



In This Issue:

Letter from the Editor/p1

Letter from the President/p1

Building News/p2

Education News/p2

Membership News/p3

Membership Briefs/p5

Community & Public Programs/p6

Academic Affiliation & Research/p7

Conversations with Board Members/p9

Patients with Eating Disorders/p12

Patient's Impact on the Analyst/p14

Web Update/p16

Info Sessions/p16

Susan Kattlove, MD
Editor

Bernard Edelstein, MD
President

James S Dalsimer, MD
Chair, Board of Trustees

Catherine R Kimble, MD
Executive Director

Carole A Nathan, MBA
Managing Director

letter from the editor

At the Membership Meeting on November 9, I was struck by how much things have changed at the Boston Psychoanalytic Society & Institute in the last few years. One Member summed it up: "A few years ago we were saying we should do that [referring to new programming], and now we're doing it." But I was struck not just by the wealth of new initiatives, though there are many. Nor was it simply the plans for the new building, though those are beautiful and exciting. What most struck me was how the organization seemed to be working as an organization. There was a feeling of unity among the Members present. This became particularly clear in the discussion about the \$1.3 million shortfall in the budget that will need to be addressed in order to renovate 141 Herrick Road (formerly known as Colby Hall). It is a lot of money, and it came as a surprise. After all, wasn't the move supposed to eliminate our financial woes? Nevertheless, although there was some grumbling and worry, the feeling I got was that we were in this together and we would figure out how to get that money. In short, we were moving forward, not arguing about the past.

In this issue, we publish my conversations with two community board members who shed light on some of the decisions that have brought us to this point. We also have reports on some of the new initiatives BPSI is launching; updates on the website and the building; a thoughtful discussion of understanding and treating eating disorders from a psychoanalytic perspective, by Rita Teusch; a summary of an old but still relevant book, newly out on Kindle, by Judy Kantowitz; and, of course, introductions to all our new Candidates and Students and news of the accomplishments of our Members. As always, send comments and contributions to skattlove@comcast.net.

— Susan Kattlove
Editor

letter from the president

I was delighted to see so many of you at our November 9 Membership Meeting.

I thought that the December issue of the *BPSI Bulletin* would be a good place to report back to all of you on the small-group discussions that took place at the Membership Meeting.

One theme commonly sounded was the need to further strengthen psychoanalytic and psychotherapy education, particularly in the areas of supporting the development of analytic cases and actively promoting the education of Candidates and ATP Students in the post-seminar years. In fact, this was an area of significant attention during the site visit, and at the wrap-up session, site visitors, Candidates, and Faculty offered a raft of ideas. In the last few months, under the leadership of Phillip Freeman, the Education Policy Committee has been hard at work on this challenge, and it's planning to launch a number of new initiatives soon. Similarly, Richard Gomberg is working with those most involved in psychotherapy education to think about how to provide like support to ATP students.

Another area of concern and challenge is how to help new graduates find a comfortable place at BPSI after losing the formal structure of weekly seminars. In addition, as the ATP has become reinvigorated, we are thinking about how to reach out to graduated psychotherapist Members. The Membership Division and the Community and Public Programs Division continue to

continued page 2

letter from the president **continued**

generate thoughts about how to create a home that will feel relevant to the work and interests of our Members. One example is the Committee on the International Application of Psychoanalysis, being explored by Michele Baker and Alex Harrison, which would bring together those interested in global treatment, whether by travel or by Skype tele-travel, to China, Eastern Europe, India, and Central America.

On the subject of the Building Campaign, a number of small-group members spoke about how we might take our campaign beyond the BPSI membership, appealing to those who have benefited from experiences with BPSI, by announcing our new building through a more public venue—an article in the Boston Globe, for example. We will look into such possibilities, and I welcome any further ideas you may have regarding this effort.

— Bernard Edelstein
President

building news

We are rapidly moving ahead with the development of 141 Herrick Road (formerly known as Colby Hall). The Real Estate Committee, working with our creative and ingenious architects, has come up with a plan that provides gracious spaces in which BPSI Members can meet, engage, and comfortably talk with one another. (Architectural drawings are available from the Real Estate Committee. See page 16 for sample.) We have been able to expand our Community Room and our kitchen area and have saved a great deal of money by using only half of the basement floor. The library will be housed in a beautiful room with a soaring timbered ceiling. On occasion, that space will also function as our auditorium. It can hold approximately 90 people, thus reducing our need to rent outside space. There is a considerable amount of parking immediately adjacent to the building, and there will be gentle and well-lit paths to the entrance hall. This will make the building easily accessible for Members and guests.

Our owner's representative, Lee Sollenberger, has been selecting four general contractors while our architects finish the construction plans. Their bids will be completed by mid-December, and the Real Estate Committee will then meet to select a contractor. Our plan, and hope, is that construction will be completed by the end of August 2014, so that we will be able to begin classes in the new space this coming September. Despite some of our doubts, our architects assure us that this is a reasonable goal.

The project does present a financial challenge. At current estimates, pending the contractor bids, BPSI will need to raise approximately \$1.3 million to complete the renovation. This investment, approved by the Finance Committee and the Board of Trustees, will create a building that will beautifully provide for our current and future needs and will markedly increase the property's long-term value.

continued page 4

education division news

The recently concluded site visit by the American Psychoanalytic Association gave us a chance to highlight the latest accomplishments of the Education Division, including welcoming interested clinicians and academics to explore the Boston Psychoanalytic Society & Institute training offerings and programs, admitting robust classes of excellent Candidates, and improving the procedures to help Candidates begin supervised psychoanalytic cases. We detailed for the site visitors the current effort to review the didactic curriculum (see below), and we described improvements in progression procedures and documentation—namely that, beginning with the most recent academic year, we have implemented annual reviews for all Candidates in seminars. This will provide the Candidate, Faculty, and the Students Committee with a clearer idea of the Candidate's development throughout the course of training.

The site visitors encouraged us to gradually extend annual reviews beyond the seminar years. They also suggested we consider immersion requirements during the seminar years and participation in seminars beyond the five-year curriculum pending graduation, in order to achieve the most satisfactory education for each Candidate.

— Phillip Freeman

A Curriculum Review for the Institute

BPSI's psychoanalytic curriculum was last given a thorough review and revision 10 years ago, and since that time, there have been a number of issues to suggest that another review is in order. The Joint Curriculum Committee/Faculty Executive Committee posed questions to be taken up by a Curriculum Sub-Committee, led by myself as Curriculum Vice Chair of the FEC.

Questions include: Are we providing an integrated program that adequately teaches Candidates how to be analysts today?

continued next page

education division news **continued**

Do we have a philosophy regarding how such teaching is to be done? Is there a shared set of goals and values that offers a direction regarding what we teach? It seems that we offer a “big tent” of eclectic approaches. Does this fit our identity as an institute? Does our current format of eight-class seminars match our current education needs? Does the organization of classes into groups called “sequences” (Theory, Clinical, Technique, Development, Psychopathology) continue to work for us? Do we want to consider other teaching modalities? Is the current balance between core courses, selectives, and electives working? What is the current role of the lecture offered to all candidates three times a year? What are the limits of the current course offerings? Are there gaps in our curriculum?

To grapple with these substantial questions, we have formed a committee of 12 members selected from the various Institute committees, including two Candidates. We are working on a Curriculum Goals Statement, to be finished this year, and have identified a key goal: achieving greater integration in our curriculum. We are exploring two kinds of integration: first, an emphasis on clarifying progression from seminar to seminar within each sequence, and second, finding points of connection between seminars of different sequences. Beyond this, we hope to deepen our course offerings by addressing a set of crucial tensions. We hope to offer courses that encourage scholarship while teaching the skills of psychoanalytic praxis, address psychoanalytic history in relation to contemporary trends, and teach core concepts within their context in a way that clarifies their current relevance.

Thus far, the committee has met 10 times. We have reaffirmed our sequence structure and are in the process of completing a review of courses in each sequence. We are looking for ways to better integrate writing and ethics into our course work, and we hope to suggest new formats for seminars that integrate individual Faculty innovations.

We expect to complete this project in 2015.

— Jack Foehl

membership division news

The Membership Division develops and implements programs that enhance the professional life of all Boston Psychoanalytic Society & Institute Members. Randy Paulsen and Bernard Edelstein chaired the new division until this past spring, when I became chair. We have much to celebrate in the richness of our programs and the devoted work of so many Members. I want to highlight some of these programs and recognize the people behind them.

Janet Noonan, Donna Fromberg, and Carole Nathan have worked tirelessly to help us launch our new website, which enriches our experience at BPSI and provides us with new opportunities to connect with the community. Susan Kattlove, as our thoughtful and humorous editor of the BPSI Bulletin, keeps us up-to-date on what’s happening at BPSI in our divisions and also provides a forum to learn what people at BPSI are thinking about.

Although we should all take responsibility for greeting visitors to BPSI, Donna Fromberg has done a wonderful job coordinating our innovative Greeters Program. Alison Phillips will assume responsibility for this program as Donna turns her attention to other projects.

The Members Seminar, under the leadership of Pat Wright, is offering programs this year on the psychology of money, the impact of family on character development, the treatment of a torture victim, and the treatment of eating disorders. This year, Steven Cooper and Allen Palmer developed clinical seminars for graduate Members who might be interested in becoming Training Analysts, and two groups appreciative of the educational opportunity have already begun meeting.

After a number of years of inspiring programs under the leadership of Ellen Pinsky as co-chair of the Program Committee, we are fortunate to have Paul Lynch join Rafael Ornstein as co-chair of the committee. Paul and Rafael are planning new and exciting programs. Our year began in September with the Nemetz Lecture and Bennett Simon’s remarkable presentation and paper titled “Is There a Psychoanalytic Contribution to the Ethics of Sexual Relationships?” Another highlight of the year will be the Skinner Lecture in April, when three humanists will discuss Freud’s “Remembering, Repeating, and Working Through” with Adam Phillips as moderator. We truly have a vibrant analytic community with these opportunities for growth, development, and shared intellectual stimulation.

— Jim Walton

Report from the Executive Council of APsaA

The spring meeting of the Executive Council of the American Psychoanalytic Association (APsaA) was held on June 9, 2013. I served as BPSI’s representative to the meeting as Councilor Cary Friedman was unable to attend. Following is a summary of topics discussed that might be of particular interest and relevance to our Members.

continued next page

membership division news continued

1. Report from the Ad Hoc Task Force on Temporary Objective & Verifiable Requirements for TA Appointments. The temporary requirements for the designation of TA status adopted by the Executive Council at the January 2013 meeting were reviewed. Subsequent to the January meeting, Robert Pyles, President, appointed an Ad Hoc Task Force to implement this policy. The task force is in the process of developing an application process for TA appointment and, depending on the outcome of pending litigation, will let the membership know when applications from qualified applicants will be accepted. (The following developments occurred subsequent to the meeting: On August 14, the Supreme Court of the State of New York ruled in favor of the petitioners representing the Board of Professional Standards, designating BoPS as the standard-setting body. A communication from Robert Pyles and Mark Smaller, President-elect, dated August 30 indicated that the Executive Committee, acting on behalf of the Executive Council, plans to appeal that court decision.)

2. Report from the Task Force on Externalizing Certification. Richard Lightbody, chair of the BoPS Task Force on Externalizing Certification (TFEC), reported that the task force is exploring the most effective way to establish what is being called the American Board of Psychoanalysis as a freestanding enterprise. The mission of the ABP is to develop and provide reliable procedures for national certification in Adult and in Child & Adolescent Psychoanalysis. The question of funding the enterprise looms large. There was considerable discussion in council regarding the work of the task force. Several council members expressed appreciation for the effort expended, and others expressed disagreement with the idea of externalizing certification as currently proposed.

3. Bylaw Amendments. The proposed bylaw amendment regarding BoPS Fellows was approved by the Executive Council. The amendment would make it possible for one of the two Fellows of

the BoPS to be a member of APsaA who is not certified or a training analyst. Uncertified Fellows would be eligible to serve on subcommittees of BoPS. The proposed bylaw amendment creating new membership categories for the Academic Associate Candidate and the Academic Associate was also approved by the Executive Council. The idea behind creating this new category was to reduce confusion about where candidates who are accepted into non-clinical training at APsaA institutes fit into APsaA and to provide a seamless pathway for them as they progress through training. The proposed bylaw changes will be submitted to the Members for a vote in January 2014.

4. Report from the Social Issues Department. Council approved recommendations to establish a Committee on Advocacy for Children and to grant standing committee status to the Service Members and Veterans Initiative. Two position statements from the Committee on the Status of Women and Girls were approved: the Position Statement on the Elimination of All Forms of Discrimination Against Women and the Position Statement on the Endorsement of US Ratification of the Convention of the Rights of the Child. Also, the Revised Position Statement on Physical Punishment was approved.

5. 2013–2014 Fellows.

The proposed APsaA Fellows for 2013–2014 were approved. One APsaA Fellow, Brian Schulman, M.D., is a student in the Advanced Training Program for Psychoanalytic Psychotherapy at BPSI. Brian is a staff psychiatrist in the MGH Bipolar Clinic and an Instructor at Harvard Medical School. He maintains a private practice in downtown Boston. Congratulations to Brian.

With the conclusion of the Executive Council spring meeting, Cary Friedman's and my tenures as Councilor and Alternate Councilor have ended. We have been honored to serve in these capacities during an important time for our national organization.

—Carol Coutu

building news continued

We are working diligently to develop plans to raise this money from our Membership and from outside donors. Our Treasurer, Fred Schultz, has suggested that we apply for a temporary line of credit while we undergo our building campaign. This will enable us to maintain our endowment to fund our educational programs and the many activities for our Members. The Real Estate Committee is always happy to answer any questions about all aspects of this complex project.

We are excited as this project moves forward, and we think you will be as well.

— Jim Dalsimer

membership briefs

BPSI would like to welcome our new Members:

Transfer in: Teresa (Tessa) Cochran, PhD, recently became a member of BPSI after relocating from Alexandria, VA to Orleans, Cape Cod. She is a psychologist and writer who will be opening a local private practice in 2014.

Candidates Year 1

Mary Anderson, PhD, MFA, is an interdisciplinary scholar, artist, and writer whose work bridges theology, continental philosophy, aesthetics, and theory. She is on the faculty of the School of the Museum of Fine Arts and Tufts University and is an associate at the Mahindra Humanities Center at Harvard University. Her research interests are in intersubjectivity, representation, and the formation of ethical subjectivity. She is an Affiliate Scholar.

Andrew Bush, MD, is a child and adult psychiatrist with a private practice in Arlington. He has taught and supervised at The Cambridge Hospital and the Brigham and Women's Hospital.

Lisa Citrin, LICSW, graduated from Simmons College. She teaches and supervises at Cambridge Health Alliance in the Division of Child and Adolescent Psychiatry. She has a private practice in Cambridge, where she treats adolescents and adults.

Rachel Dresner Jacobs, PhD, is in private practice in Newton, where she sees adolescents, couples, and adults. She received her doctorate in clinical psychology from NYU in 1992, followed by a postdoctoral fellowship at New York Hospital–Cornell Medical Center on the Personality Disorders unit. She has lived and worked in Israel and was on staff at the Tufts University Counseling Center. Rachel completed advanced training in couples therapy at PCFINE. She is excited to begin analytic training at BPSI and, most especially, to meet all of you.

Deborah Manegold, MD, completed two years of the ATP before deciding to become a Candidate. She has a private practice in Brookline, where she sees patients for

psychotherapy and psychopharmacology. She co-teaches the "Becoming a Psychiatrist" course in the Harvard Longwood Residency Program.

Lazaro Zayas, MD, is a first-year child and adolescent psychiatry fellow at MGH/McLean. He is interested in psychotherapy and analysis and hopes to practice child analysis. He is interested in the analytic understanding of identity formation and eating disorders.

Fellowship Students

Michael Bolton, MD, is a fourth-year resident in the MGH/McLean Adult Psychiatry Residency Program. He has a wide range of interests, including psychoanalysis, emergency psychiatry, consult-liaison psychiatry, college mental health, and body image issues.

Christina Brezing, MD, is the Chief Resident of Addiction Psychiatry in the MGH/McLean Adult Psychiatry Residency Program. She received the MGH and BPSI Travel Award to the 2013 American Psychoanalytic Association meeting, is the invited resident presenter for the 2014 MGH Ppsychodynamic Case Conference, and is a recipient of the 2013–2014 American Psychiatric Association APIRE/Janssen Resident Research Scholars Fellowship, which is providing support for her study of cigarette-smoking severity and its relationship to gender differences, substance use, and psychiatric symptoms. Next year, she will serve as a Substance Use Disorders Fellow at Columbia University College of Physicians and Surgeons. She plans to pursue psychoanalytic training.

Ying Cao, MD, MEng, is a psychiatry resident who is splitting her final year of formal training between St. Elizabeth's Medical Center and Harvard University Health Services. In addition to psychotherapy, she is also trained in traditional Chinese medicine and engineering and has interests in cognitive neuroscience and genomics. She hopes to combine these perspectives and find ways to deliver personalized and integrated mental health and wellness care.

Genny Feinberg, DO, is a third-year adult psychiatry resident at Tufts Medical Center.

Kristina Gaud, MD

Gwendolyn Kelso, MA, is a PhD candidate at Boston University and is completing her psychology internship at Charles River Counseling Center in Newton, where she sees children, adolescents, and adults.

Aarti Khullar, PsyD, is a staff psychologist at Boston College's Counseling Service and in part-time private practice in Brookline.

Amal Kimawi, MD, is a third-year adult psychiatry resident at Tufts Medical Center.

Mariola Magovcevic, PhD, is a psychologist in private practice and a staff psychologist in the Borderline Center Outpatient Clinic at McLean Hospital. She is trained in DBT, CBT and Acceptance and Commitment Therapy and supervises psychology interns and psychiatry residents at McLean Hospital.

Amy E. Meade, PhD, has a private practice in Arlington, MA where she sees adolescents, adults, and couples. She has received formal training in various treatment modalities, including: Integrative Behavioral Couples Therapy, Emotion Focused Therapy, Cognitive Processing Therapy, CBT, DBT, Mentalization, Internal Family Systems, Exposure and Response Prevention, Acceptance and Commitment Therapy, Motivational Interviewing, Mindfulness-Based Cognitive Therapy, and Interpersonal Psychotherapy for Depression. She looks forward to continuing her clinical training with BPSI.

Paulina Fuentes Moad, MA, is a fifth-year clinical psychology student at the Massachusetts School of Professional Psychology. She is a psychology trainee at the New England Conservatory Counseling Center, where she sees music students for individual psychodynamic psychotherapy. She is also a psychology fellow at MGH/Harvard Medical School, where she primarily coleads DBT groups at MGH Chelsea.

continued next page

membership briefs *continued*

Elizabeth T. Murphy, PhD, is a staff psychologist in the Outpatient Clinic at McLean Hospital, where she runs the DBT Skills Group Program. In addition, she has a small private practice in which she sees individuals in DBT and CBT primary and adjunctive therapies.

Karlín Nazario, MD, is a third-year psychiatry resident at Boston Medical Center. Being from Puerto Rico, she is particularly interested in working with the Latino population and exploring psychoanalytic theory in that population.

Mili Priyanka, MD, is a fourth-year psychiatry resident at St. Elizabeth's Medical Center, where she is serving as the Chief Resident for the academic year 2013–2014. Through the fellowship opportunity at BPSI, she hopes to attain the necessary tools to help her better understand her patients and treat them in a whole manner.

Herb Rothfarb, PhD, is a psychologist in full-time private practice with offices in Harvard Square and Fall River. He provides individual and couples psychotherapy and consultation as well as psychological, neuropsychological, and Social Security Administration evaluations.

Roman Roytman, MD, is a third-year psychiatry resident at Tufts Medical Center.

Christopher Stravato, LMHC, is the associate clinical director of a group private practice providing treatment and assessment to forensic populations in the state of Rhode Island. The fellowship program at BPSI has felt enormously enriching to him; he hopes to continue to be a part of the training and community at BPSI by enrolling in the ATP

Nauman H. Taj, MBSS, ECFMG

Chris Tangren, MD, is an attending psychiatrist in the McLean Hospital Women's Treatment Program. He divides his remaining time between hospital administration at McLean and a small psychotherapy-focused private practice. He hopes to

continue to develop his career in the areas of psychotherapy and hospital administration.

Karina Umanskaya, DO, is in her third year of training in psychiatry at Tufts Medical Center.

ATP Graduate

Marina Kasdaglis, MA, EdM, graduated from the ATP in July 2013.

BPSI would like to congratulate the following Members:

Brian Schulman, MD, was named an American Psychoanalytic Association fellow for 2013–2014.

Sharon Weinstein, MD, was awarded the first Lifetime Achievement Award presented by the New England Council of Child and Adolescent Psychiatry (NECCAP), for her outstanding leadership and contributions to education, clinical practice, and advocacy in the field of child and adolescent psychiatry. Sharon was also named Distinguished Life Fellow by the American Psychiatric Association.

We mourn the loss of our deceased Members:

Ernest Hartmann, MD

Peter Reich, MD

Member resignations:

Ellen Wilson, PhD

Patricia Bresky, PhD

Nora Schwartz-Martin, MD

Herb Brown, MD

Robert Whitman-Raymond, LICSW

community and public programs news

On a shoestring budget, members of the seven committees of the Community & Public Programs Division are walking forth, bringing psychoanalysis into the world through such means as leading talks on films and teaching classes to members of our larger communities, including colleagues in mental health and child care, and engaging in thinking and discussions in the politically rich areas of gender and sexuality and social awareness. The following programs fall under the Division of Community & Public Programs Division:

1. Film Committee, led by Virginia Youngren

2. Explorations in Mind, formerly known as the Program in Psychoanalytic Studies, led by Jane Hanenberg and Chris Morse

3. The Psychoanalysis and Social Awareness Committee, led by Deborah Choate, Bennett Simon, and Roberta Apfel (see next page)

4. The Committee on Gender and Sexuality, led by Gerald Adler and Lawrence Hartmann, with a discussion group on sexual orientation and gender identity, led by Cary Friedman and Paul Lynch

5. The Psychoanalytic Education Forum of Boston, led by Jan Seriff and Rita Hurwitz

6. Childcare Conference, led by Judy Yanof

7. The Kravitz Award Committee, led by Jonathan Kolb

— Michele Baker

continued next page

community and public programs news **continued**

The newest committee in this division, the Psychoanalysis and Social Awareness Committee, hopes to help focus our attention on the social and political context in which we do our analytic work, an area that seems neglected. We will use the new BPSI website to inform members of various conferences, talks, and articles of interest—for example, a recent talk on unconscious biases, a film series at a local high school on race issues, a conference on mass incarceration, and an upcoming conference in New York on guns in schools and on the street. Equally important, we want to let the wider community know of BPSI-sponsored events. Our first BPSI program will be on February 3, 2014, a Members Seminar with Dr. Michael Grodin on the ethical issues raised by political differences between therapist and patient in the treatment of a torture victim.

Please let us know of any areas of interest or events you think we at BPSI should be aware of. We welcome anyone interested in working with us. If you have thoughts, questions, or ideas, please contact Deborah Choate at dchoate123@comcast.net or 617-868-1825.

—Deborah Choate

BPSI's community education program, most recently known as the Program in Psychoanalytic Studies, has a new name: Explorations in Mind. We wanted a name that was less suggestive of a formal program of study, and that better reflected the wide range of interests and audiences we intend to serve. Explorations in Mind offers talks, short and longer-term courses, and other opportunities for discussion on an array of topics related to clinical and applied psychoanalysis. We urge Members with ideas they would like to present to contact us.

—Jane Hanenberg and Christopher Morse

academic affiliation and research news

I. Developing Programs in Psychodynamics

The Boston Psychoanalytic Society & Institute is expanding its partnership with other institutions to increase the role of psychoanalytic thinking in the training of tomorrow's mental health professionals. New programs involve bringing colleagues into BPSI for shared learning as well as having our Faculty and Members teach in outside institutions. In every case, numerous Faculty participate in creating a program, usually starting with those who have been "wearing two hats." Soon, faculty in the sponsoring institution who were formerly not affiliated with BPSI feel like they are a part of us in some way, and a meaningful new connection and sense of shared mission has been developed with another program.

The Program in Psychodynamics in the MGH/McLean Psychiatry Residency Program, now well established and very popular among the residents, has led a number of residents to pursue further study at BPSI. Further, it has become a model for newer programs in psychodynamics, each tailored to the needs and interests of the leadership, faculty, and trainees in the particular postgraduate training program. This year, two new programs have been launched. In the Harvard Longwood Residency Program, many faculty members, including many BPSI Members, have pulled together to create an exciting program. And three Harvard Child Fellowship programs, MGH/McLean, Cambridge Health Alliance, and Children's Hospital, have joined with BPSI Members to develop a program in psychodynamics.

The PiP programs feature the award of coveted travel grants, funded by BPSI and cosponsoring institutions, that support trainees' attendance at the annual meeting of the American Psychoanalytic Association (and sometimes other meetings) and provide mentorship for the academic year ahead.

We are pleased to congratulate these travel grant recipients:

The MGH/McLean Adult PiP has awarded four travel grants this year to: Emily Mukherji, MD; Michael D. Nevarez, MD; Kayla Rosen, MD; and John Teal, MD.

The Harvard/Longwood Adult PiP has awarded a travel grant to Anthony Marfeo, MD.

The Child PiP awards include one from each of the three Child Psychiatry programs. The recipients are: Gabriela Iaguru, MD, from Boston Children's Hospital, Claire Brickell, MD, from the MGH/McLean program, and Lee Robinson, MD, from Cambridge Health Alliance.

Also new is our pilot project at Cambridge Health Alliance awarding travel grants of \$1,000 to two social workers, again providing funding to attend the annual APsA meeting and mentorship for the academic year. The response to this initiative has been robust and impressive, making the selection process challenging. We're very pleased to announce the two grant recipients for 2014: Deepa Ranganathan, MSW, and Lydia Onofrei, MSW.

We are in earlier stages of development in planning a Psychology PiP at Cambridge Health Alliance and building further bridges with colleagues at the Massachusetts School of Professional Psychology. We invite the participation of Members affiliated with these institutions.

continued next page

academic affiliation and research news **continued**

II. The Center for Multidisciplinary Psychoanalytic Studies

BPSI is committed to deepening our connections with other academic institutions that share our interests in psychoanalytic thinking. Our Academic Affiliation and Research Division has brought together Affiliate and Silberger Scholars, along with other BPSI Members, to create COMPASS (Center for Multidisciplinary PsychoAnalytic Studies), a locus for collaboration across disciplines and for the application of psychoanalytic ideas and concepts in the arts and sciences. The center is available to our former and current scholars, interested BPSI Members, and other colleagues and students curious about the world of psychoanalytic thinking.

The goal of COMPASS is to build bridges to undergraduate and graduate communities; enhance the teaching of psychoanalysis, through both its history and contemporary practice; foster multidisciplinary discussion; and serve as an umbrella for collaborative activities and the cross-fertilization of ideas. We envision COMPASS as an open portal to BPSI programs, a point of contact with programs of interest in the academic community, and a virtual home for interdisciplinary initiatives.

Among our affiliations is Psyart.org, which promotes the psychological, including psychoanalytic, study of the arts and literature. Psyart.org hosts an online discussion forum for the continuous exchange of ideas about the psychological study of literature and the arts. The Psyart Foundation sponsors an annual interdisciplinary conference, "Psychology and the Arts," and operates a free, online, peer-reviewed journal featuring articles about psychological approaches to the arts, at www.psyartjournal.com. You can link to Psyart.org directly from the COMPASS area of the BPSI website.

Murray Schwartz has taken a leadership role in developing COMPASS and organizing efforts to define and develop its programs. One exciting COMPASS initiative is a proposal that Murray has made to the administration of his home institution, Emerson College, to develop an undergraduate minor in psychoanalysis, similar to the one already offered at Emory University. He plans to convene an academic course development committee, which will include BPSI members, and to request funds from Emerson to help launch this new academic offering. Once it was established, BPSI Faculty would have the opportunity to help teach the undergraduate courses at Emerson.

Also under the umbrella of COMPASS is a new paper prize. The former Silberger Scholar Program, which had become somewhat conflated with the Affiliate Scholar Program, has been unbundled and reshaped into an academic paper prize. The Board of Trustees has approved an annual \$1,000 award, and Dawn Skorczewski, PhD, has agreed to chair the Silberger Paper Prize Committee. We're very pleased that this initiative will reach out to the broader interdisciplinary academic communities; advertisements will be posted this spring in various academic publications.

As co-chairs of the division, we're excited to shepherd these outreach efforts and to help develop these new community bridges and affiliations.

— Cathy Mitkus and Howard Katz

Building BPSI's Future

The fund drive to support our new building is called "Building BPSI's Future" and our campaign goal is 1.3 million dollars.

For information about ways to contribute toward Building BPSI's Future, please contact Jim Dalsimer, Bernard Edelstein, or Carole Nathan.

conversations with community board members

by Susan Kattlove

Most of us don't have much sense about the men and women who join us from the outside to help us run the Boston Psychoanalytic Society and Institute. In this edition of the Bulletin, I report on my conversations with two of our Community Trustees, Fred Schultz and Phil Burling. (In the spring, I will report on conversations with the other two Community Trustees, Martha Kleinman and Barry Korobkin.) Fred is a senior financial professional. He founded Beacon Fiduciary Advisors in 1990 and joined Seaward Management in 2010. He has been formally elected by the board to serve as BPSI's Treasurer, making him an Officer of the Corporation and the chair of our Finance Committee. Phil was an attorney with Foley Hoag in Boston and is now the Covington & Burling Distinguished Visitor and Lecturer on Law at Harvard Law School, where he teaches legal writing. Phil serves on our Finance and Real Estate Committees. I was impressed by Fred's and Phil's dedication to BPSI and by the tremendous energy they have put into their roles on the board. They are clearly not armchair advisers. And both have interesting thoughts about BPSI and our way forward.

Conversation with Fred Schultz

Susan Kattlove: I'm interested in how you got involved with BPSI.

Fred Schultz: Judy Kantrowitz I've known for 30 years. I was getting off the board of the Park School, where my kids went to school a long time ago, and she knew that BPSI was going through issues with the building, and she thought I could add something if I got involved. I said no two or three times and finally decided I would do it. I do love it. It's very different from anything I've done before. The people (BPSI members) are very, very different. Meetings end at 9:30. In my first meeting, we broke into groups. It was 20 minutes after 9, and no one had talked about the building, and all of a sudden they started talking about the building, and then at 9:30 they stopped. That was my first introduction [to working with analysts]. Everybody is very respectful and listens to other opinions. People aren't afraid to express what they think. I have tremendous respect for the profession, what it does for people. For me, it's been challenging. I'm pretty type A. It's harder to sit and listen. To me the building decision was very simple. [15 Commonwealth] was old. It needed a lot to fix it up. There were code issues. There was no choice. The big question was, where do you go from here? This building is an investment just like the endowment is an investment. There should be enough money to allow the organization to do new programs. It's very exciting.

SK: So when you came on, your focus was the building?

FS: Yeah, finances and investments. That's my background. ... People like Catherine [Kimble], it's incredible what she does. Carole [Nathan] was an incredible hire. And the staff, all the time they put in. Next year is going to be really fun to see it built. Once they're done with that, everything else should take care of itself.

SK: What does a board member with a fiscal focus do?

FS: There are certain reports. The financial system has changed a lot. Pharrel [Wener] has been another incredible addition to the staff. He does have a very good background in it. He's done a good job at modifying the reporting. Because most of the board members don't have a background in finance, it's been challenging to get the reporting so that people understand it.

SK: We sold 15 Commonwealth, we thought we had enough money, and now we need another \$1.3 million. Where are we going to get it?

FS: There is some skill set on the board now relative to raising money and fund-raising, because that's clearly not where most BPSI members come from.

SK: We have a hard time asking our patients for money.

FS: I don't particularly like soliciting people for money. I like presenting the case. You look at 15 Commonwealth. We didn't get as much as we originally thought we were going to get. Not as much went into the endowment as we originally thought. Just as we actually sold the building and started building, the economy started getting better and prices started going up. The expense side went up. I understand the finances of it. I'm not sure how we're going to be able to bridge that gap, raise that money. But as I said at the Membership Meeting, there are a couple of ways. There's a short-term way to handle it and then a long-term way to handle it. We're not going to raise all the money, but I'm convinced we'll raise a portion of it. It's just a question of how big a portion it will be. BPSI will have a beautiful building, and the budget will be set up so that there will be X number of dollars set aside to maintain the inside, to maintain the outside. There are four of us (community board members), and we've all enjoyed being on the board.

continued next page

conversations with community board members **continued**

Every year has gotten better. We've hit bumps along the way, but everything is better. The only disappointment relative to this space is that it's ended up costing more than what we thought, even with the revised numbers. Some people said, we have this money in the endowment; why don't we take what we need from it? The endowment is for programs; we're not going to touch it. At this point, people have bought into that. People are still concerned about the amount of money, because they've never raised that kind of money.

SK: It's a lot of money for a group of therapists to raise.

FS: Yeah, it is, particularly because you are restricted. Hospitals can solicit anybody they want to solicit.

SK: I was going to ask you how you got involved with this institute as opposed to others, but it sounds like getting involved with an institute was not on your mind at all.

FS: I was just finishing up with the Park School, and that was very intense. I'd been involved with Bates College, where I went to undergrad school, and that was very intense, in terms of time and everything else. So I had no intention of doing this. But I don't regret it. I enjoyed it. It's been fun. It's positive and forward. BPSI is in a great place and has great people. I'm very confident. If we go another year and by next fall they're in that building...

SK: And then you'll feel like your job is done.

FS: That's right. Exactly.

SK: Are you going to join another board after this?

FS: No. I still work.

SK: How old are you?

FS: Sixty-seven.

SK: Here that's like a spring chicken.

FS: This will be the last board. I'm done with this. It's enough. It's a responsibility. You make a commitment. You have to do it. Otherwise you shouldn't be involved in the first place. That's why I was reluctant in the first place. It's a lot of time. A lot of the financial issues that had come up have been straightened out, and with Pharrel here, the day-to-day stuff is in good shape. It's all programs and stuff you want to do. As far as I'm concerned, everything else is done.

SK: It's great. To me it's like a different place.

FS: The amount of time people commit to doing the stuff they do, I've never seen anything like it in any other organization at all, not even close. It's impressive.

Conversation with Phil Burling

Susan Kattlove: How did you get involved with BPSI?

Phil Burling: The way I got to BPSI was through Jonathan Kolb. While I was practicing law, Jon was my go-to person if there was some situation that involved a psychiatric issue. After I retired, he had just finished his year as president. People had gotten organized to redo bylaws and rethink the sale of 15 Commonwealth, and he asked me to go on the board. I was put on because about half of my legal practice was representing schools and colleges, not-for-profit institutions, and I had done 20-plus years on the board of New England Medical Center, so I knew something about hospital- or medical-type things. And I'd represented a bunch of physician groups—nothing overtly psychiatric, but the groups had psychiatrists. So I had some knowledge of institutional governance, medical group governance, and I'd done a bunch of purchases of buildings and construction of new space for institutions. So it was simply, bring somebody on board who had skills BPSI needed.

SK: And you were eager to do it?

PB: I was willing to do it. I didn't know exactly what I was getting into. I knew a little bit about psychiatry and psychoanalysis because my parents were both patients and had been involved in it. But as a practical matter, what I knew was from outside. I never read more of Freud than what you read in a humanities class. And it's worked out. Once I signed on, the first major thing I worked on was the bylaw revisions, and since then I've been on the Real Estate Committee working on the design and various parts of that.

SK: What was wrong with our old bylaws?

PB: They were very diffuse. The organization that they represented, if they represented an organization, was divided into multiple parts, and nobody knew who ran what, and they were out-of-date. What had happened was that as events drove BPSI, somebody would create a new bylaw. The classic example being that there was a lawsuit, and basically it forced the creation of a series of bylaws about ethics. The problem was that the organization wasn't terribly well structured to deliver the job it was trying to do. In this instance I'm kind of an outsider looking at the organization. It was a fascinating group to work with. There were about a dozen of us. We met for the better part of two years, looking at various different models. And we came up with what is now in place. The really important thing was trying to work out the reporting relationships and balances between the components of BPSI: membership, teaching, research—all those different components, which no one had seen as separate entities before, and which weren't integrated terribly well.

continued next page

conversations with community board members **continued**

SK: That's what I notice on the ground, in the new structure, the different divisions with one central meeting place.

PB: The special nature of BPSI was those different divisions and how they related. From my standpoint, the interesting thing to discover was that BPSI really was both the Institute and the Society. It wasn't entirely clear within the organization what those two things were. It was clear that a very important part of it was the training piece, the educational piece. But equally, a very important part of it was the Chowder and Marching part of it. It's hard to imagine a group of professionals who are more isolated than psychiatrists. They typically have an office. They don't typically have anything else. They answer their own phones, they have one room, and spend all day sitting in that office. The kinds of experience other professionals have in the outside world don't happen, so BPSI provides a lot of that.

SK: I want to ask about the real estate.

PB: By the time I got there, the angst about "we can't sell 15 Commonwealth" was over. It was perfectly clear that it only made sense to sell it. It was going to cost so much to bring it into the 21st century that it wasn't going to work. Not the least of the problem was that the bulk of the membership was getting to an age where all those stairs would have been a problem. There was no way to put an elevator in without messing with the building. The Community Trustees helped to figure out how to provide the financial support that was needed to bridge the gap between realizing what we needed to do and actually getting the cash by selling the building. Then, there was the decision made to buy the new building, 141 Herrick Road. Then the problem was first to choose the architect and second to work with the architect to come up with a set of designs that were actually viable. At the same time, there were other things going on, notably the website. There were also a group of events going on that were completely outside my expertise, because they were all about expanding the connection between BPSI and Mass General and other institutions, something which as far as I'm concerned is essential to the organization. Just look at the demographics of it. The bulk of the members are over 70. You need inflow at the bottom. You come on as a child. We need more of you.

SK: In most professions, I would be past my peak.

PB: So what I've been pushing at them is that it's essential that we protect the endowment piece so that there are programs, so that in fact we can invest money in doing things that will prove that talking therapy works and that it has a role, that it is viable. Things have to be done to make that argument, and places like BPSI have got to be places that do it. The greater Boston area is a community where there is so much going on in all venues of healthcare that it's almost ideal to be working in it. So I'm really hoping that we will be able to generate money to do the kinds of studies that will prove that psychoanalysis and psychotherapy, the talking mode, really does something.

SK: So you're really hoping that the money will be spent on research. Right now it seems like a lot of money is being spent on the travel grants for the residents, the PIP.

PB: It's hard to argue that that isn't appropriate. From practically no new students, the enrollment has gone up significantly. I've sort of been saying, look, the one place that everybody says psychoanalysis works is with trauma issues. Why don't we work with the VA hospitals some, try to do some stuff so that we're documenting the effectiveness of talk therapy? Fundamentally, what the Community Trustees do is provide some consulting advice based on what we've done.

SK: So what about this \$1.3 million gap we have to fill now?

PB: The building is an old building, and there's no fat in this plan. Catherine doesn't even have an office. There was a very strong feeling by the members that this was home, that this needed to be a space that everyone wanted to come to. It needed to be a place that was attractive. We found ourselves in a place where we couldn't do what we wanted to do without that hunk of cash that we needed to fix it. One of the things that is very important to people is to keep to the existing schedule of basically a day or two a week when everything happens. People plan around that. Their lives, professional and otherwise, depend on having all those classes on the same evening. Some of us said, you wouldn't need as many classrooms if you spread things out. In the dream world where BPSI is successful and a lot of people start coming, there's not a lot of room in the plan as it now stands for a lot more people. If suddenly there were classes of 30 or 40 people, you'd have to go to multiple days.

SK: Do you have any thoughts on how we're going to get that money?

PB: The problem is that BPSI, rather as one might suspect, has had no developed fund-raising capacity. Everybody is starting from scratch. One thing I'm certain of is that you can't expect that money to come in the first three to five years. You have to build up people who are comfortable with giving money and make it a pattern. The base BPSI has is tiny. Just members and members' families. And a few people who are really interested in psychoanalysis, which again is why I think we have to do the research to show that this is a singular medical approach, and then find the person who will pay for it. The answer, I think, to your question is that we have to have a bridge loan. We have to work very hard on broadening the base. We've got to have new members.

SK: So have you enjoyed working with BPSI?

PB: Yes.

SK: Are you going to continue?

PB: Until they get sick of me.

—Susan Kattlove

treating patients with eating disorders

by Rita Teusch

Given the high prevalence of eating disorders among young women, and reports that there is now an increasing incidence of eating disorders in older women, men, and prepubertal children, it is likely that everyone in our community has come across a patient with either anorexia, bulimia nervosa, or binge-eating disorder (which is now a distinct diagnostic entity in DSM-5). It is estimated that 20 percent of the college student population suffers from a subclinical form of an eating disorder.

In the current mental health milieu, these patients tend to be treated by behavioral therapists and eating disorder specialists. Many psychodynamically oriented clinicians shy away from this population, perhaps because of anxiety about symptoms of severe restricting, bingeing, and purging, and perhaps because they fear they have nothing to offer such patients. There may also be a worry that the coordination of care will take up too much time and that, should questions arise in the treatment, there will be no resources to turn to. I would like to address these concerns and encourage clinicians to consider treating patients with eating disorders, because, after all, the dysfunctional symptoms of overeating, purging, or restricting have a meaning in the patient's psychological economy, which needs to be elucidated by a skilled and empathic therapist or analyst. The eating disorder is the patient's way of expressing with food and acting out on her body what she cannot say with words. Five years ago, the Cambridge Eating Disorder Center agreed to add psychodynamic supervision to its behaviorally oriented treatment program, following a proposal by Margaret Sablove, EDD (also a member of the study group mentioned below), who supervised there until recently. The supervision is greatly welcomed by the staff, and anecdotal evidence suggests that it has enhanced patient outcome.

People engage in eating-disordered behavior for many different reasons, but the usual dynamic involves a punishing superego; a sense of narcissistic vulnerability, which is manifested in a self-perception that the ego (or self) is not strong enough to handle the emotional demands of life transitions; object loss or manifest trauma; and a feeling of being "out of control." To compensate, the patient develops an ego ideal (a part of the superego) of perfection, which becomes her internal standard for self-esteem. Starving herself or bingeing and/or purging allows the patient to regain a sense of control and regulate emotions without depending on other people, who are experienced on a deep level as not helpful. While the symptoms of the eating disorder begin as a compensation for (or defense against) overwhelming psychological vulnerability, they subsequently become compulsive and "out of control," because the ego ideal of perfection is ever elusive. The eating disorder becomes the "voice" of the harsh, demanding, and punishing superego/ego ideal. Any deviation from the ego ideal—e.g., not being perfect with regard to achievement, low

weight, or being "good" (which excludes feelings of aggression or anger) or "not being perfect in recovery"—leads to further guilt and shame and increases the compulsive cycle of the eating disorder.

The demands of the eating disorder to restrict/binge/purge can, in severe cases, completely take over the patient's ego/self, with the result that the eating disorder becomes totally ego-syntonic. It is not uncommon for these patients to deny their self-harm and believe that they are not ill but rather "choose" not to eat or to binge and/or purge, adhering to the mental principle that the ego will strive to maintain the illusion of being in control at all costs. A considerable number of eating-disordered patients suffer from an unconscious internalized object relationship with a significant other who has a narcissistic vulnerability, which has left the patient with a sense that she is not her own person but rather is an extension of the other. The most severely ill patients also tend to have suffered, in addition, some overt childhood abuse or later sexual trauma. In these cases, the loss of control and dissociation which were part of the trauma experience are then enacted in the eating disorder.

Eating disorders occur in a wide range of personality organizations ranging from a relatively intact neurotic personality to a vulnerable borderline personality. The eating disorder can be the main, and seemingly only, clinical symptomatology, or it can co-occur with other diagnoses such as major depression, dysthymia, anxiety disorder, PTSD, OCD, or substance abuse.

Clinical research has shown that patients with eating disorders benefit from a multidisciplinary treatment team with a clear division of responsibilities—i.e., a psychotherapist to provide empathic support and insight into the functions of the symptoms, a psychopharmacologist (if needed), a nutritionist to help with meal plans and food choices, and an internist to monitor medical well-being and safety. Such a division of responsibility prevents confusion in the patient about where to take her various concerns. The psychodynamic therapist can be extremely helpful by providing support (if needed) to the other treatment-team members and tactfully clarifying transference and countertransference reactions among team members.

continued next page

treating patients with eating disorders **continued**

Assessing a patient with an eating disorder involves getting a clear picture of the eating disorder symptoms and of how much restriction of food; binge-eating episodes; evacuation techniques of purging through vomiting or laxative abuse; or compulsive exercise have taken control of the patient's ego and are causing the patient to feel out of control. If eating disorder symptoms are suspected because of a patient's low or high weight, weight fluctuations, or allusions to a struggle with eating or food, it is helpful to ask directly about behaviors around food in a nonjudgmental way. Questions asked out of concern and caring about her health can never be a mistake. If the therapist takes the position that the patient will talk about her dysfunctional eating behaviors when she is ready to, s/he runs the risk of colluding with the patient's denial of the eating disorder. Patients feel great shame about this secret aspect of their functioning and need encouragement from the therapist to address harmful behaviors. Many fear that they will be asked to give up their coping mechanisms before they feel ready to do so. Many higher-functioning patients have hidden an eating disorder from their significant others, including their therapists, for years, at significant cost to their health.

If the patient's ego is still relatively intact and has not been taken over by the superego/ego ideal, the patient may be able to work with her therapist to reduce or stop self-starvation, bingeing, and/or purging behaviors when gently confronted. Providing education about the medical consequences of self-starvation, bingeing, and purging is important. A referral to an internist should always be made. If the therapist is comfortable talking about the details of the patient's thoughts about food in a nonjudgmental way, the patient will be increasingly forthcoming about this painful side of her functioning and will be able to collaborate on a plan for recovery. The therapist needs to actively side with the patient's healthy ego until her ego is strong enough to advocate for her own health.

If a patient is not able to reduce her dysfunctional starvation/ bingeing/purging behaviors in a reasonable period of time, the eating disorder has become a compulsion. The superego, in the form of the patient's eating disorder, has taken over the whole of the patient's ego, and suggestions or pressure regarding changing her behaviors will be perceived as criticisms, which will preclude therapeutic influence. These patients have often lived with their eating disorder for many years. The therapist or analyst can be effective if s/he is able to meet such a patient at her level of readiness for therapeutic engagement. If the patient is able to agree to be monitored medically and nutritionally by other healthcare providers while in therapy, the therapist can work with the patient on developing empathy for herself (as

a result of her therapist's empathy for her) so that she becomes aware of her self-destructive (self-aggressive) behavior around food and purging. Eventually the patient may come to feel that she deserves a higher level of care, at least temporarily, in addition to the outpatient therapy. There are evening programs and intensive outpatient programs that can be very helpful both physically and emotionally. Some patients need residential treatment or inpatient care to attain a more solid base for recovery.

Working with eating-disordered patients requires our usual analytic skills, but with some modifications. The psychodynamic therapist or analyst can be most helpful in the role of the patient's unflinching ally, no matter what she brings to the treatment. Consistent empathic listening to the patient's point of view and her experience of other people is essential to her recovery, as this repairs, over time, her deep sense of alienation from others. Such a therapeutic stance can be a challenge in the face of the painful struggles for control that tend to develop with the healthcare providers who monitor such patients' medical and nutritional safety and status.

Helping the patient gain awareness of the functions that her symptoms serve for her is an important part of the clinical work. This requires, especially in the early stages of the treatment, a more active approach by the therapist or analyst. Restricting, bingeing, and purging behaviors serve to soothe feelings of neediness, disappointment, loneliness, emptiness, and even happiness, and they undo guilt and shame about angry feelings and a lack of perfection. Starving the self provides the ego/self with a sense of accomplishment and agency, but also functions as a self-punishment, which needs to be empathically acknowledged. The therapeutic challenge is to help the patient discover and articulate her own voice (her true self) and accept her needs for nurturance, both physical and interpersonal. When the patient no longer criticizes and limits her authentic voice (which is often very angry at herself and others), she will, over time, be able to let go of her eating disorder.

The therapist does well to assume a stance of non-neutrality to counteract the patient's pervasive guilt, shame, and self-criticism, which are covered by denial and fantasies of omnipotence. Such patients tend to project their harsh superegos onto their therapist and elicit the therapist's own shame and self-criticism. The therapist needs to be aware of his/her reactions to the patient and avoid getting caught in projective identification with the patient's sense of not being good enough, as this will intensify the patient's guilt and shame and her eating disorder symptoms. Many patients have told me that the most healing aspect of their treatment was that I consistently wanted to know them as a person,

continued on page 15

the patient's impact on the analyst, kindle edition

by Judy Kantrowitz

When I wrote *The Patient's Impact on the Analyst*, published in 1996, the two-person nature of analytic work had only recently been accepted by traditionally trained analysts—and not yet by many of them. We were trained in an era when countertransference reactions were viewed as interferences in our work, problems that required our seeking further personal treatment. Yet I, like many other analysts, knew from personal experiences and from communications with colleagues that working with patients stirred powerful emotions, and that we, and not only our patients, were often changed by these encounters. Today we take for granted what was in the mid-1990s a source of shame.

I undertook a study of these phenomena with the hope that anonymous presentations of intense transference-countertransference experiences by a relatively large number of analysts might normalize such reactions, and that analysts might come to see their responses as an opportunity for emotional growth for themselves as well as their patients. To that end, I sent questionnaires (1,100) to American Psychoanalytic Association institutes with a request that they be distributed to their graduates. Of the total, 399 were returned; 200 provided clinical examples. I then had open-ended telephone interviews with 26 analysts, asking them to describe the impact their patients had on them. Many of these analysts revealed an analytic process that involved reverberations between the patient's and their own difficulties. Since each analyst had his or her own specific constellation of characterological and conflictual issues, the content that was reworked varied. The methods employed for self-exploration were also diverse. Some engaged in private self-reflections—for many, dream analysis was prominent. Others engaged in discussions with colleagues, frequently a kind of mutual supervision. Finally, some sought formal consultations.

The stimuli arising in the analytic interactions that led the analysts to inquire more deeply about themselves were broadly defined as (1) similarity of conflicts or issues, (2) a quality more developed in a patient than in the analyst that the analyst admires, (3) transference perception of the analyst by the patient, and (4) transference-countertransference awareness and enactments by the analyst. The first two categories describe issues that are conscious or preconscious for the analyst, while the third and fourth may unearth previously unconscious conflicts, sometimes unexplored or unrepresented during the analyst's own analysis.

Just as patients can more readily take in, and make use of, observations and interpretations that are closest to the surface of their awareness, so analysts are more likely to be able to integrate previously unintegrated or only partially explored aspects of themselves that are nearest to consciousness. Their awareness comes as they begin to make conscious comparisons between their patients and themselves. In one example,

a patient's intense, but not yet understood, anxiety around separation and loss reawakened similar memories of early anxiety about separation in an analyst. The similarity of the situation and the affect aroused brought new "memories" to the analyst's consciousness. Whether these were actual events is not clear, but she used the "memories" as a guide to understanding both her patient's panic and her own. The patient calmed in response to the analyst's understanding, while the analyst began to rework her own traumatic period in her dreams, leading to her own calming over time. Another analyst described his admiration for a patient's positive identification with an aspect of his father. His admiration for his patient provided the analyst with an opportunity to rediscover, and ultimately recover, a positive identification with that same aspect of his own father, which he had previously repudiated

When patients observe or interpret some aspect of the analyst that was hitherto outside the analyst's awareness, it affects the analyst in a manner similar to the way that interventions from the analyst affect the patient. Something previously out of awareness becomes conscious. In one example, a patient confronted her analyst with lacking her usual curiosity about symptoms of the patient's that had turned out to be signs of menopause. The analyst then recognized that she had been resisting acknowledging her own menopausal symptoms, which were more advanced than her patient's. She began to recognize that she was transferring onto the patient feelings of sibling rivalry with her sister. The analyst's competitive feelings were stirred in a way that they had not been in her own analysis. These recognitions led the analyst to explore these issues, resulting in her being more accepting of her own experiences, including her previous countertransference blind spot, and renewing her ability to work with her patient on concerns related to the patient's menopause.

Countertransference reactions were by far the most frequent stimuli for self-exploration (69 percent). These responses were recognized either through an affective experience, in which analysts recognized that they had brought an aspect of themselves into the work that differed from their conscious intent, or through the perception of an enactment. In one example,

continued next page

the patient's impact on the analyst, kindle edition **continued**

an analyst told of the pleasure he experienced, and his horror at himself for it, when a woman patient cried with frustration about her love and erotic longing for him. Exploring his reaction with a colleague-friend with whom he had long been meeting weekly for mutual "confessing and confiding," he revived memories of himself as "an intensely wanting and frustrated child." He saw that his "satisfaction" in the patient's wanting something from him that he would not give was his way of not identifying with her—a defense against painful reawakened longing for something from someone that would never be forthcoming.

It was notable that analysts did not spontaneously provide examples of patients' having a negative impact on them. Nonetheless, when asked in interviews, analysts could think of such situations, even if not from their own experiences. One example was a weakening of superego restraints, resulting in boundary crossings or violations. Another was a loss of confidence and self-esteem when a treatment did not go well or when the analyst was faced with the inevitability of limits. While analysts did not expose these experiences about themselves, many described pain and conflict stimulated by their work. They tried to use these struggles to learn more about themselves and become better analysts.

The therapeutic process for the analyst has parallels to that of the patient. Defenses were most often what was first perceived.

The analyst must feel safe enough in the process to feel unsafe, permitting a loosening of defenses. Through reverberations with a patient's affects and conflicts as they emerged in analysis, many analysts became aware of identifications with their patient, allowing them to be more conscious of their own affects and conflicts. The self-exploration that was stimulated led to different depths of affect and insight. Some, but by no means all, analysts illustrated how they worked through their discoveries. Recognitions often seemed to loosen the hold of earlier, sometimes unconscious, beliefs and distressing affect. Insights sometimes stimulated psychic shifts and at other times consolidated them. And just as is true for patients, how and what shifted for the analyst was related to the "match" with the individual patient. Some analysts expressed relief at having described experiences with patients that, while often beneficial to them, had made them feel shame at previously being less self-aware.

In a shift from when this book was first published, we now assume that learning something about ourselves from our patients is part of what happens in treatment, and the expectation is that all case presentations will contain references to countertransference reactions. The pendulum swings.

—Judy Kantrowitz

treating patients with eating disorders **continued**

with all their struggles, without judging their feelings or actions, and that I saw that they were "more than their eating disorder." If the therapist is able to listen with empathy to the "voice" of the eating disorder, and is able to help the patient become aware of her ego's helplessness in the face of the demands of her eating disorder, the patient will gradually become able to have a perspective on her behavior instead of being caught up in it.

I am only one of a group of psychoanalysts in our community who are part of an Eating Disorders Study Group (founded by Debbie Shilkoff, LICSW) and have expertise in the psychodynamic treatment of eating disorders, including complex conditions. If you find yourself with a patient with an eating disorder, we would be glad to provide clinical consultations. Linda Gelda, PsyD, currently president of the Massachusetts Institute for Psychoanalysis, is a supervisor at MEDA (Multi-Service Eating

Disorder Association, Newton). Mimi Pantuhova, PhD, of BPSI treats children, adolescents, and adults with eating disorders. Debbie Shilkoff, LICSW, a PINE analyst and BPSI ATP Graduate, and Pat Wright, MD, of BPSI (who recently became a supervisor at the Cambridge Eating Disorder Center) will offer an elective on eating disorders to BPSI and PINE Candidates and Members in the spring. Finally, our group is planning two Members Seminars at BPSI in the spring to advance the treatment of eating disorders.

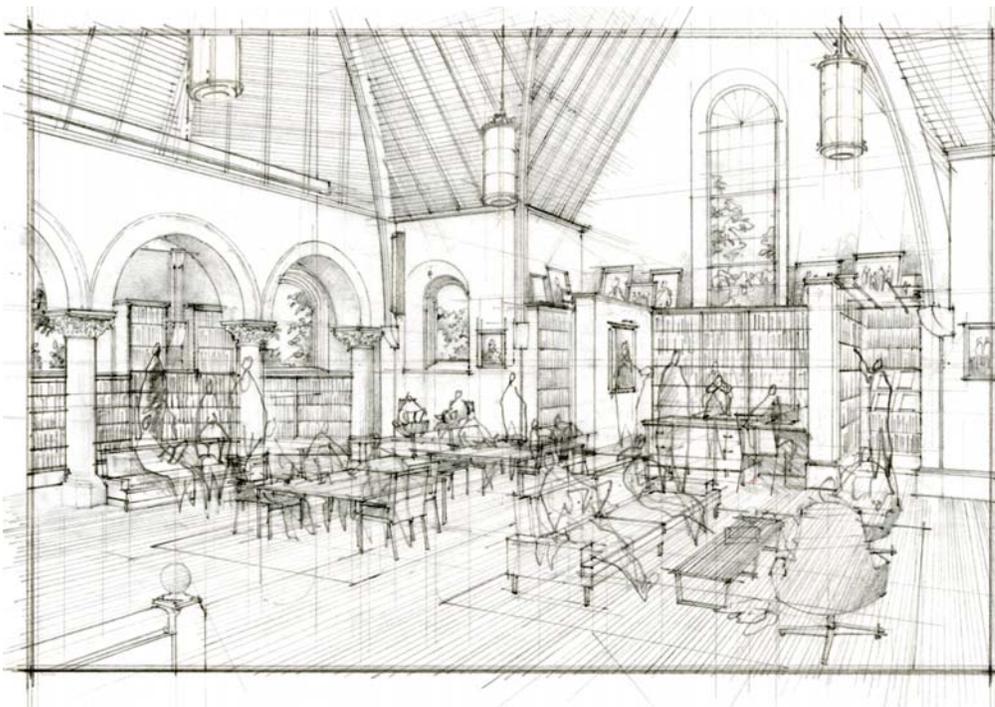
—Rita Teusch

website update

Phase II of the Boston Psychoanalytic Society & Institute website has launched! The latest phase of our redesign focused on the Members log-in section. If you haven't already, please register and explore what's new. Start at www.bpsi.org and click on "Members." You will find the Membership roster, syllabi for all classes with PEP web links to readings, committee reports, the referral directory, and a calendar and announcements. On the public side (not needing a log-in) are the new sections "What's New at BPSI," about BPSI members, and "COM-PASS," describing the exciting new Center for Multidisciplinary Psychoanalytic Studies.

The web team will continue to develop plans for Phase III. We welcome your ideas for the current, as well as the future, phases. If you have any edits or suggestions, or if you would like to underwrite this important project, please contact webteam@bpsi.org.

architect's rendering of library space at 141 herrick



UPCOMING INFORMATION SESSIONS

Our lively, welcoming and open Information Sessions are designed for anyone interested in learning more about psychoanalysis and BPSI. Candidates and Students come together and enthusiastically share their experiences with training at BPSI, answer any questions, and debunk myths.

Please invite anyone you supervise, teach or know who might be interested to learn more about what training at BPSI can offer.

Email Janet Noonan for more information:
janetnoonan@verizon.net

Clinical Program and Info Session

Tuesday, February 25
at Cambridge Health Alliance

*more info to be announced
check www.bpsi.org for details*

Annual Open House for ALL Training Programs*

March 11, 7:30 pm to 9:30 pm
at BPSI

- *- Adult Psychoanalytic Training
- Child and Adolescent Psychoanalytic Training
- One-Year Fellowship in Psychoanalytic Psychotherapy
- Advanced Training Program in Psychoanalytic Psychotherapy