of developing a genuinely neutral attitude, truly non-judgmental, toward the conflict based on seeing the issues from the patient's point of view, not from the analyst's biases.

I am, of course, only recommending neutrality specifically as a technical approach in psychoanalysis. I am not advocating neutrality in life outside of analysis, especially not in politics, love relationships, negotiations, child-rearing or business. I apply this view only to the analyst's attitude toward each conflict the analysand presents to the analyst. This concept of scientific indifference applies to the analyst's attitude toward the way the analysand resolves each conflict. In my view, it is the analysand's responsibility, not the analyst's, to resolve his or her relevant conflicts – or not. By this I mean it is also the patient's responsibility if he or she chooses to maintain rather than resolve the conflict. This touches on two issues: (1) therapeutic ambition, when the analyst's need pushes for conflict resolution, and (2) interminable analyses, when the patient doesn't want to resolve the conflict. The analyst's responsibility, in my view, is limited to helping the analysand to elucidate each conflict.

As I hope to demonstrate, indifference refers not to the analyst's caring about the patient but to the analyst's attitude regarding conflict outcome and resolution; it does not imply, in my view, blandness, lack of feeling, involvement or engagement. The main reason for the confusion – and for some of the arguments about neutrality – is that the everyday meaning of both neutrality and indifference does imply withdrawal from engagement with the person. That is one reason that the object relational and intersubjective schools have trouble with the concept of neutrality. In the everyday meaning, neutrality and indifference imply not caring about the person and not having, or not admitting to, any feelings to speak of. While advocating "indifference," Freud often broke his own rule. For example, he urged an undecided Ferenczi to marry the older Gizella, not her daughter, Elma. Doing so, Freud interpreted, would mean that Ferenczi had successfully resolved his oedipal conflict. Ferenczi complied and married Gizella. Freud sometimes didn't practice what he preached. I am advocating here what I believe Freud originally had in mind when he advocated "indifference" in 1915.

Applying my specific analytic definition of scientific, engaged indifference to clinical psychoanalysis, I believe that an optimal attitude for the analyst is to maintain a neutral attitude in elucidating the patient's conflicts from the patient's point of view, not siding with one side or the other. The analyst's task is to bring to consciousness the analysand's point of view for analysis. Prior to analytic elucidation, the analysand may not be aware of his or her actual point of view. I recognize that this attitude privileges the patient's autonomy; it also avoids a societal, interpersonal or conventional "should." This is a reminder that psychoanalysis is often seen as subversive in relation to society's demands. Again, I assume the analyst's first task is to help elucidate the patient's conflicts with a clear understanding that the resolution of the conflict – or even non-resolution – is the responsibility of the analysand. The analyst does not take sides. "Here's what I would do if I were you," is not relevant here. It is the patient's conflict. We need to remind ourselves of the obvious: "I, the analyst, am not you and I don't need for you to be me." I do advocate more attention to how we unknowingly take sides in a patient's conflict. I urge more attention to the importance of responding to our tilting in one direction or another as a signal for countertransference analysis.

The conventional analytic attitude toward homosexuality is a painful example where psychoanalysis as an organization took a side. Homosexuality was judged to be not as developmentally mature as heterosexuality. Based on a theoretical judgment, homosexuality resulted from an inadequate resolution of the universal oedipal conflict. Therefore it was a developmental arrest, or a disease, which needed to be treated. I believe if psychoanalysts had taken a neutral position with people struggling in conflict with their own homosexual feelings, as we finally have recognized, we would have saved ourselves and many potential analysts and patients a great deal of trouble and suffering. To repeat, a genuinely neutral position allows and encourages the analysand to bring forward his or her conflicts, with less inhibition, shame and opposition evoked by the assumed – and often correctly perceived – judgments of the analyst.

"Of course it's your job to be neutral," patients have often said to me. But patients don't really believe that for a minute. I argue strongly that it is not our job to appear or pretend to be neutral; rather I maintain it is our job to do the difficult emotional work that genuine neutrality requires. Students sometimes misunderstand my concept of neutrality when they say to me, "I try to control my feelings to be neutral." My view is quite the opposite. Pretending to be neutral cannot work; there is no place for pretence in the analytic relationship. I believe that the analyst needs to be fully and deeply aware of and feel his or her feelings. Simultaneously, the analyst recognizes that those feelings are important clues to one's countertransference. Becoming aware of a bias or even a slight leaning to one side of the patient's conflict or another can be used by the analyst as a red flag. That red flag is a trigger that signals awareness of a countertransference intrusion, requiring important self-analysis.

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What is the nature of the difficult work that I am advocating? One way to describe it is based first on awareness of our countertransference wishes in response to the conflicts the patient presents to us. After we become aware of how we might want to resolve the conflict, we need to become aware of our wish that the patient resolve it the same way. That is the "If I were you, I would do such and such" phase. After becoming aware of the temptation to convey and convince our patient of our wish which we might naturally do in an ordinary conversation, we can then recognize our wish as a valuable signal, a red flag. When we respond to the red flag by refraining from indulging in our wish, we become free to pay close attention to the patient's conflict. Here is the crucial step: without ignoring our feelings, we focus our attention on the patient's experience of whatever choice, decision or conflict is relevant in the analytic moment. Herein lies the arduous work necessary to achieve a position of genuine neutrality. Awareness of both our feelings and the patient's feelings is the essential ingredient. When we focus on the patient, our feelings can then recede into the background of our attention. What is required of us is maintaining a clear distinction between conflicts and feelings that belong to us and those that belong to the patient. Our genuine neutrality is repeatedly tested. If we pass the daily test, the patient gradually rewards us with freer associations. Our genuinely neutral attitude allows the analysis to proceed.

An example to illustrate my point is the imagined conflict of a Roman Catholic analyst, personally passionately opposed to abortion, analyzing a woman who is struggling with the decision to have an abortion. A neutral analyst would need to be keenly aware of maintaining his or her personal religious beliefs separate from the analytic task. This would include great care that a line of questioning does not explore mainly one side, the analyst's preferred side, of the patient's conflict, while minimizing exploration of the other side. Of course, if the analyst finds a patient's behavior intolerably incompatible with deeply held values, referral to another analyst could become necessary.

I would like in the following clinical example to suggest that we are too often tempted to abandon neutrality when it would be analytically more useful not to do so. For example, a woman wants to marry a man who is an artist. He is also a recovering drug addict. The patient says, "My boyfriend is an artist who has profound insights. He understands me and sees me as no one has seen me before." Is it part of the analyst's task to warn her, perhaps subtly, of potential trouble because of his addiction? Or does the analyst realize that this relationship might provide her with the intimate relationship for which she has always yearned? Does Father or Mother Analyst really know best? Is it the analyst's clinical responsibility to warn her about how this relationship sounds to him or her? Often patients present these questions to the analyst as parent. Do we say this is a bad choice or do we explore fully both sides of the patient's conflicts about her choice of a lover? There are many such challenges to the analyst and I find that patients often look to the analyst for advice on these important choices. They look for hidden clues about the analyst's judgment. They often feel, and sometimes say, "You know me better than I know myself. What do you think I should do? We are temped to indulge in the role of the "one who knows what's best." I am proposing that we do the difficult work to bring us to the hard won position of genuine humility, the position of "not knowing." "I really don't know what is best for you. Let us explore your conflicts deeply enough to find out what you really want and how best to get it."

The analyst's neutrality is daily, indeed constantly, challenged; there are clearly times that the analyst for both clinical and ethical reasons needs to abandon neutrality. Suicidality is, of course, an extreme example. On one occasion, this "neutral" analyst was confronted by a patient who suddenly told me she was quitting a two-year treatment with me in despair. I used my keys to lock her in my hospital office (while I called security) to immediately hospitalize her. She was actively suicidal…not a time for neutrality. But the challenge to neutrality with a chronically suicidal patient is well known to most of us. What is best for the patient's development and autonomy keeping well in mind the risk to his or her life requires constant monitoring. The analyst must pay constant attention to where the patient is and where the countertransference despair, irritation, fatigue or hatred may be hidden. As I have written elsewhere (Hoffer, 1985), challenges to neutrality also include toxic states and dementia, situations where the patient is not capable of being responsible for him or herself. The question is: who is responsible for the decisions.

What are the arguments against neutrality? The most challenging argument against neutrality is a developmental model based on a diagnosis, a judgment of incapacity in the patient. A patient, judged by the analyst as too irresponsible or immature, is incapable, by reason of neurosis, to make responsible decisions about his or her life. For example, is a patient with Asperger's disease or a history of trauma that leaves him or her with various cognitive, developmental or social incapacities capable of being responsible for social interactions? The analytic model I've been describing is based on a neutral exploration of the patient's conflict. That model assumes the patient is responsible for his or her conflict resolution. If, however, the patient has been judged incapable of making responsible decisions, an educational model may then be deemed necessary to meet the needs of the patient. The analyst consequently takes on the role of explainer of reality or of relationships and becomes wittingly or unwittingly a teacher. The analyst is seen as more competent or more mature or wiser than the patient. It is not unusual to see treatments that are hybrids of analytic and educational models. The analyst is not only seen as parental in the transference but is here actually playing a parental role. Is the analyst a teacher? What is the analyst teaching? Does the analyst teach the ingredients of a "good life" or "good relationships" or "healthy ones?" Or is the analyst limiting the teaching to his or her conceptualization of how the mind works?

Another argument against neutrality is that a neutral analyst offers a blank screen which limits the patient's

engagement in what may not feel like a real relationship between two real people. This is the stereotyped neutral, blank screen, silent analyst of the fifties and sixties. I assert that the issue of the analyst's self-revelation and of conveying his or her feelings and humanity are independent of the technical commitment to neutrality in relation to the patient's conflict. I assert that the analyst can engage, joke and be appropriately self-revealing, spontaneously showing his or her humanity, while steadfastly maintaining an attitude of neutrality toward the patient's conflicts. Renik argues that neutrality is a flawed concept because of our irreducible subjectivity. Therefore, rather than a desirable ideal one should work toward, he feels it should be cast aside as a remnant of a one-person psychology. Disagreeing again with Renik, I believe that the pursuit of neutrality, while an ideal never to be perfectly attained, is a cornerstone of psychoanalytic practice. Post-modern criticism asserts that the very concept of neutrality implies an out-dated, authoritarian, positivist position of objectivity. According to that view, the neutral analyst thinks of himself or herself as "objectively" seeing "reality" or "the truth." As you can see in my clinical examples, nowhere in my use of the concept of neutrality do I make any claim to objectivity. My primary interest is in the conflict as experienced from the patient's point of view; objectivity doesn't enter the picture.

Finally, another argument, with which I happen to agree, is that the way individual conflicts are seen may be largely culturally determined. For example, in the West, there is a cultural bias in favor of autonomy; in the East, the bias is away from the individual and toward society and interconnectedness. I imagine that an analyst who is neutral to the patient's conflict would approach the patient's conflict differently in each society.

I am particularly mindful of the dangers of a "mental health morality" which replaces old-fashioned morality as a standard we may unknowingly impose on our patients. For example, the analyst says, "In my opinion, this boyfriend would be a healthier choice for you than the other one you spoke about." Are we and do we want to be arbiters of health, behavior and decisions?

I will present briefly a typical case which challenged my neutrality. This is a composite case made up of three women who, although not in analysis but in a psychoanalytically oriented psychotherapy, presented me with typical challenges to neutrality. I assume that the choice of a companion, partner or spouse is one of the most important decisions one makes in life.

Doreen is a 40-year-old married woman who is having an affair with a man 10 years older than she. She loves her husband but does not find him as sexually exciting as she does Marco, a colleague at work. She does not want a divorce and does not want to marry Marco, who is also married. Much of the treatment consists of painful conflicts with Marco, who is sometimes distant but often blissfully intimate with her. Guilt about the affair and moral qualms are sometimes mentioned in passing but there is little interest in exploring the meaning of the affair or a wish to end it. Rather, the patient is most interested in understanding better her career and the career choices she has made and now is considering making in the future. She takes great pains to keep the affair hidden from her husband. Should the analyst make an issue of the affair, even if the patient says she is reasonably satisfied with this arrangement? It could be argued that the affair indicates a problem in her integrity, or her ability to be honest and in an intimate relationship with her spouse. Is her deceiving her spouse an issue that the analyst believes the patient should resolve? Would she be happier without carrying on a separate secret life, or does the alternate life give her the happiness she seeks? Should the analyst confront her decision? Is it for the analyst – or the patient – to decide what she wants to explore?

I would argue that the analyst's task is limited to elucidating conflict experienced by the patient and from the patient's point of view, not from the analyst's point of view. I am passionate about neutrality, which privileges personal responsibility and autonomy. Simply stated, I advocate a specific, unique, actively engaged scientific indifference to the patient's conflict. Furthermore, a neutral, nonjudgmental attitude is ideal not only in responding to the analysand's free associations with evenly-hovering attention, but also to the analyst being open to any and all of his or her own associations. For the analyst, expansive and fully open awareness is the desired goal. As Semrad (Good, 2009) said: "You try to '…help a fellow to free associate and then get out of the way.'" Or as Ogden (2006) said, "Teaching psychoanalysis is a paradoxical affair: someone who is supposed to know teaches someone who wants to know what it means not to know." Our thinking that we know leads us to think that we know the answer to the question. The conceit of knowing stifles the question. When we are able to tolerate not knowing and not feeling we have to know, we are impelled to genuinely and sincerely ask the questions that really matter. Each patient, by asking and being asked questions, can find the answer that the soul is seeking

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A NEW STRUCTURE FOR PINE

Michael Dvorkin, Ed.D.

January 24, 2010 was a historic day for PINE. That evening we came together as a group and voted to ratify the proposed by-law and structural changes that had been in the works for some time. A number of people were involved in this project, but Julia Mathews should be singled out for special praise. She did an enormous amount of work on this from start to finish, and she was instrumental in moving it forward during the long, and sometimes tortuous, process of revision and consensus-building that was necessary to its completion. Put simply, I'm not sure it would have happened without her efforts.

Quite a bit will change at PINE with this vote, but one vital thing will remain the same. We have created an organizational structure that will continue to support our core philosophy and mission: the provision of high quality psychoanalytic education, and the collaborative learning and growth of candidates and faculty alike. We have also now created a structure that can more flexibly adapt to meet the demands of a changing landscape for psychoanalysis in the years ahead.

One of the changes we can expect from the new organizational structure is that we have a new name. The new corporation is the PINE Psychoanalytic Center, Inc. The PINE Institute and PINE Society now exist as divisions of that entity. The New England Foundation for Psychoanalysis will remain as a separate legal entity.

With the new structure we can also expect better communication between committees, divisions, and members, as well as generally smoother functioning. The new organization also provides immediate full membership for candidates and makes provision for their direct involvement in governance. We can also expect a more democratic, transparent, and participatory organization, with all of the benefits that can potentially flow from that. Training analysts will no longer be burdened with primary responsibility for administration, freeing them to be more involved in education. Given the flexibility that's been built in we should also be better positioned to adapt to changes from the American Psychoanalytic Association and other sources.

With this task now behind us, we are free to move forward in addressing the question of what we want to do with what we have created. Who are we going to be moving forward into the future? That is the challenge that still remains. This question will be further addressed in the upcoming retreat as well as in the next edition of the newsletter.

DRAMATIC CHANGE AFOOT AT APsaA

Sarah Ackerman, Ph.D.,
With Advisement by Myrna Weiss, M.D.

On January 13th, 2010, a significant change came to pass at the American Psychoanalytic Association (APsaA). The Major Revisions Task Force and the Minor Revisions Task force, subcommittees of the Task Forces on Educational Standards Revision, presented a preliminary compromise agreement on the revisions of the Principles and Standards For Education in Psychoanalysis, heretofore called "educational standards." This compromise agreement brought resolution to a divisive debate that has been ongoing for many years, and offered the potential to mend internal strife within APsaA. Thanks to the presence of our own Dr. Myrna Weiss, Co-Chair of the Board on Professional Standards, at these meetings, I was able to get an inside read on the events that took place in January and their practical implications for the PINE community. My hope is to report these changes as directly as possible, without judgment or bias.

I will begin with some general background information for those of you who, like myself, have been successful at remaining oblivious to most of the inner workings of APsaA. The central role of the Board on Professional Standards (BOPS) is to oversee all aspects of the education and training of psychoanalysts as it is conducted at each of the institutes and training facilities that are part of APsaA. This includes overseeing the certification of analysts, the accreditation of institutes, and the establishment of the educational standards of the American Psychoanalytic Association. Each institute and new training facility elects or selects two representatives, who are senior educators in its community, to represent its interests at BOPS. (At PINE, our current representatives are Bob Pyles and Fred Busch.) The BOPS holds a daylong meeting on the

Wednesday of the national meetings, in order to fulfill its responsibilities. These meetings involve consideration of site visit reports, the appointment of Training Analysts, the certification of applicants, and other educational issues that arise within institutes. Over the past three years, BOPS has been co-chaired by Myrna Weiss, M.D., of PINE, and Cal Narcisi, M.D., of the Denver Psychoanalytic Institute.

Prior to this January meeting, an ongoing dispute among members of APsaA was moving toward a decision to create two separate revisions of the educational standards of APsaA. This would have forced each individual institute to come to an agreement on which track to accept, inviting risks of ruptures and splits—within each institute and within APsaA at large. In the interest of avoiding this outcome, Drs. Weiss and Narcisi created a Major Revisions Task Force, chaired by Erik Gann, and a Minor Revisions Task Force, chaired by Robert Glick. Both were comprised of volunteers of the BOPS and the Council. Each task force created a proposed revision to the educational standards. Subsequently these two groups agreed to come together for a two-day retreat prior to the January meetings. The goal of this retreat was to try to integrate these two models, and to avoid moving forward with requiring a divisive choice between the two revisions at the level of each institute. Eric Nuetzel, a former Chair of BOPS, oversaw this process along with Drs. Weiss and Narcisi, and through attention to the potential damage that could result from a two-track system, the task force members were able to agree on a compromise. Although this compromise has been provisionally approved of at the BOPS, there is still work being done to elaborate and complete the revision to the educational standards. Once the standards document is completed, and after the institutes have an opportunity to discuss it, a vote to implement the revised standards document will be held at the Board on Professional Standards meeting in June, 2010. At that time, the "Principles and Standards, Revised Edition" will be available for all to read on-line.

Thanks to Dr. Weiss' generous assistance, I present the following summary of the compromise that was reached. In italics, I have tried to elaborate the way in which these changes might be experienced within our community at PINE.

Waiver from Training Analysis Requirements

The task force voted in support of an option for individual institutes to request a waiver from the current training analyst requirements with regard to an individual candidate's training analysis. If a candidate comes to PINE already in a productive, established analysis with an analyst who is not a Training Analyst, PINE could request a waiver from BOPS to allow this analysis to proceed. Such a case could only be eligible for a waiver, however, if the analyst meets the following standards:

- The analyst must be a graduate of an APsaA or IPA institute.
- The analyst must meet most of the eligibility requirements for training analyst status required by the IPA. This includes being five years post-graduation, being in good ethical standing, and having had four non-supervised, non-psychotic analytic cases after graduation.

As well, the institute must have a means of assessing the analyst's suitability for performing this role of ad hoc training analyst. This is not intended to serve as an alternate track for a training analyst appointment.

This means that should an individual apply to train at PINE and request to continue in an existing analysis with an analyst who is not a PINE Training Analyst, PINE would have the option of requesting a waiver from BOPS. The rationale for this change is an effort not to interfere with a productive analysis, and a concern for the effects caused by requiring candidates to change to an analysis with a Training Analyst. However, the BOPS has not yet fully resolved how it will manage the vetting process required of the analyst in this situation. Further, the requirements of the treating analyst for whom a waiver is requested are nearly equal to the terms by which analysts are eligible to become training analysts, with the exception of the requirement of certification. The reason for these requirements is that APsaA's status in relation to the International Psychoanalytic Association is contingent upon the preservation of the training analyst system. Any indication of an intent to undermine the requirements for Training Analysts would jeopardize APsaA on an international level. The IPA's requirements for the appointment of Training Analysts are available online at: http://www.ipa.org.uk/Public/?language=eng, by selecting "procedural code" under IPA.

New Route To Training Analyst Status

The task force also agreed on creating an additional pathway to the appointment of Training Analyst. Along with the current, or direct pathway, a "developmental model" was approved. In order for this model to be available, the applicant's institute would need to elect to offer this route to certification, as has already been done at the San Francisco Psychoanalytic Institute. In this model, prior to graduation from an institute, candidates could be evaluated through two colloquia, which would serve as phase one and phase two of the certification process. After a candidate has completed phases one and two of certification in this way, she or he will need to graduate and fulfill the TA requirements (being five years post-graduation, with four cases treated after graduation and being in good ethical standing), before moving to the third phase of certification. That phase requires that the candidate be evaluated by a TA development committee, which would include faculty from his or her institute, along with one or two BOPS-approved represen-

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tatives of APsaA. One of these APsaA representatives would be selected by the applicant, with the caveat that it could not be someone with whom the applicant has a prior relationship. This committee would meet over a six or more month period and if they agreed upon successful recommendation and TA appointment, the committee would be able to confer a certification status as well. As stated above, this developmental model would only be available to candidates if an institute elected to adopt this developmental option. If it did, then the current candidates and non-certified graduates could be grandfathered into this model. The traditional model would still be an option for applying for certification and TA status.

This offers each institute new flexibility in how it engages with the certification process. Dr. Weiss also pointed out that many pathways are already available to becoming certified. The intention in adding this route is to permit each institute to individualize its requirements for certification. At PINE, we would need to determine as a group whether we want to bring more of the process of certification down to a local level, which has the benefit of being a more comfortable process of evaluation and the negative of requiring more work on the part of our community. However, this "developmental" option integrates the Training Analysis application with the certification process.

New Route To Supervising Analyst Status

The task force unanimously agreed to separate the appointment of a Supervising Analyst from the Training Analyst appointment process, in the event that an applicant wants to apply to become a Supervising Analyst and not a Training Analyst. The applicant for Supervising Analyst status must meet the criteria required in order to apply for TA status. Certain skills would be evaluated if the applicant is applying to be an SA. Applicants would need to be able to: quickly identify central dynamic themes in psychotherapeutic work; conceptualize and elaborate their thinking about analytic process; and engage in the educational activities of the institute. He or she will be required to participate in an ongoing learning process regarding supervision that is similar to the process provided for TA applicants and to demonstrate immersion in the conduct of supervision and the skills and knowledge acquired through that.

At PINE, we might have analysts who, because of their age or their interests, did not want to undertake the role of Training Analyst, but would like to contribute to the educational atmosphere through supervising analytic candidates. These members would need to fulfill the usual requirements for applicants to become TA's, but could elect to be evaluated only on their supervisory skills. By delineating a separate process by which an analyst can apply to become an SA, the hope is to broaden the opportunity to supervise trainees without diminishing the high standards for this supervisory role.

What's Next?

Hopefully, it is now more clear just how monumental it is for this task force to come to agreement on these modifications to the Principles and Standards for Education in Psychoanalysis. However, the process is not yet complete. The standards document is still being revised and will be sent out to the institutes in the spring. At that point, everyone will receive a copy of this document. Discussions will then begin at the institute level, so that our PINE representatives to the BOPS (Bob Pyles and Fred Busch) can vote according to our opinions. In this decision, we are being asked whether we can accept the revisions to the standards as an option for institutes at large. A separate, and later, decision for members of the PINE community will be whether we want to institute the developmental model for certification and Training Analyst evaluation.

The BOPS vote on this proposal will occur at the Spring Meetings in Washington, D.C. in June, 2010. According to Dr. Weiss, the vote will almost certainly go through and will become effective immediately. Reaching this agreement represents the avoidance of a major calamity, in the form of a series of splits within and between the institutes that comprise the American Psychoanalytic Association. On an international level, as well, the concern about these events was having an effect. In the words of Charles Hanley, the President of IPA, who was in attendance at the meeting on January 13th, "This work will result in a sigh of relief throughout the International Psychoanalytic community." Kudos to Drs. Weiss, Narcisi, and Neutzel for their instrumental role in this historical feat!

ON THERAPEUTIC ACTION: THE ANALYST AS MEDIUM

OPEN SCIENTIFIC MEETING ON NOVEMBER 7, 2009

Presenter: Ira Brenner, M.D.
Discussants: Julia Matthews, Ph.D., M.D. and David Reisen, M.D.
Moderator: Carol Rubin, Ph.D.
Reporter: Rodrigo Barahona, Psya.D.

At the PSNE scientific meeting on November 7, 2009, Dr. Ira Brenner presented his paper "On the Therapeutic Action: The Analyst as Medium." The moderator that afternoon was Dr. Carol Rubin, and the two discussants were Dr. Julia Matthews and Dr. David Reisen.

Carol Rubin began the afternoon by raising an intriguing question that set the stage for the afternoon's presentation: regarding severity of pathology, are patients really different today than in the past? Dr. Rubin thought not. Rather, she suggested, it is our vision of them that has changed; our lens has grown sharper, our focus has acquired a greater depth. According to Rubin, if pathology was previously seen as solely organized around the Oedipus Complex, today, we have a different vision. Dr. Brenner's work with severely disturbed, traumatized, resilient patients highlighted this vision. He described not only some of the difficulties inherent in working with "widening scope" patients, to use Stone's term, but also the challenges of holding a "widening scope" frame of mind, an analytic attitude closer to that of a medium, than to the traditional view of analytic listening. Brenner's talk centered on technique, in an effort to make a contribution to working analytically with people "who normally wouldn't have a diagnosis," people with whom work often involves mobilizing the holding environment of the hospital. After years of working intensely with these patients, Brenner began asking the question he brought to the audience that afternoon: how and why do these patients get better?

Speaking with only minimal reference to his notes, Dr. Brenner seemed to engage his audience in an immediate and very personal way, reflecting perhaps the intensity and frankness of his analytic demeanor. He first introduced us to a "largely unsuccessful" case as a way of setting the stage for the at times bitter enactments that can befall both participants in this type of work. His patient, over time, and in spite of her genuine suffering, began showing a lack of credibility and major inconsistencies, in her narrative. After several incidents when it became clear that continuing the work was impossible, the patient handed Brenner a farewell gift, according to the patient a family heirloom. Brenner described his inner struggle contemplating the possible repairing qualities of the gift, and then his bitter sense of being "duped" and "mocked" by the patient upon realizing that the "family heirloom" had really been a recent purchase from a gift shop. Nevertheless, Brenner picked up on the significance of the gift, in fact a crystal ball, perhaps representative of the patient's own fraudulence, projected onto him as a fortune teller/charlatan. Dr. Brenner thought of the role of mediums, who like fortune tellers purport to help people communicate with spirits in the afterlife. "In a manner of speaking," according to Brenner, "all analysts are mediums." That is, they allow for the patient's temporary projection or depositing of his unconscious world into his, the analyst's, psyche. It is the depositing of internalized representations that, like departed ghosts, haunt the patient's encounters with the analyst that the analyst must make use of in order to help re-establish communication. Brenner explained that it is the analyst's successful interpretations that "allow the past to become freed up from the psychological bondage of unresolved mourning and neurotic conflict." In the remainder of his presentation, however, Brenner's emphasis appeared to shift to the equally important analytic frame of mind, viewed by him through a plurality of perspectives, without which the analyst, as medium, could not intervene effectively.

Brenner wondered, could the concept of "medium" be applied as a condensed formula of how treatment works? As a growth-promoting substance or environment, it is inherent in Winnicott's (1953) holding environment as well as Loewald's (1960) new object. Brenner did not mention Bion (1970) explicitly, but the analyst's function as a container for the patient's unmetabolized experience could also fall into this conceptual space, as might indeed much of contemporary theory that deals with clinical psychoanalysis as a two-person enterprise. By quoting Marshall McLuhan's (1964) phrase, "the medium is the message," Brenner came closest to exemplifying how the analyst's position, if he is to be a medium to his patients, is generated in between the ideological poles of contemporary debates over the "role of the relationship versus the traditional approach of the anonymous, neutral, and abstaining analyst."

Next, Brenner gave a very brief discussion of the literature on therapeutic action, though limiting himself to one volume of *The Psychoanalytic Quarterly* (2007 supplement) where various authors, representing "North America, South America, and Europe" summarized their views on how analysis works. The views ranged from the classical point of view, or "modern conflict theory," which "basically maintains the traditional viewpoint" (Abend), to Self-Psychology (Newman), the Kleinians (Hinshelwood), the "relational perspective" (Spezzano), and the "intersubjectivists" (Renik). According to Brenner, this diversity of viewpoints served well to caution us not to rush into assimilating them

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into a coherent whole, but rather to "appreciate the significance of pluralism in contemporary thought." It was suggested, though not stated explicitly, that keeping the tense space between theories open in the clinical moment is part and parcel of maintaining the analytic position of medium.

At this point of his presentation, Dr. Brenner moved on to his discussion of Marvin, in his sixth year of a five times a week analysis. This case provided many examples of the type of endurance demanded of the analyst when functioning as a medium through which to allow his patient to play out his conflicts. Marvin, on a multitude of occasions, invaded his analyst's privacy: impersonating family members in order to get information about him by telephone, internet, and mail; visiting his father's grave; sending his (the patient's) son to wait in his waiting room when he missed a session lest the analyst waste time during that hour, and so on. "Containing the affects of shock, helplessness and rage over discovering this (these) egregious violation(s) was extremely challenging to me and jeopardized the treatment." Brenner reasoned that his countertransference reactions originated in the patient's own dissociated experience from a traumatic childhood, induced in the analyst through identification with the perpetrator.

A little later, Brenner described how his patient wondered if he was wearing a suit on Friday instead of his usual Friday sports-coat in order to pre-empt Marvin's usual chiding. To this, Brenner decided to comment on the patient's having found "a home in (my) mind," paraphrasing Spezzano, rather than what would have been his more usual strategy of interpreting Marvin's need for omnipotent control. Empathically he communicated to the patient that it must feel good to feel carried around in his analyst's mind and to feel he'd influenced him in various ways. Marvin's resistance evaporated and he moved on in the session to deeper, more meaningful material.

Dr. Brenner concluded his discussion of Marvin by highlighting how in his work he served as "an empathic object, an interpreter of unconscious conflict, a bridge to the world of the dead, lost objects, a holding environment for the patient's developmental growth, a container of disowned mental contents, and a pliable artistic medium for playing in (our) speilraum, or play space, (quoting Herzog)." These are six forms of medium, according to Brenner, that comprise therapeutic action, necessarily in a synergistic way. Not only did the patient improve at various levels, each reflecting progress as measured by various theories (…increased cohesion of self, modification of defenses, more ownership of disowned psychical contents), but he also began taking more care of his physical health. Brenner wondered about how little there is in the literature linking therapeutic action with the mind-body connection, and invited the audience to think about a possible difference between the life expectancy of an analyst compared to other mental health professionals. He ended his presentation by recalling Kernberg's view of therapeutic action as a hybrid viewpoint that "retains the classical position while acknowledging the importance of the relationship."

Because of my own work with very disturbed patients, I was particularly interested in Dr. Brenner's discussion of contemporary theory of therapeutic action and how he applied such a diversity of viewpoints to such difficult, if not to say at times compromising, clinical situations. However, precisely for this reason I was left confused by his choice to limit himself to the 2007 issue of *The Quarterly* already mentioned, which he considered representative of the "prevailing ideologies" from North and South America as well as Europe. I wondered if his discussion of theory could have, perhaps with more time and space, delved deeper into the literature. A more thoroughly international perspective and a wider net cast among different clinicians even within the same theories may have shed more light on how complex, though fruitful, his conceptualization of the analyst as medium might in fact be. For example, working psychoanalytically with psychotic patients, or patients with character disorders in hospitals or on an ambulatory basis has a long tradition in Latin America. "Intersubjectivity" has been a concern among Latin American psychoanalysts since Pichon-Riviere and the Barangers (among many others), in the 1960's and 70's. Can "intersubjectivity" be sufficiently addressed as a point of view or "prevailing ideology" referencing only Renik? Would a more inclusive perspective have enriched Dr. Brenner's presentation, or would the elusive task of defining therapeutic action have become even more elusive, finding itself ensnared in the unchecked infinite progression of what a truly integrative stance threatens, in the worst case, to be? I certainly understood from his talk and demeanor as a thinker that the challenges this might impose would be something Brenner would welcome. But I also think that a point brought up by Harry Smith in his introduction to the above mentioned issue of *The Psychoanalytic Quarterly,* concerning the "confusion of tongues" in psychoanalysis (lightly touched upon by the discussants) could have been addressed. For example: the conflation of concepts, the mixing of paradigms and the confusing of levels of abstraction, especially in the context of metapsychology, become important when one approaches this type of plurality in clinical work; this would have been an interesting discussion to have had with Dr. Brenner.

Dr. Julia Matthews began her discussion by thanking Dr. Brenner for his presentation and stating that her discussion would primarily address the theoretical concerns brought up in the talk, but not the clinical material itself. She had three issues she wanted to raise: 1. the meaning of the term "therapeutic action; 2. our theoretical diversity and not so occasional animosity "that swirls around theoretical difference;" and 3. the limits inherent in the concept of therapeutic action and necessary conceptual shift that has occurred in regards to it.

Apropos of her first point, Matthews stated that Brenner's notion of therapeutic action is not what is usually meant by the term: he spoke of what the analyst does rather than what actually happens in the change process. Matthews asserted that the term therapeutic action refers to structural change *within the patient* as "inferred from the patient's subjective experience, symptoms, conflicts, and relational patterns, and so on, as well as the intersubjective shared experience of the patient and analyst." As an example, she referenced Loewald's ideas on structural change in the patient's personality: resumption of ego development contingent on a relationship with a new object (this was briefly mentioned by Brenner earlier). Dr. Matthews included a partial list of theories from Abrams (1995) summing up the final effect of treatment in the patient's mind, a list that read like Brenner's description earlier on the postulated changes that occurred in Marvin, i.e., resolution of internal conflicts and "structural change;" integration of past split-off earlier pathogens, healing of the fractured self, etc. She emphasized Abrams' cautionary observation that some of these ideas of therapeutic action "…are nowhere near the others, some might prove complementary, and a few others are downright contradictory."

In contrast to the focus on changes within the patient, Brenner's metaphor of medium appeared to maintain most of his focus on what occurs *outside* of the patient. According to Matthews, he was addressing the "medium" that influences and the "curative factors" or "active ingredients" that *cause* change, rather than *what* changes. Interestingly, however, the concept of "medium" was perhaps already implicit in Loewald, according to Matthews, in one form or another. For example, words like "mediate" or other derivatives of the word medium, which he actually never used, appear 13 times in Loewald's 1960 paper from which Matthews was working.

Next, Dr. Matthews discussed the issues of theoretical diversity and animosity between theories. Mentioning Pine and Mitchell's views on the possibly counter-therapeutic effect of holding any general view of therapeutic action, she described how the psychoanalytic world has been drawn, through heated debate, to a greater attitude of tolerance and inclusion. Matthews then went on to discuss Brenner's different conceptualizations of "medium," viewing them to be "in this vein of tolerance."

She finalized her presentation by reaching her third and powerful point. Emphasizing Brenner's work with patients suffering from dissociative disorders, where complex, contradictory, and often warring alter states are contained within the patient, Matthews mentioned how analysts working with these patients "may need to move flexibly between theories, to respond now to one developmental level, now another…." She made the case that perhaps Brenner's work can be seen as reflecting a pluralism that likens the analyst's plural states of mind in attempting to grasp the diversity of the patient's split-off self-states. A fruitful and fascinating notion, this type of clinical-theoretical parallel process suggested to Matthews that the narrow historical meaning of therapeutic action, locating change only within the patient, may no longer be useful or tenable. Therapeutic action, she stated, is not located exclusively within the patient, but is a reflection of changes within the dyad; changes in the patient come hand in hand with changes in his environment. That is, the analyst emerges from his patient's analysis uniquely changed.

Dr. Reisen began his discussion by lightly summarizing some of Brenner's ideas of medium, providing the audience with a synopsis of the literature reviewed earlier. Touching briefly on the case of "Marvin," he moved to stake his claim. Apropos of the debate over what the "active ingredient" or "curative factor" is in analysis, Reisen contended that this is currently an irresolvable issue. His project was to explain to the audience why this was so, and to offer his ideas on approaches towards a possible resolution.

Reisen's discussion kicked off with a long quote from Colin McGinn's "The Mysterious Flame, Conscious Minds in a Material World," where an alien explorer speaking to his alien commander attempted to explain to him the nature of humans on earth. The conversation that ensued, as comical as it was insightful, had the explorer trying to tell the commander that all he can detect in earthlings is "meat." The commander asked, if this is so, then who sends the radio signals to the stars, only to hear the explorer say that "meat" sends the signals. Do they have a brain, asks the commander? Yes, but the brain is made out of meat. So what does the thinking, asks the commander? "You're not understanding, are you?" responds the explorer. "The brain does the thinking. The meat. "And so on.

Reisen wanted to call attention here to the question of the "oddity of the mind-brain link" and to address the issue of the "confusion of tongues" written about by Smith. "When we talk about what the 'primary active ingredient is in the analysis' without making any reference to our brains, we are in a position of pre-modern physicians who observed urine. Some noted its color and realized that if someone drank a lot, the color lightened up and the reverse." He noted that it was not until Vesalius that a fuller understanding of kidney abnormalities was achieved. By analogy, in psychoanalysis, without reference to our brains, Reisen contended, we are in the position of the physicians before the role of the kidneys was elucidated. Reisen noted that around the same time that Freud was collecting clinical material from patients, "madly collecting and just as furiously, trying to schematize his specimens," and trying to see underlying patterns, Santiago Ramon y Cajal was staining brain cells. Dr. Reisen at this point stated what I considered to be the focus of his argument: in keeping with the scientific "tradition," as analysts, we gather facts, build laws, and deduce theories. The problem comes down to what is counted as a fact, and the thorny issue of reproducibility.

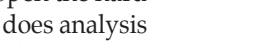
At this point Reisen focused his discussion on the scientific status of psychoanalysis and its relation to brain science. He took the audience into the history of science in search of parallels to the current status of knowledge in our field. Biblical literalism hindered attempts at classification of specimens in the 18th century until Darwin gave us the tools to understand speciation. Einstein's work on relativity did not negate Newton, though it did place Newtonian physics in its proper place: "It became clear that Newtonian mechanics were a special case of a broader world-view." Reisen stated that he suspected the same fate will befall psychoanalysis, and that with the accretion of new evidence from other disciplines the current model of psychoanalysis will be seen as a small piece of an as yet unknown picture. He described one more parallel: the paradigmatic shift (without using these terms) from Ptolemaic to Copernican views of the universe—Copernicus, after viewing a map of South America (maps belonging to a different scientific discipline) realized that the old model of the universe simply could not hold.

Dr. Reisen closed his discussion by describing what he thought was the course psychoanalysis should take to avoid marginalization in the scientific community, by learning more about what analysts do and how change occurs in the analytic process. One area psychoanalysis can learn from is linguistics. Reisen explained that analysts have already become experts in the "interpersonal" realm of linguistics, but could learn more about the biological rules governing language learning. Another area is neuroimaging: "We are going to have to see what happens in our brains during therapy. Imaging may be one useful instrument." Another area is learning theory: Kandel learned, through the study of giant snails, that "cells that fire together wire together." Reisen stated that "someday we may be able to understand the microcircuitry of our brains such that not only could we decipher the ways in which any individual would deal with typical conflicts but also know which interventions could lead most efficaciously to changes and why."

Thinking about Reisen's words, I was left feeling somewhat perplexed. To me, it seemed clear that Brenner was looking for answers to the question of what works in analysis in the consulting room. Reisen's emphasis seemed to be that it was necessary to gather data from fields outside of psychoanalysis to make "truer" sense out of the data of the consulting room. I was left feeling in conflict with this—did we not have, already in psychoanalysis, a language for describing, "how individuals deal with typical conflicts?" How would discovering the microcircuitry of our brains during these moments of conflict not merely be exchanging one language—one set of representations, for another (less marginalizing) one? Was this not the real lesson in the story about the alien explorer—that ultimately all we are left with is *representations* of meat?

Dr. Reisen ended by saying that Dr. Brenner had found, in his concept of "medium," a useful simile to guide us in our work. He mentioned the German chemist, Kekule, who had one night dreamt of a snake swallowing its tail and next day discovered the ring structure of benzene. Reisen stated that he was convinced that to "crack open the hard nut questions" like, "how does analysis work," knowledge must be attained from outside of the consulting room. It appeared to me that his view implied that biological knowledge necessarily underlies the phenomenon studied in psychoanalysis. He seemed to be saying that there was a hard kernel inside that hard nut, and ultimately a whole picture over time, bit by bit, becomes filled in, psychoanalysis being just one piece of a much larger, universal metanarrative. This was not, however, what I absorbed from Brenner's paper, which seemed to say that clinical reality was multiple, divided, fragmented, and that this was not a limitation of a limited model but a reflection of the nature of knowledge itself. I was also left thinking of Eissler's lament, in 1964, that psychoanalysis' rise in the United States was mainly due to its ties to psychiatry, that is, to medicine, which, according to him, ultimately altered psychoanalysis in the service of the aims of biological science. I had three questions turning in my head after Dr. Reisen's truly thought provoking discussion of Brenner's paper: would his suggestions shed any light in my day to day work with the sometimes very disturbed patients that fill my clinical hours? Is today's emphasis on neuroscience in our field an indication that psychoanalysis is heading, ideologically at least, towards a newer form of remedicalization? Hadn't pschoanalysis become appealing to me because, as Freud warned Jung on their trip to the U.S., there was value in the fact that it *was* marginalized?

The afternoon's presentations ended with a very vivid and clinically focused question and answer period, where Brenner's cases, specifically Marvin, were discussed in greater detail. Marvin brought to my mind Dr. Rubin's feeling that patients today are no different than in the past, only our views have changed. Was it significant, then, that as Brenner began to describe the at times extreme nature of his "very disturbed, traumatized, and resilient patient's enactments," someone near me in the audience exclaimed, 'Finally, a case presentation I can relate to!?'



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NEW CANDIDATE - RODRIGO BARAHONA, PSYA.D.

I first became acquainted with psychoanalysis in college in my home country of Costa Rica, where I studied psychology in a program heavily influenced by psychoanalytic theory. Many of my instructors, mostly Lacanian psychoanalysts teaching a wide variety of courses, had a great impact on me at a time when taking up a career as a psychotherapist seemed the most reasonable, intuitive, if not compelling choice. Reading Freud, as well as Lacan, Winnicott, and Klein in my early twenties opened up a curiosity for learning more that, fifteen years later, leads me to PINE.

I came to the U.S. to obtain academic credentials and formalize my training as a psychoanalyst. In Costa Rica, training is still done mostly informally, without a specific accrediting body and in analysts' homes, in small study groups, into late hours of the evening. I began my training at the Boston Graduate School of Psychoanalysis, finishing in 2005 and becoming a member of the faculty, where I sometimes teach courses and supervise new students. I have tried to keep connected with my psychoanalytic friends in Costa Rica throughout the years and became an adjunct instructor of a new psychoanalytic center in San Jose that is training a handful of psychologists and sociologists in psychoanalysis. But having my life in Boston—keeping a small private practice in Brookline and spending most of my day hours running a partial psychiatric hospitalization program for Hispanics where group psychoanalysis with severely disturbed patients is the focus—has fueled even more my desire to learn more and increase my involvement in the psychoanalytic community at large. After attending many PINE conferences and meeting with faculty analysts, further training, at PINE, seemed the best choice at this point in time for my career and life.

In the spirit of re-finding objects, this next step in my training has me returning to analysts' homes, working with small study groups, and into the late hours of the evening...

UPCOMING PROGRAMS

Title:	The Fate of Language in Psychoanalysis & its Impact on American Views of the Earliest Relationship: From Dyad to Dialogue
Presenter:	Bonnie Litowitz, Ph.D.
Discussants:	Stephen Rosenbloom, Ph.D. and Jeanine Vivona, Ph.D.
Moderator:	Ana-Maria Rizzuto, M.D.
Date / Time:	Saturday, March 20, 2010, 1:30 - 4:30 p.m.
Location:	Macht Auditorium, The Cambridge Hospital, 1493 Cambridge Street

Title:	Repeating and Recalling Preverbal Memories through Play: The four year psychoanalysis of a six year old boy who suffered trauma as an infant
Presenter:	Inge-Martine Pretorius, Ph.D.
Discussants:	James Herzog, M.D.
Moderator:	Ava Bry Penman
Date / Time:	Saturday. April 17, 2010, 1:30 - 4:30 p.m.
Location:	Macht Auditorium, The Cambridge Hospital, 1493 Cambridge Street

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ANNOUNCEMENTS

It is with great pleasure that we announce the election of **Robert L. Pyles, M.D.** as President-elect of the American Psychoanalytic Association.

We are pleased to announce that **Stephen D. Kerzner, M.D.** was approved as Training and Supervising Analyst and **Graham Spruiell, M.D.** was certified by the Board on Professional Standards of the American Psychoanalytic Association.

Congratulations are extended to **Judy L. Kantrowitz, Ph.D.** who was named National Woman Scholar by the American Psychoanalytic Association for 2008-2009. The inscription on the award reads: "In recognition for her distinguished career as a psychoanalytic educator, researcher, writer, and clinician and for promoting the highest standards in all areas of psychoanalysis. As a model, she has inspired and mentored others, especially women, through her many accomplishments, warmth and generosity."

NEWS AND NOTES

Rodrigo Barahona, Psya.D. presented "Costa Rica: Attitudes towards war, peace, and torture," at the 32nd Interamerican Congress for Psychology in Guatemala City, June 29, 2009. The view presented is that a collective denial of aggression lies at the base of the idealized Costa Rican self-identity. (Costa Rica is known throughout the world as "the Switzerland of Central America" for its peace, diplomacy, and democratic values.) While in Guatemala, Dr. Barahona was also invited to present a case, "Forgetting Margarita, or Shared Unconscious Fantasy: When resistance is an artifact of the analytic interaction" at the Universidad Fransisco Marroquin and the Universidad Rafael Landivar, on July 2, 2009.

Nancy Chodorow, Ph.D. presented the Plenary Address at the American Psychoanalytic Association on January 15, 2010, in New York. The title of her presentation was "Beyond the Dyad: Individual Psychology, Social World."

David Diamond, M.D. recently performed five programs with the Longwood Opera Company, singing selections from Lucia di Lammermoor, L'Elisir D'Amore and La Gioconda.

Gary N. Goldsmith, M.D. was the moderator of a symposium entitled "The Experience of the American Psychoanalytic Association in Russia, 1998-2005" at the January meetings of the American Psychoanalytic Association in New York.

Michael I. Good, M.D. presented a paper entitled "The Present in the Past: A Presumptive 'Case of Childhood Incest' As Seen through the Lens of Screen Reconstruction" as part of his participation on the Panel "A Clinical View on the Directions of Time: Here and Now, the Past in the Present, from the Present to the Past' on August 1, 2009, at the 46th Congress of the International Psychoanalytic Association in Chicago. He also served on the Board of Readers for Individual Papers for the Congress.

Kimberlyn Leary, Ph.D., who is the 2010 recipient of the Division of Psychoanalysis Psychoanalytic Scholarship Award, has been invited to give a lecture entitled "On being part of the picture" at the Division 39 Spring Meeting in Chicago. Dr. Leary was also appointed to the IPA committees on "Prejudice" and "Outreach" for North America and is on the IPA's Sponsoring Committee for the newly established Study Group in South Africa. Dr. Leary presented a paper titled "Racing for the top: Adaptive leadership and race" at the San Francisco Psychoanalytic Center in September and at the Massachusetts Institute for Psychoanalysis in

Cambridge in November, 2009.

Martin Miller, M.D. was a discussant for the presentation by Neal S. Kass, M.D. titled "The Music of Fear, Love and Transformation" at the Psychoanalytic Society of New England, East on January 30, 2010.

Charles Morgan, Ph.D., MFA became President of the Center for the Study of Groups and Social Systems (CSGSS), the Boston affiliate of the A.K. Rice Institute. The Center's mission is to further the understanding of groups and organizations as social systems, with particular attention to covert and unconscious processes and their elucidation through negotiated interpretation. He has recently begun collaborating with artist Yossi Veissid with the goal of producing a series of children's books with covert psychodynamic (i.e, "human") themes.

Jacqueline Olds, M.D. gave a lecture with Richard Schwartz, M.D. at the Baltimore Museum of Art on their recently published book *The Lonely American* on January 10, 2010. Drs. Olds and Schwartz gave a book talk at the Blum Family Center of Massachusetts General Hospital on September 21, 2009.They also gave a talk on the same topic at the Annual Meeting of Sheppard Pratt Hospital on October 28, 2009, and McLean Grand Rounds on November 5, 2009.

Mark F. Poster, M.D. presented a modified version of "Ferenczi and Groddeck: Simpatico – Roots of a Paradigm Shift in Psychoanalysis" at the Wege Zum Es, 4. Symposion der Georg Groddeck-Gesellschaft, Baden-Baden, Germany, on September 26, 2009; and at ConFerenczi 09, 7a ConFerencia International Sandor Ferenczi, Buenos Aires on October 22, 2009.

Kenneth I. Reich, Ed.D. received the Paul Myerson Award from the Massachusetts Institute for Psychoanalysis for co-founding the Psychoanalytic Couple and Family Institute of New England (PCFINE) and Strategic Outreach to Families of All Reservists (SOFAR) and was named a Purpose Prize Fellow for Innovation, for *Using Creativity, Experience to Solve Long-Standing Social Problems* as a Social Entrepreneur, Encore Careers, Civic Venture, Stanford University, California. He conducted a workshop on psychoanalytic couple therapy titled "If You Saw the Face of God and Love Today Would You Change" at the Center for Psychoanalytic Studies, University of Delhi, New Delhi, India. Dr. Reich conducted a workshop on Strategic Outreach to Families of All Reservists at the Meetings of the American Psychoanalytic Association in January of 2009 in New York. Dr. Reich and Jaine L. Darwin, Psy.D. presented "Psychoanalysis and Hollywood Meet the Military: The Valley of Elah and Stop Loss" at the Spring Meeting of Division 39 of the American Psychological Association on April 23, 2009, in San Antonio.

Paula Wolk, M.D. presented "Have we found a neural correlate of Vertical Splitting?: A FMRI study of switching in a patient with DID" at the Boston NeuroPsychoanalysis Workshop on December 8, 2009.

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