

Upcoming Events

Fall 2010/Winter 2011

Peter Lawner, Ph.D., ABPP, "Expressive Uses of the Countertransference" on **Saturday, December 4, 2010** from 9:15 AM-1:00 PM to be held in the Learning Center

Michael Healy, Ph.D., "Nuts and Bolts: A Forum for Early Career Clinicians" on **Saturday, January 8, 2011** from 9:15 AM -1:00PM to be held in the Macht Auditorium

Holly Levenkron, LICSW, "Dissociation in Clinical Practice" on **Saturday, January 22, 2011** from 9:15AM-1:00PM in the Learning Center

Ed Mendelowitz, Ph.D., "Transience and Possibility: The Existential Psychotherapy of Rollo May" on **Wednesday, February 9, 2011** from 7:45-10:00PM in the Macht Auditorium

Jack Foehl, Ph.D., Title to be announced, on **Wednesday, March 9, 2011** from 7:45-10:00PM in the Macht Auditorium

All of the above programs will be held at Cambridge Hospital,
1493 Cambridge Street, Cambridge, MA.

For further information, log on to MAPP's website at www.mappsych.org.

MAPP

Massachusetts Association for
Psychoanalytic Psychology
American Psychological Association
Massachusetts Chapter, Division 39
c/o 1 Eagle's Nest Road
Westford, MA 01886

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President's Column Fall 2010

Gaiana Germani, Ph.D.

Dear MAPP Member,

Despite the shadows cast by insurance companies' encroachment on our work as mental health practitioners and the sharp decline in state budgeting for mental health, there are sparks of light. Communities are rallying together in support of efforts to ensure our patients get the care they need and practitioners the reimbursements which we are entitled. Dr. Jonathan Shedler's (2010) recent article demonstrating strong empirical evidence for the efficacy of psychodynamic psychotherapy have provided psychoanalytic psychotherapists with a strong voice to debunk the myth that only therapies utilizing RCT protocols are valid. Efforts like his and others remind us that there are many royal roads to greater mental health. Teachers and mentors are gathering to address the issue of how best to continue to teach psychoanalytic ideas in training programs both locally and nationally. MAPP plans to fan these sparks in our the community to generate a warm local fire at which we can gather, share ideas, be inspired, and feel supported and nourished in our efforts to stretch professionally and intellectually as psychoanalytic psychotherapists.

MAPP's warmth starts with members' generous commitments to facilitate progress. Peter Lawner has agreed to be the new Chair of the Program Committee. He has developed exciting programs this year taking a fresh look at therapeutic impasse, great psychoanalytic theorists, dissociation, countertransference and more. Gerald Zurich has taken over my term as treasurer. We are really lucky to have his special expertise. With the budget in balance, Gerald will work to continue to assure MAPP's to new financial solidity by streamlining our systems, making each dollar of your membership dues grow. Last but not least, MAPP has created a new Committee for Technology chaired by Jennifer Bortle. With her creativity and skills, she plans to help MAPP expand its use of social networking tools, developing new forums in which we can communicate and express ourselves.

Of course our other committees are also hard at work. For instance, Janet Sand, Chair of the Education Committee, brings culture to MAPP providing a forum for members to explore literature, film, and plays from a psychoanalytic perspective. In the Spring we'll start with a reading of Dostoyevsky's *Brothers Karamazov* with a discussion led by Paul Ornstein. MaryBelle Fisher, as editor of *MAPP News* is devoted to bringing us the

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Memories of Alvin Semrad, M.D. Presented by Gerald Adler, M.D.

By Marcia Smith-Hutton, LICSW, BCD

Dr. Gerald Adler is training and supervisory analyst at the Boston Psychoanalytic Society and Institute (BPSI). He was a student of Alvin Semrad at Boston State Hospital and became a colleague and friend of Dr. Semrad until his death in 1976. On April 3, 2010, Dr. Adler spoke at MAPP of the influence the teaching of Alvin Semrad had upon all clinicians who trained with him. He was greatly idealized by his students, in spite of many contradictions, such as the fact that although he was known for his work with psychotic patients, in his private practice he seldom worked with non-neurotic patients.

In the course of two decades, Semrad conducted more than one thousand case conferences illustrating his approach to working with difficult patients. The few articles published during his lifetime were grounded in his schooling in classical psychoanalysis. This was at a time when the one-person model was mostly practiced. Winnicott and Kohut had not yet reached prominence in the United States, and therefore most clinicians were unaware of the two-person model. Yet Semrad was sensitive to his impact on patients. A bipolar patient whom Semrad was presenting during a case conference at Mass. Mental Health Center felt that Semrad had pushed him too far, and he raised his fist and his voice. Semrad said, "You scare me." This response to his affect had a calming effect on the patient, who felt responded to and heard by Semrad.

Semrad formulated a set of basic principles which he intended for all patients, regardless of diagnostic category:

1. *Using a psychodynamic formulation to define the problems and guide the treatment.*

One of Semrad's major contributions was his emphasis on the psychodynamic formulation. He describes psychotic patients' utilization of avoidance defenses, e.g., denial, projection, and distortion, to obscure the painful reality and their response to it. Semrad emphasized the need to collect data in order to understand the events that led a vulnerable person down the path of psychotic regression. The psychodynamic formula-

tion is equally important with all patients because it helps the clinician avoid the relative obfuscations common in everyone when painful events occur or when old, unresolved conflicts converge in the context of current situations.

2. *Helping the patient to take responsibility for his or her actions.*

Semrad's clinical stance was that people need to take responsibility for the difficulties they encounter in their lives, as well as for the role they play in their relationships with others. He also recognized that different patients have different capacities to acknowledge, bear, and put in perspective their past and present painful experiences.

3. *Connecting bodily feelings with affect.*

Because of their denial mechanisms, patients frequently are disconnected from their bodily sensations. While interviewing patients, he would often ask, "Where do you feel it?" Semrad's students would call this line of inquiry a "tour of the body." He linked specific parts of the body to certain emotions; anger could be felt in the arms and hands, sadness as an ache in the chest, and longing was felt in the genitals.

4. *Helping the patient acknowledge and bear losses.*

Mourning in the everyday psychotherapy hour helps the therapist formulate issues of loss, whether through death, separation, or disappointment, in all patients. This model can be helpful in keeping the therapy focused, which helps counter the tendency of some to obscure and defensively avoid the issues at hand.

5. *Accepting and tolerating the patient's confusion.*

Although Semrad attempted to clarify the patient's confusion, he implicitly communicated the ability to tolerate the ambiguity and uncertainty that accompany good psychotherapeutic work. He demonstrated that the therapist could live with the paradoxical nature of personal dilemma and that he had the necessary patience to

War on Families and the Stigma of Mental Health Treatment: A Psycho-Education Approach." Grand Rounds, Cambridge Hospital, Cambridge, June 2010.

Kenneth Reich Discussant for the film festival "The Messenger" The Collaborative of NASW, Boston College and Simmons College Schools of Social Work, Boston, Sept. 2010.

APPOINTMENTS AND AWARDS

Marvin Brams, Ph.D., has been appointed to the Leadership Council of the National Institute for the Clinical Application of Behavioral Medicine.

Jaine Darwin, Psy.D., ABPP and **Kenneth Reich, Ed.D.** were recipients of the 2010 Harvard Medical School/Harvard School of Dental Medicine's Dean's Community Service Award for their work with Strategic Outreach to Families of All Reservists, Sept. 2010.

Mark Davilia, LICSW became a Teaching Associate in Psychiatry at the Harvard Medical School/Cambridge Alliance. He will also be co-leading a Social Work Professional Development Seminar at the Cambridge Health Alliance, 2010.

Lynne Layton, Ph.D. is a fellow at the Centre for Advanced Study in Oslo, working on a group project title "Personal Development and Socio-Cultural Change."

Kenneth Reich, Ed.D. received a Proclamation honoring SOFAR

from Governor Patrick, State House, Boston, 2009. He received the Paul Myerson Award from the Mass. Institute for Psychoanalysis for cofounding the Psychoanalytic Couple and Family Institute in New England and Strategic Outreach to Families of All Reservists, 2009. He received the Purpose Prize Fellow for Innovation for "Using Creativity, Experience to Solve Long-Standing Social Problems," as a Social Entrepreneur, Encore Careers, Civic Venture, Stanford Univ., CA., 2009. In Sept. 2010 he received the Harvard Medical School Dean's Award for Community Service in recognition for the work of SOFAR, Boston.

Members at Work and Play

Compiled by MaryBelle Fisher, Ph.D.

JOURNAL ARTICLES

Celenza, A. (2010) Mutual Influence in Contemporary film. *Contemporary Psychoanalysis*, 46 (2): 215-223.

Layton, L. (2010) Irrational Exuberance. *Subjectivity*, 3, pp. 303-322.

Pizer, S. (2010) Bridging Multiplicity and Paradox: Plea for a Measure of Negotiation. *Psychiatrie Francaise* (in press).

Spielman, E., Paris, R., & Bolton, R. (2010) Evaluating a Home-Based Dyadic Intervention: Changes in Postpartum Depression, Maternal Perceptions and Mother-Infant Interaction. *Infant Mental Health Journal* (in press).

Spielman, E., Paris, R., & Bolton, R. (2009) Mother-Infant Psychotherapy: Examining the Therapeutic Process of Change. *Infant Mental Health Journal*, 30, 301-319.

PUBLICATIONS

Naiburg, S. (2010) *Structural and Spontaneity in Clinical Prose: A Writer's Guide for Psychoanalysts and Psychotherapists*. Routledge (in press).

PRESENTATIONS AND WORKSHOPS

Andrea Celenza "The Guilty Pleasure of Erotic Countertransference: Searching

for Radial True." Presented at Therapeutic Action of Psychodynamic Psychotherapy Conference, Boston, 2010.

Andrea Celenza "Passion and Perversion in Therapeutic Settings." Full day workshop at Senior Analyst Presentation, American Psychoanalytic Association, New York, 2010, and Master Series in Clinical Practice, Massachusetts School of Professional Psychology, Dedham, 2010.

Rona Knight "Turning Psychoanalytic Theory On Its Head: Nonlinear Development in Middle Childhood." Presented at American Psychological Association in New York City in Jan. 2010.

Suzi Naiburg "The Poetry of What We Do and the Playground of Clinical Prose." A web seminar, Feb. 5-March 12, 2011 for the International Association for Relational Psychoanalysis and Psychotherapy.

Stuart Pizer "From Black Hole to Potential Space." Invited paper for Philadelphia Institute for Relational Psychoanalysis, Sept. 10, 2010. Clinical Seminar (via Skype) co-taught with **Barbara Pizer** for Philadelphia Institute for Relational Psychoanalysis.

Kenneth Reich "Strategic Outreach to Families of All Reservists." American Psychoanalytic Association, Winter Meetings, January 2009, New York.

Kenneth Reich "Psychoanalysis and Hollywood Meet the Military: The Valley of Elah and Stop Loss." Co-taught with **Jaine Darwin**. Division of Psychoanalysis (39) American Psychological Association, Spring Meeting, April 2009, San Antonio, TX.

Kenneth Reich "Improving Care to Returning War Fighters Through the Use of Behavioral Health Programs Supporting Reserve Component Service Members and Their Families." Co-taught with **Jaine Darwin**. Panel Discussion, Force Health Protection Conference, 2009. United States Army Reserve, 2009, Albuquerque, NM.

Kenneth Reich "If You Saw the Face of God and Love Today Would You Change." Workshop on Psychoanalytic Couple Therapy, 2009. Center for Psychoanalytic Studies, Univ. of Delhi, New Delhi, India.

Kenneth Reich Chair: Applications of Psychoanalysis to Families of Soldiers Serving in Iraq and Afghanistan. SOFARUSA: Strategic Outreach to Families of All Reservists, American Psychoanalytic Association, Winter Meetings, Jan. 2010, New York.

Kenneth Reich "The Experience of American Psychoanalytic in Russia, 1998-2005. Symposium at American Psychoanalytic Association, Winter Meetings, Jan. 2010, New York.

Kenneth Reich "The Impact of

help clarify these dilemmas over time.

6. Validating the patient's experience and helping the patient to make decisions.

Implicit in this discussion is that psychotic patients have difficulty in making solid, thoughtful, and constructive decisions about their lives. The application of Semrad's principles affords the psychotherapist the opportunity to hone a technique approach while working with all patients. This includes living with contradictions, tolerating uncertainty, and making decisions in the face of ambivalence.

7. The therapist as "the rock."

The therapist's courage to pursue painful material while accepting the patient's vulnerability provides a "holding environment" that allows productive work to be accomplished.

8. Human responsivity.

The area of inter-subjectivity was also implicitly developed by Semrad, even though he worked in an era when one-person psychology was paramount. He was sensitive to his impact on the patients whom he interviewed and would let them know he was aware of the effect of his words upon them.

Clinicians who are supervised by former students of Semrad have expressed their appreciation for the depth of inquiry and the sharp diagnostic skills of their teacher.

Those who knew Alvin Semrad recall his warmth and his ability to capture and convey his understanding of what was said to him. Above all, Semrad is remembered for his human approach to living. He felt that we can only help others when we are in touch with our own vulnerabilities. He has often been quoted as saying, "We're just big messes trying to help bigger messes, and the only reason we can do it is that we went through it before and survived."

Marcia Smith-Hutton, LICSW, B.C.D. is in Private Practice in Brookline, Mass.

Psychopharmacology for the Non-Prescriber

Presented by

Katherine LaPierre, M.D.

By Louis Chagnon, LICSW

On Sunday, April 18, 2010, Dr. Katherine LaPierre addressed an audience of about thirty interested clinicians at Lesley University in Cambridge. Dr. LaPierre was comprehensive, encouraging questions from the audience, and covered a wealth of topics too broad to include in a short report.

She began by explaining the general proposition that no medicine is perfect and all brains are different. That is why so many patients take multiple psychotropic drugs together. Prescribing often involves trial and error to determine the best combination of medicines to address targeted symptoms while minimizing side effects.

Dr. LaPierre first discussed mood disorders. She defines depression as an inability to experience pleasure. Depression tends to be a recurring illness. Each episode increases the chances of another episode. This fact informs both the dosing and length of psychopharmacological treatment as prevention of relapse is a fundamental treatment goal. Adjusting the choice of medicine and dose is aimed at the patient becoming "Well" instead of "Better." Remission is considered achieved only when there are no symptoms, and the patient feels the same as if she was never depressed. Patients treated for depression who are not treated until full remission are four times more likely to relapse. Continued maintenance of treatment after symptoms have abated is aimed at preventing recurrence. NIMH standards suggest maintaining such treatment for six to nine months after the first episode, one to two years if there is a second episode, and indefinitely if there is a third.

The brain uses many chemicals to modulate mood. Most medicines that treat depression effect serotonin, dopamine, or neuroepinephrine levels in the brain. One challenge for the prescriber is the brain's tendency to sense changes to levels of these chemicals and adjust back to pretreatment levels. In

many instances, pharmacotherapy includes strategies to “fool the brain” so that the therapeutic levels can be maintained.

The most popular antidepressants are the Selective Serotonin Reuptake Inhibitors (SSRI's), such as Prozac and Paxil. These increase serotonin levels in the brain. Patients who do not improve on one SSRI may improve on a different one. Wellbutrin, another drug prescribed for depression, works on norepinephrine. Which antidepressant to try first is not always clear, but a drug that has been effective in treating a family member with same illness may be tried first. Sometimes if a patient has a partial response to an antidepressant, a second antidepressant agent is added. This is called augmentation.

Many antidepressants have side effects. The primary approach to reducing side effects is to try a similar drug that may not have the same side effect profile. However, if only one medicine works on the depression with efficacy, the unwanted side effects may be treated with an additional medicine. This should be done judiciously. For example, 30% to 40% of patients taking SSRIs have decreased libido. The erectile component of this side effect can be treated with Viagra, but Dr. LaPierre thoughtfully points out that the ability to ejaculate is not the same as the restoration of pretreatment libido. Abrupt discontinuation of SSRIs can create physical symptoms, especially if the SSRI has a short half-life (e.g. Paxil).

Dr. LaPierre also reviewed many non-prescription methods of augmenting antidepressant therapy. These include SAM-e at doses between 400 and 800 mg. daily. Folate (folic acid) at a dosage of 1,000 micrograms per day, Light therapy for 20 to 30 minutes daily (but there is some evidence that it may promote cataracts and macular degeneration), and exercise. Fish oil (Omega 3) has been shown to help many people in controlled experiments. It appears to be very helpful to patients with Borderline Personality Disorder as well as depressed patients. The efficacy of fish oil may be related to the ratio of the two beneficial fats it contains, EPA and DHA. The higher the ratio of EPA/DHA the better. Ratios of 7:1 and 5:1 are available under the brand names of Omega Bright and Omega-3Mood. Dr. LaPierre responded to a question about how lay therapists might introduce the idea of non-prescription agents to a patient with the suggestion of simply saying, for

example, “Have you read about fish oil?”

She went on to discuss psychopharmacological treatment of bipolar disorder, psychosis, anxiety disorders, obsessive-compulsive disorder, attention problems and sleep problems.

Dr. LaPierre described psychopharmacology in a comprehensive yet easily understood way that demonstrated how much more than science is involved in good practice. The thoughtfulness and art of prescribing include knowledge of the influence of the prescriber/patient relationship on outcomes, and a willingness to continue trying new drugs, dosages, and augmentive therapies even beyond the achievement of feeling better in order to obtain complete remission of symptoms and minimal interference with the enjoyment of life.

Louis Chagnon, LICSW is in private practice in Cambridge and Milford, MA.

with a catatonic, barely verbal young woman that things felt hopeless? It didn't feel therapeutic, in fact, it felt sadistic. But if that's how she was feeling, how else to be empathic? And how to get her to talk about what mattered? Semrad's response was

“You don't reassure, you don't encourage, you don't agree with her that it is hopeless. That's a diagnosis. Going after the specificity of the reality of the events is an indication that you're not hopeless, that you're willing to be there with her. As a matter of fact, you're insisting to be there with her. The kind of question that gets her attention comes closest to hitting the nail on the head in terms of what she did to create a situation which she now wishes she had not done, and carries with it the empathic effort on your part to get into the same shoes that she's standing in, to indicate to her that you have some appreciation of what she's really up against, not only as it really is, but as she really feels it and lives it.”

And what about love? As became clear, one of the most difficult feelings that beginning therapists of psychotic patients have to bear is the love our patients feel for us. Many of us brought to Semrad our anxieties regarding our patients' expressions of strong love for us. Even more difficult to acknowledge and bear were the intense feelings that our patients sometimes aroused in us. In one such case, to my surprise and relief, Semrad answered, “Well if that's the way you feel about him, maybe he can get better.” He helped us to see that it is, in part, the love that we therapists can feel for our patients, our acceptance of them as they are, that enables them to stick to the painful process of facing previously unbearable feelings.

The bottom line is that every person, psychotic or not, has to struggle with the same developmental issues, and it is built in to us to have the capacities, more or less, to do this. As Semrad would say, “We're all messes, some are just bigger messes than other.” Life is hard for us all. Some people are more or less impeded by nature or nurture in this life process. We are either fortunate enough to have good genes and a good enough environment to carry on relatively smoothly, or we may inherit genes which predispose us to illnesses, physical or emotional, that affect the ways we respond to the great variety of life experiences and traumas that

we may encounter. We learned from Semrad that through an empathic psychoanalytic approach, even the most disturbed individuals can become psychologically strong enough to bear their feelings without the need to regress into psychosis. And finally, if they are no longer psychotic, then within the context of the therapeutic relationship, it's time to get back out there and deal with life.

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(A longer version of this article, co-authored with Max Day, M.D., was published on-line in PSYCHIATRIC TIMES: 2/5/10, www.psychiatrictimes.com./home/content/articles/10168/1519938)

treating him or her with medications) don't have to be mutually exclusive if one goes with the first approach. Medications may be part of what some patients need to be able to master a life problem, although Semrad rarely felt they were necessary or usually used in this fashion. On the other hand, he thought that simply medicating someone to mask psychotic symptoms without helping him move forward in his life is likely to doom him to becoming a chronic patient.

The concept that through a relationship, by talking and encouraging patients to experience feelings, we could be helping such seriously impaired people seemed both incredibly exciting and humanistic, and at the same time overwhelming. Trainees were stuck between those supervisors who would say, "Medicate these patients, get them out of the hospital as quickly as possible, and don't talk to them about emotionally loaded subjects; they can't stand that and will regress," and Semrad who would urge us (within the context of establishing an empathic relationship with the patient) to go right to those emotionally loaded subjects. He would say, "In order for it to help, it has to hurt like hell!"

The following quote from one of our supervision sessions illustrates Semrad's focus on the underlying emotional struggle that can result in psychosis:

Psychosis is a detour in development in which the patient is not functional. Something happens which is intolerable. Decompensation is due to a loss or failure. You need to diagnose the loss and help the person mourn. In the failure situation, you diagnose the discrepancy between the person's expectations of himself and his achievements. You help him bridge the gap or mourn the expectations. You are aiding and abetting the integration of actual life experiences that have been avoided by the regressive defenses.

Clearly his attitude was that in order to help the patient one has to understand the nature of the regression, and not just focus on the clinical presentation.

Although Semrad would not have argued with the concept that some people who have the capacity to become psychotic may be neurologically different than others, he also had the conviction that there was an element of choice involved in the presentation of psychotic symptoms. He believed that the emotional connection between patient and therapist could help

mitigate the need for the patient's use of psychotic defenses:

"It's all very conscious-this regressive behavior-as it has a specific design, a specific purpose, and if one is lucky enough to make the impression that you know what they're talking about, they will talk. Emotionally touching the patients. What matters to people is what they are actually feeling, irrespective of content, irrespective of the issue. But what matter most is the feeling, the reverberation in that person, in his total being."

Semrad believed that a patient needs the therapist's presence to enable him to tackle his attempt to get back into life's circulation, and that a psychotic patient could and did recompensate on the basis of a therapeutic relationship. As we observed him interview patients, Semrad convinced trainees of the power of a "holding relationship" to at least temporarily obviate the need for psychosis. Watching a floridly psychotic patient recompensate in Semrad's presence during a teaching conference and carry on a perfectly lucid conversation about something important in his life provided a dramatic example of the potential power of the therapeutic relationship. The difference between a patient regressing and one who was able to bear intolerable feelings lay in what Semrad called "giving with one hand and taking away with the other." The taking was taking away the defenses and talking directly about what hurts. The giving was the empathy in the therapy relationship. With these powerful demonstrations, Semrad showed us that during empathic contact with another person, a patient could begin to experience feelings that he could not tolerate alone.

He taught us that, "relationships can provide the only true healing there is from human pain, and that is love." Of course the question of what love and empathy meant in the context of psychotherapy often became anguished topics of discussion in our weekly sessions. We had to muddle our way through finding out what really constituted empathy. Semrad would say, "It's all so simple if you think simply-the simplicity of life-and use your own experience to get some appreciation of what this poor person, overwhelmed by it all, is going through." Some students thought of empathy in Rogerian terms, repeating back a patient's words. But, I wondered with Semrad, how was it being empathic if I agreed

Using Developmental Theory of Agency to Navigate Therapeutic Impasse

Presented by
Judith Arons, LICSW & George Fishman, M.D.

By MaryBelle Fisher, Ph.D.

On Wednesday evening, October 20, 2010, Ms. Arons and Dr. Fishman presented their work on using the concepts of agency to understand and work with therapeutic impasses. They emphasized that this is new work for them, and that refinements will come with further work.

Dr. Fishman presented the theoretical underpinning of their work. He places their thinking in the school of thought of Dynamic Systems and Chaos theories leading to Relational Psychoanalytic thinking and an intersubjective frame. This focuses on the body-mind-environment combination in attempting to understand development for any one individual. They have paid special attention to the work of Lou Sander, M.D. and his focus on understanding the parent-infant dyad. It was Dr. Sander who was first insisted that it is the mother-child (therapist-patient) dyad that was the object of study and understanding. He believed that it was mother's responsiveness to infant movement and gesture that was the precursor to childhood initiative which in turn leads to meaningful interactions in the dyad.

In the theoretical framework they are using there is a primary paradox for all living beings: Living beings must embrace sameness and difference at the same time. Sameness with the other provides cohesion, and difference from the other provides uniqueness, leading to connecting and remaining separate at the same time. The exact nature of this paradox is "match specific," meaning that it is particular to each parent-infant dyad in which both parties are working at connectedness and separation. The process of recognition with the infant begins with parent sensitivity to the baby, and responsiveness to her which produces a fit between them. The baby feels known and regulated which leads to self-regulation, experiences of the self and expressive action within the dyad. There is mutual adjustment as the baby initiates action. Parents, then, respond in harmony with this action, and this leads to baby embracing a sense

of agency with an awareness of distinction from the parent.

These comments about theory were illustrated by three vignettes of parent-baby interactions: two supportive of cohesion and separateness, and one in which the parent could not empathetically respond to the infant, creating distress and withdrawal.

The second part of the program consisted of Judith Arons, LICSW, presenting two therapies with adults in which an impasse has occurred. The first case in which the impasse was resolved successfully enough for therapeutic work to continue involved Ms. R, a 65 year old single woman who would come to her therapy session with her dreams from the previous night written out in duplicate so that both she and therapist could have a copy. While being very denigrating of herself, Ms. R. wanted the therapist to interpret the dreams. She wanted approval from the therapist, but experienced input as impinging upon her, which would result in a loss of the ability to take initiative. She wanted feedback which then stifled her. She was angry because she would lose the sense of connection with the therapist when she left the office. Her history included living in a family with a distant father, and a self-absorbed mother who paid little attention to her. She also had a sister with whom she was close, but sister was seen as the pretty, accomplished one, and Ms. R as the unattractive, not very bright one. In understanding something of the development of the paradox of living with connectedness and separateness, and that change is not linear, the therapist and Ms. R. were able to move along and hope that time together would lead to a match specific connection-separation in some moments which would lead to more of a sense of agency in Ms. R's life. They were successful often enough in this enterprise that she made progress in how she lived her life, and became much less self denigrating.

The second clinical illustration is one in which the impasse was not resolved. Mack was a man

who had been in therapy with various therapists for a number of years. He was living a minimal life, saying that he felt that “he didn’t know how to be in the world.” As his parents, who had been unresponsive to him as a child, aged and needed care, he decided to move back into their home and care for them. Although he had previously experienced himself as having no sense of initiative, he came to like himself as he cared for his parents. The earlier childhood struggles he had with his mother seem to resolve themselves as he cared for her. But, as was inevitable, his parents died. Mack then began to regress, and therapy took a bad turn. He wanted the therapist to replace his parents, and at the same time to be taken care of by her. He came to treatment less often as his finances diminished. Mack felt that his differences with the therapist could not be bridged. The therapist urged him to try things, but he said he didn’t know how to live. He wanted a sense of agency from the therapist, who was feeling more and more frustrated and alienated from him. She repeated the earlier struggles with his mother because no joint intervention was possible. Mack closed off to care for himself, and the therapist pulled back to protect herself and regulate her own emotional states. Mack became disorganized and ultimately left treatment. The process of recognition and bridging had collapsed.

Arons and Fishman ended with several conclusions. The first is that initiative cannot be given or demanded. Rather it is inherent in the emerging dyad. It is built on the scaffolding of joint intentionality which builds a positive core self with a sense of agency in the mutual recognition of both partners in the dyad. All living beings contain an impetus to action, but for this to lead to a sense of agency, connection and separation with the other are necessary.

A sense of mutual recognition grows out of repeated experiences within the dyad as they find their way to connection often enough. This is true in the therapeutic relationship as well as the parent-child relationship. Impasse grows out of old battles which happen again. This prompts a fear of abandonment which leads to a loss of a sense of being a separate being, with sameness and difference from the other. The therapeutic impasse is worked on with repeated relational interchanges which include mutual recognition which leads to change in the way of relating.

The discussion which followed the presentation

mainly centered around further elucidation of the process of building a mutual relationship in which the impasse can be examined and experienced.

MaryBelle Fisher, Ph.D. is in private practice in Cambridge and Hingham, MA.

President’s Column

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news about MAPP’s programs and events with thought provoking summaries and discussions. She also developed a special column entitled “I’ve Been Thinking,” inviting MAPP members to tell us what’s been on their minds with opportunities for ongoing conversations. The newsletter as a whole is a forum for new writers who would like to bring their ideas to the community.

As a group, inspired by Caryn Mushlin’s creative thinking, we are working to generate new ways of serving as a resource for members in their efforts to expand their practices and expand the range of professional endeavors. This includes exploring new ways to offer support to beginning clinicians, with mentoring, forums offering new writers an audience in which they can explore their own voice and ideas, matching members who are interested in reading and supervision groups, and social events to enjoy each other’s company, blow off steam and network. Additionally, we are lucky to have Michael Healey’s ongoing commitment to offer his workshop on the Nuts and Bolts of Starting or Enhancing a Private Practice.

I have been a MAPP member since 2003 and have inhabited many roles. I’ve watched us develop a secure financial and intellectual base over the past few years that allows us to launch a very exciting year. I am so pleased to have the opportunity this term as president to watch our committees expand their creative capacities, to be in step with the times and to serve as a greater resource to the psychoanalytic community. We are energized as a group and always welcome fresh ideas and new blood. Please come and make MAPP yours.

References

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I HAVE BEEN THINKING

By Stephanie Adler, Ph.D.

I’ve been thinking (for over thirty years) about my internship experience at Mass. Mental Health Center in Boston and, in particular, about what to do with boxes of transcripts of group supervision sessions with Dr. Elvin Semrad. For those of you who didn’t know him, Dr. Semrad was a much loved psychiatrist and psychoanalyst who had the ability to connect empathically with even the most psychotic of people. During his over four decades of supervising trainees at MMHC, he conveyed his strong conviction that psychotic and other seriously mentally ill patients could benefit from long term psychoanalytically oriented psychotherapy.

Although Semrad’s supervision groups were usually restricted to psychiatry residents, I was fortunate, as a psychology intern, to be included in a group of first year trainees from July 1975 until Semrad’s death in October 1976. The climate at that time had begun to swing to the view of schizophrenia as a chronic neurological illness; a perspective which called for quick treatment with anti-psychotic medications, minimal time in the hospital and supportive therapy. Semrad represented what seemed to be a more humanistic approach. He emphasized the ordinary human pain of the people whom we saw in the hospital expressing their struggles in the most extraordinary ways. Perhaps the most profound moments of our learning occurred while watching Semrad interview inpatients during weekly case conferences at “Mass Mental.” With his no-nonsense empathic style, he was able to engage and “hold” even the most disturbed patients, and for those moments, the patients were able to talk non-psychotically about the painful events in their lives that had led to their hospitalization. Semrad gave his students the strength and the encouragement to persist in doing intensive psychotherapy aimed at, in his words, helping patients to “acknowledge, bear and put into perspective” the feelings associated with the life losses and disappointments that had driven them crazy.

After unsuccessfully struggling alone and then with colleagues who had also trained with Semrad, to find a meaningful way to use the transcripts in my possession, I began meeting with Dr. Max Day.

Dr. Day, first a student and then a colleague and personal friend of Semrad’s, and I met weekly for two years reading and discussing the material. In the end, I decided to work only with the transcripts of supervision of my own patients at MMHC. By using direct quotes from these sessions, I hope to convey what was so special about Semrad’s approach in his own words.

The experience of coming face to face with a person in the grips of acute psychosis can be terrifying. Those with more chronic psychoses often appear less frightening but more off-putting with their bizarre mannerisms. In either situation, most psychotherapy trainees have a natural inclination to distance themselves from their patients. It’s “them” and it’s “us.” While we can feel sympathy and concern for our patients, it is very tempting to regard them as their illnesses, waiting to be diagnosed and cured, rather than as human beings stuck in being unable to navigate some life situation because of feelings that have become intolerable. More than anything else, Semrad helped us to understand that our patients are more like us than we may wish to see.

Semrad helped us to see our patients truly as human beings, and to understand their psychopathology as a defense against intolerable feelings of loss or failure. He taught us that through empathic connections with our patients we could help them bear these feelings, and thereby begin to heal. He often told us, “People become psychotic because they are mad, sad or scared and cannot stand it.” He stressed that rather than getting preoccupied with treating symptoms, we needed to help patients feel the feelings that had become unbearable to them, and then to find ways to solve the same kinds of life dilemmas with which we all struggle. Semrad once said, in response to a presentation of a psychotic woman I was treating, “There are two main approaches: A) do something with the problem, with the person who has the problem and help her master it, or B) stay away from the problem, from the person, and do something to her.”

Doing something with the person to help master a problem and doing something to the person (like