MESSAGE FROM THE PRESIDENT

Welcome to the return of Section I’s member publication, *The Round Robin*. As with much regarding the Section, the Board of Directors is considering a change of the Newsletter’s name, to perhaps better reflect the where and what of the times and the Section itself. Given the Section’s changes of the By-Laws, ratified by the Section I membership, and the Division 39 Board of Directors, you will note from our masthead that the Section is becoming more inclusive: we have several new Board members which include Early Career Professionals, as well as Graduate Students, in addition to continuing the tradition of having a Candidate Representative.

In this issue, we bring an interview with a colleague of mine, who represents that possibly [and unfortunately] rare professional who shifted from a decidedly cognitive-behavioural orientation to a much more psychoanalytical one. We also are sharing reflections on life and practice during the COVID-19 pandemic by Board Member Dr Greg Novie; and Dr Shalini Masih, of New Dehli, India – a new International Affiliate of the Section as well as a Division 39 Scholar. We also include Introductions of our new Graduate Student Representatives. And, while all members of the Section should have received this by now, we offer a reminder of the ‘Call for Papers’ for the next, ‘Special Issue’ of *The Round Robin*. In short, this issue will, hopefully, satisfy. Read on!

The Board is set to have its *fifth* Board Meeting tele-conference in 2020 in September, reflecting the spirit of active renewal and creativity in which the Board – and the Section – is engaged. We still, however, have positions for Secretary and President-Elect which are open, as we engage in building up the new Board to assist and lead in accomplishing the goals and ideals of the Section’s Mission. Please do contact me if you would like to nominate yourself, or a colleague. In the case of the latter, of course, be certain to have the consent of the person whom you are nominating beforehand.

Finally, I would be remiss if I did not make a pitch to renew your membership, if you have not done so. During the recent virtual Division 39 Board of Directors’ Meeting, it was noted that Section I has only 108 members. This means that we have lost voting privileges, and reimbursement from the Division for our Section Representative to attend in-person Board Meetings [when these resume]. We need at least 150 members in order to return the Section to its prior position. As the only Section within Division 39 whose mission is wholly focussed on psychoanalytical praxis, and given the times in which our discipline finds itself, even within the broad field of psychology itself, we need to be able to exercise as much authority and visibility as possible on as great a scale as possible.

While it is, in fact, not yet time to renew your membership for 2021, please consider doing so, and making a note of the intention to apply this to the coming year to the Section’s Administrator, Ms Ruth Helein. Note that we have continued to keep your dues at a modest level! Once more with feeling, please consider re-joining Section I and telling a colleague about us. The link for signing up for Membership is on the Section I web-site: https://sectionone.wildapricot.org/. Your support is appreciated!

David L Downing, PsyD, ABPP, FAPA
President
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As the world deals with the unprecedented crisis of the coronavirus, those of us in the psychoanalytic community may turn our attention to what comes after. What structural changes in society will occur, if any? From our analytic perspective, can we discuss potential psychic structural changes in individuals? To be sure, some will be more affected, more permanently than others, but are there internal psychic changes that would apply to most people? For example, the Great Depression of the 1930s led to structural changes in society and it was called the New Deal. In essence it was a fundamental change in the government’s relationship with the people – the government took on the role of a parent and this has persisted to present day. Less identifiable is the internal psychic changes from experiencing the Great Depression. Children of that era came of age in the 1950s and we could say that was an era of excess as a reaction to the widespread poverty in the 1930s. The internal psychic structure was one of lack, of emptiness to be continually filled.

The experience of World War I led to a change in society’s attitude toward “the Other,” the immigrant with strange language and custom. Indeed, the first legislation restricting immigration was enacted in the 1920s, aimed at immigrants who were other than Anglo-Saxon, primarily eastern Europe and countries in the Mediterranean world. It was a collective, and individual psychic hardening of paranoia of an Other, a fear that ideas (principally Communism) would “infect” American citizens. Now we are faced with an actual, physiological infection, originating from an Other. The virus itself is acting like an Other, one unseen, a “subject” with no desire. In Lacanian terms, we are being confronted with the Real, an experience we still can’t believe is happening, how could it in such an advanced society? How could a virus bring the world to its knees? We are indeed confronted with the Real in a way we never have before in our lifetime.

So what could be the lasting effects of such an unprecedented contact with the Real? For soldiers in combat we have at times called such contact battle fatigue (WW I), shell shock (WW II) and Post-traumatic Stress Disorder beginning in Vietnam and all subsequent wars. As psychoanalysts we think of PTSD as a structure, a structure of such magnitude that it has rendered some totally disabled. When this pandemic subsides will we as practitioners be confronted with a new version of PTSD? Is this best or the only way to conceptualize structural psychic change as a consequence of the pandemic?

In “Love in the Time of Cholera” Femina and Florentino are forever quarantined in a boat on a river. But maybe one hopeful sign for us comes from the same story:

“…It was a time when they both loved each other best, without hurry or excess, when both were most conscious of and grateful for their incredible victories over adversity. Life would still present them with other moral trials, of course, but that no longer mattered: they were on the other shore.”

References

PANDEMIC, MARCHING PARENTS
AND SLEEPING BABIES
Shalini Masih, PhD
New Dehli, India

I am not sure what sounded louder. The sound of my pounding heart echoing inside my head or my little girl’s screams splitting my ears as if begging to be heard not from one ear but from many ears. I stood there next to my husband, feeling his helplessness colliding with mine, magnifying with each passing second. In front of us two doctors and one nurse held our 21 months old baby down. All in the name of treatment. We had rushed her to the hospital that night when she had 104 degrees fever. It was not a good time to fall sick especially when the symptoms resembled the deadly pandemic that plagued our world killing many in its path. We stood there helplessly looking at the doctors inject a cannula in our daughter’s right hand. She screamed and resisted. The doctors allowed me to step in. I held her other hand in mine, gently stroking her forehead, calling out to her because in her screams she seemed too far gone. The mother’s eyes could only see her baby’s face, pain and fear glaring through it and a lot of shock - Was it possible to experience such pain? Even though I kept calling out to her, it seemed she couldn’t see me or her father. Pain, fear and shock overpowered any comfort we could offer in this few minutes. Subsequently she and I were admitted in the hospital’s isolation ward for the next 2 days. Those first few minutes had left a scar not just on her wrist but her mind too. As a result for the rest of our time in isolation my daughter clung to my body at all times. I would hold her close to my body and march up and down the room, ushering her into sleep. And it became stark to me yet again that as my body could expand in pregnancy to nourish a life, in this moment it shrank to sustain a life. I did not feel sleepy and ate very little and did not feel the urge to relieve myself. My only thought as a mother was to make sure my daughter could feel better. As soon as she felt physically better, my husband brought both of us home. Our daughter took some time to be her usual playful self. Until then my body was her couch when she was awake and became her bed when she wanted to sleep. I would hold her close and remain alert as she entered sleep and dreaming. She is playing now and not too dependent on physical holding from me. Through this experience I have wondered that her shock was stemming from the pain and fear she was going through but also she might have felt shocked to see her parents, her demigods just standing there, helpless. Indeed parenthood is not for the fainthearted. It entails allowing oneself to also become a disappointing object. A task not any God is cut out for.

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Since Freud’s time, Psychoanalysts have increasingly dwelled into the baby’s psychic states as they evolve through moment to moment interaction with the surrounding environment forming an internal environment.

Paediatrician and psychoanalyst Donald Winnicott in his many works wrote about the value of disappointment in the internal life of an infant from where is born externality, a recognition of parents as persons in their own right. A prerequisite for this necessary stage of development is a parent who can allow her or himself to be experienced as failing and disappointing. However, to make sure that disappointment does not spiral into deep despair, the parent has to soothe the wounds of the trauma by the holding s/he provides. Disappointment and holding are held together in parenthood. Any parent who has the mammoth task of cultivating the capacity to bear her or his own image as disappointing and powerless in the eyes of her or his child.

I was able to hold my daughter’s resentment for failing her to protect her from pain. It is also a luxury I can afford by being born in a given family, having received good enough education and professional opportunities. But this story is not about my daughter or me. It is about a parent. His name is Rampukar Pandit – a name that has woven in it the ‘call to the divine forces’. He is introduced to us with a picture clicked by a journalist. In it he is seen holding a phone and on the phone call finding out that the divine forces had plans of taking his 11 months old son. This essay is about many parents like him. You might recognise or address them as migrant workers walking miles to reach their homes in native villages. Our government’s strategy to deal with COVI-19 left millions of migrant workers stranded on the roads. With no transport facility masses of migrant workers were seen marching a thousand kilometres of journeys to their homes on foot. This article took form in me on the day after me and my daughter got discharged from the hospital. I was reading an article where one migrant worker’s plight was captured. With my daughter watching nursery rhymes as she lay in the cradle of my lap, I held my phone and read about Rampukar’s painful story, a migrant worker stranded on Delhi’s Nizamuddin bridge, prohibited by police from walking home to his family miles away in Bihar. My gaze lay fixed on his face, contorted with wordless pain, his eyes and mouth almost indistinguishable, both crying out loud in grief. He held a phone in his right hand and seemed to be talking to his wife on the other end. Based on the stories shared I could picture the two parents on either side of the line talking about their 11 months old son who was critically ill. What words would have been exchanged? What emotions would have accompanied them? How is my son? It doesn’t look like he will survive. When will you come home? I looked at Rampukar’s grief stricken face. It was face of a parent dying to hold, comfort perhaps even try all he can to heal his dying son. Perhaps to hold him in his last moments so it could become easier for the little life to depart. Rampukar couldn’t reach home in time to hold his infant son. His son fell into an eternal sleep. I wonder what part of Rampukar as a parent died that day with his 11 month old baby. Having worked with trauma one can say that when idealisations shatter it can drive people to contemplate and even succeed in ending their lives. One hopes Rampukar does not idealise the parent part of him, that his disappointment with himself does not spiral into despair he cannot bear. One hopes he survives and returns as a parent to his three daughters who long for his embrace. What can one do? One hopes parents meet their babies and babies can sleep and dream in the safe haven of parent’s embrace.
NEW STUDENT REPRESENTATIVE TO THE SECTION I BOARD OF DIRECTORS

Susana Gomez

My name is Susana Gomez. My vision is of creating ever-widening spaces where each person can recognize themselves - and be recognized - as not-yet-known, as well as relating constantly to vast worlds unseen. This informs my commitment to bringing psychoanalytic ways of attending to bear wherever the human experience is considered, and was what brought me to the Section I Board as a Student Representative.

I am privileged presently to be working as a therapist in a community-based mental health clinic in my neighborhood, guided not least by the insights of Winnicott, Kohut, Klein, Bion, Ogden, Bromberg and Jung; to be a continuing Postgraduate Fellow with the Massachusetts Institute For Psychoanalysis (MIP) - West, and to be a doctoral (Psy. D) student at Antioch University New England, engaged in a practicum at the university’s Psychological Services Center. My psychoanalytic involvements at Antioch include building and coordinating the Psychoanalytic Society for Your Dreams (PsyDreams), an initiative of the Antioch Society for Psychoanalytic Psychology (ASPP) of which I am a part, and applying psychoanalytic understandings to the development of several research and community initiatives to address society’s collective need for inner decolonization, re-humanization, and mourning. In addition to the above, I am grateful to be on the Division 39 Graduate Student Committee, to have had the opportunity to participate in Section IX’s social justice collaboratory, and for past and present roles involving the expansion of access to a psychoanalytic education through curricular work. The latter has in part been my way of paying forward my own depth-psychological education, which began in my undergraduate years. I knew then that I had found my vocation, and never looked back.

My research and clinical interests in psychoanalysis are many. They include dreams, reverie, and numinous phenomena in the therapeutic encounter and all forms of unconscious communication; liminality; non-human objects, selfobjects and subjects; the dynamics of creativity; schizoid phenomena; conditions necessary for psychic indwelling; music; the disenfranchisement of grief; working with tendrils of health in suicide-nearness, and developing experience-near conceptualizations of autism. As someone who considers Indigenous grassroots movements toward community healing and sovereignty my first encounter with psychoanalysis, I am also interested in the parallels between psychoanalytic perspectives and ancient perspectives that have survived genocide to remain with us today.

I consider myself someone who walks many worlds. These include numerous (sometimes perceived as conflicting) psychoanalytic communities, professional contexts with greatly differing stances regarding the psyche, the world of Disability Justice, decolonial movements with respect to medicine, psychology and education, and more. In this context, I have become accustomed to speaking and hearing psychoanalysis in many “languages,” expanding notions of where and to whom psychoanalysis applies (which so often has involved the question of whose inner worlds and psychic realities deserve witnessing) and doing the work of “linking” and “making digestible.” Being on the Section I Board feels like a homecoming, and it is a joy and honor to be a part of work that is so relevant to what needs to emerge in our world.
Steven Kvaal, PhD, is recently retired from Roosevelt University, where he was initially the Director of Training and later the Director of the PsyD Program. During most of his academic years, he was also a part-time clinical health psychologist at Swedish Covenant Hospital. He appreciated the balance of gratifications provided by both activities.

Steven Kvaal, PhD

KVAAL - DOWNING INTERVIEW

dld: ‘dr kvaal -- steve -- thank-you for taking the time to discuss your professional evolution over time, as a graduate psychology program administrator, professor, and clinical psychologist. you and i initially met about twenty-five years ago, i believe, when we were both directors of clinical training. still later, we both became directors of the graduate programs of psychology of our respective programs, as well as tenured full-professors. i think that in the beginning, we both found it helpful to have a close colleague with whom to discuss certain exigencies and demands of administrative life -- for example, preparing apa self-studies, directing internship and practica processes, and more. but before we get to that, perhaps you could comment upon your own graduate education. for instance, where did you take your graduate education, and something of the nature and foci of your program?

SK: My graduate education in clinical psychology (I earned an MA in special education for my first career as an early ed/special ed teacher) began at Ohio University, where my two main mentors were Steve Lynn (for hypnosis research) and Ken Holroyd (for health psychology research, particularly on minimal therapist contact cognitive-behavioural treatments for tension and migraine headache). My goal was to be a clinical health psychologist and work with patients with chronic pain. I did not have ambitions to be an academic…

I interned at the University of Florida (UF) in their health psychology track, mentored primarily by Mike Robinson. I remained there for my post-doc year and for a year as a clinical fellow. I worked primarily with chronic pain patients, particularly those with orofacial pain during the last 2 years at UF’s interdisciplinary Parker Mahan Clinic, but I also was assigned general out-patient adult mental health rotations, where I was supervised by two psychoanalytically-oriented psychologists, Jacquelin Goldman and Hugh Davis.

I also had the opportunity to supervise graduate students and interns at UF, which experience was my entrée to a position at Roosevelt University (more later).

dld: given what you note, how did this inform your early career professional experiences?

SK: I was fortunate to be able to achieve my goal of working with chronic pain patients. At that time (and I believe it is still the case, unfortunately [at least in the United States, that is – Interviewer note]), health psychology was quite strictly cognitive-behaviorally oriented, in training and practice, and I continued in that vein for some time after leaving UF. For example, my assessment and treatment of pain patients focused on such problems as deconditioning, catastrophizing, avoidance, and depression (conceptualized according to cognitive theory).

However, I continued to be intrigued by my psychoanalytically-oriented supervision experiences and my relatively brief experience of seeing a psychoanalytically-oriented counselling psychologist while at UF. (I remember being intrigued by a book he was reading titled, Psychoanalytic Diagnosis, by Nancy McWilliams. It sounded intimidating…)

dld: i realise that you maintained a private practice even while maintaining academic posts. please tell our readers more about your private practice. what helped determine your directions here?

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SK: Clinical practice was my long-term goal when I returned to graduate school to study psychology. My interest in health psychology was motivated by my wife’s experience with chronic back and leg pain. At the advice of her physician, she underwent spine surgery, which eliminated her pain…for 3 weeks, after which it returned unchanged. When she consulted her physician, she was told he had done all he could do for her and that when she experienced pain she should lie down and take Valium. We now know, based initially on behavioural studies of chronic pain by Fordyce and others, that that is very bad advice. I decided to explore what alternative treatments might be available, which led me to hire a psychologist to tutor me in hypnosis which, eventually, led me to health psychology.

I assumed my first academic position at Roosevelt in 1996 as the Director of Training of the PsyD Program, which admitted its first cohort of students that year. I was eager to return to the Midwest (seasons, frame houses, lakes…) and had become interested (again) in teaching as a result of my experience supervising at UF.

After some fits and starts, I began part-time work at the Pain Clinic of Swedish Covenant Hospital, on the northwest side of Chicago, in a very diverse neighbourhood (some surveys have indicated it is the most diverse zip code in the country). The Pain Clinic provided inter-disciplinary care with a staff that included anesthesiologists (who typically treat chronic pain), a rehabilitation physician, a neurologist, nurses, physical therapists, and psychologists. Because we were housed in a somewhat neglected basement suite next to the morgue, we avoided administrative scrutiny and were able to have twice-weekly 90 minute case conferences with all disciplines involved. We thus were able to deliver genuinely individualised inter-disciplinary care.

dld: what brought you into academia? being an administrator is not everyone’s cup of tea, so i am curious as to what sparked your interest in this domain. there are different models for becoming a director of clinical training and program director or chairperson. what was the model or process at roosevelt university?

SK: As I mentioned above, I had become interested in clinical training at UF. I was eager to develop that skill…and didn’t realise the extent to which the DoCT position at a new program would, at least initially, primarily involve making cold calls to find training sites and attending meetings of Chicagoland DoCTs from academic institutions and psychology clinics. However, because Roosevelt’s Program was relatively small (eventually about 20 students per year), in this position and, later, as Director of the PsyD Program, I did have the opportunity to get to know every student (sometimes much to their surprise, especially if they had come from a large undergraduate institution). I found it very gratifying to be able to witness students’ growth over the course of their years in the Program.

Because the Program was just beginning, I could help shape it, something I was very interested in doing, both as DoCT and as Director. We were fortunate in having a supportive University administration that did not press us to admit a full cohort immediately, having accepted our argument that being more selective would benefit us in the long run through our (eventually) gaining the respect of training sites.

dld: professional schools of clinical psychology [typically, psyd programs] historically have had more representation of psychoanalytical theory and technique within the core curriculum, and have had a far greater emphasis on actual clinical practice -- including psycho-diagnostic training -- than have traditional boulder model phd clinical psychology programs -- but not always. some of which with i am familiar, have in fact, almost seemed to become more like the traditional phd programs over time. how would you describe the evolution of roosevelt's program across your tenure? how would you characterise your influence?

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SK: Initially, we conceptualized our program model as a hybrid of PsyD and PhD. However, despite their claims of flexibility, that did not fly with APA, so we embraced the practitioner-scholar model, but with relatively more emphasis on research (for those students who were interested) than typical PsyD programs. That model has continued into the present. Some students are entirely clinically focused and engage in research only for their dissertation (though dissertation projects are diverse and do not only consist of quantitative studies). Others involve themselves in research from their entry into the program, particularly those interested in careers in neuro-psychology and health psychology. Others admit that they do not plan to do research after graduation but want the opportunity to involve themselves in it during their graduate years.

I confess that, when I was hired, I did not know a great deal about PsyD programs and was somewhat skeptical. As part of my strategy of exploring doctoral education before sending out applications, I had taken a course offered by a local but nationally-affiliated PsyD program. My impression was that many of the students in the class (who were in the PsyD program) had their MAs, had already been doing clinical work, and were seeking the degree to boost their vitae and not necessarily because they had identified areas of need in their training.

However, at Ohio University, I had read some papers by PsyD proponents and, at UF, I had been supervised by a recent PsyD program graduate. The more I learned about the practitioner-scholar model, the more I appreciated it. I also appreciated the candor involved in seeking a PsyD as, in graduate school, a fair number of my fellow PhD students acknowledged that their goal was to be a clinician, not a scientist-practitioner…

I would say one of my influences, along with other faculty, on the development of the Program was to ensure that courses were rigorous. I believed, and still believe, that courses that are too easy not only do the students and their future clients a disservice but are somewhat fraudulent, especially in those cases where programs are largely tuition funded. Another influence, related to this, was maintaining a balance between practitioner and scholar components, neglecting neither. Influenced by the local clinical scientist model, we presented the need to learn to evaluate research as critical when, once practicing independently, they had to evaluate the appropriateness of research not only for a particular problem but also for a particular client in a particular socio-cultural and socio-economic context.

dld: up until your retirement, you had, for many years, relinquished your administrative roles, ‘retreating to the faculty’, as they say....and it is an odd choice of phrasing, regarding a return to a wholly faculty position....what would you say occasioned this?

SK: Frankly, although I tend to be detail-oriented (as students will testify!), I found that the amount of detail required of the Director position, especially regarding accreditation, was becoming more than I was comfortable with. I also believed that some of the younger faculty would be more adept at identifying sources of funding, which was indeed the case. I really enjoyed focusing on the “within-program” details and engaging with students; I was much less comfortable with more national-level engagements.

I also just felt the pull to do more teaching, to have a more direct influence on students’ knowledge (and respect for the limitations of knowledge) of particular topic areas of interest. Those areas turned out to be psychopathology, personality and psychotherapies, practicum seminar and, eventually, psychopharmacology.

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dld: perhaps to delve into an arena closer to our readers’ hearts, you and i had conversations regarding an evolution away from a more purely cognitive-behavioural theoretical and clinical praxis orientation to a psychoanalytical one. as you and i have discussed, this is not the most common arc in the career of a professional psychologist nor academic of which i, at least, have heard. could you please expand on what sponsored these changes for you? for instance, how has your theoretical orientation changed from graduate school on, and what precipitated the changes? over what period of time?

SK: As I mentioned above, for a few years after graduate school, I was a “hard-core” CBT adherent. Then things began to shift…My usual explanation is that I began to listen to my chronic pain patients. I mean this quite seriously, not speciously. I found that although some patients could make fairly rapid use of behavioural interventions, such as activity pacing and PMR, and cognitive interventions, such as identifying cognitive distortions, many could not. One of my initial assessment questions was “How has your chronic pain problem affected your life, including your relationships and your view of yourself?” Initially, I asked this question to identify what was somewhat coldly termed “functional impairments.” What became clear over time, however, was that many patients had childhood histories of abuse or neglect or other problematic family relationships. They may have overcome such histories and held jobs, raised families, etc., but that adjustment proved fragile when under the pressure of chronic pain – a challenge that no one is prepared for. We instinctively know that we should attend to acute pain and seek help but, with chronic pain, undue attention and help-seeking can become maladaptive and cause worsening pain and impairment. I don’t want to stereotype these patients; the extent of previous adjustment varied quite a bit, from folks with terrible histories who were able to benefit from CBT interventions but who realised therapy could help them deal with those histories as well as their current pain, to patients who, in response to that question, would burst into tears and describe, often for the first time, their abuse histories.

My way of framing this limitation of CBT in such relational contexts, when students are puzzled at patients’ “resistance” to their empirically-supported interventions (I use that term, rather than “evidence-based” intentionally), is to ask the students why their patients should believe them in the first place? If they have been not only disappointed but sometimes exploited by authority figures, why should they assume you will be different? Thus, my growing attention to the influence of formative relationships on the ability to cope with chronic pain, including not only bearing up under pain but maintaining a sense of meaning in life given what are often severe physical limitations.

Reading McWilliams’s Psychoanalytic Diagnosis, which I did in preparation for teaching Adult Psychopathology (though I’m not sure what prompted me to do so), also was a major influence. Her focus on personality style and organisation matrices fit well with the problems I was encountering in my chronic pain patients.

Finally, I have also been very influenced by two mentors, the late Jerry Beigler and the still-active Irwin Hoffman. I was fortunate to be paired with Dr. Beigler through an American Psychoanalytic Association fellowship program that involved weekly sessions for about 15 months. I would bring questions about my patients…but somehow we always wound up talking about me. I initiated work with Dr. Hoffman after hearing him use the word “love” in talking about his relationship with his patients at a Division 39 forum of some kind. I thought that this was a good sign for a potential mentor.

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Prior to my retirement, I made the word a topic of discussion in practicum seminars with more advanced students and intro classes with first-year students. Some found it provocative (I have to admit I was going for that to a degree); some didn’t understand the fuss and found it a natural response.

dld: has your orientation changed over time even within the broad “psychodynamic” orientation?

SK: I became intrigued with object relations theory and therapy, though I can’t recall how. I was assigned Cashdan’s Object Relations Therapy in graduate school, but my copy still has the disparaging remarks I made in the margins (which provided some laughs to a grad student to whom I loaned the book). I eventually took a course with Frank Summers wherein he lectured on major figures in object relations, and we read their original writings. The class was small to begin with, and I was the last person remaining at the last session, but I loved it. I eventually used his list of readings for a Psychoanalytic Reading Group that some students and I created (and that lasted for several years). I am influenced primarily by Fairbairn’s model, which I think nicely articulates the conflicts children experience in their relationships with these giants who tower over them and seem to have control over their lives. Winnicott is also an influence. I continue to be intrigued by Melanie Klein’s ideas, though I stopped assigning readings from her (for first-year students) in order not to frighten them off…One of my retirement goals is to do more reading and re-reading of original writing by Fairbairn, Klein, Winnicott, Kernberg and others.

dld: do you differentiate in terms of your foundational orientation and more patient- or problem-specific conceptualisations and interventions (i.e., does your orientation apply more to case conceptualisation, whilst being more flexible in its application to interventions)?

SK: Although I conceptualise at a foundational level primarily using object relations theory, in practice I am more integrative. I have developed an idiosyncratic model for treating patients with chronic pain that progresses from behavioural, to cognitive, to object relational, to existential conceptualisations and interventions. (Every model needs a cute acronym, no? Mine is “BCORE.”) Many patients progressed through the model more or less in order; for example, beginning with walking to address the negative reinforcement power of sitting or lying down that leads to deconditioning; progressing to identifying salient cognitive distortions (which I found often to vary according to the predominant personality style); then exploring formative and current object relations, which had often affected their ability to profit from relationships with medical providers; then to the culminating existential question many patients faced, “Why should I stay alive?” I don’t believe I am unduly idealising when I say that many patients are more existentially present than most of us because they have faced that question directly, often on a daily basis.

Some patients begin in the middle of the progression: As I’ve told trainees, when a patient at the first appointment begins to cry and disclose a history of abuse, you don’t stop to ask how much walking he or she does on a daily basis or what their worst and least pain is on a scale of 0 to 10. You address the distress and its relational context.

dld: to what degree has your orientation influenced your supervision of practicum students, whether at clinical training sites or in practicum seminars?

Personally, my orientations have guided the questions I asked during assessment interviews, what I would listen for in responses, and what treatment I would provide.

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For example, the (very) structured interview I used earlier in my career was several pages long, with detailed questions on pain severity (answered using numbers), activity impairment (numbers by domain), treatment history, and symptoms of depression and anxiety (DSM based). Later on, and as I would say to patients at the start of our first meeting, I would ask about their daily experience of pain, so I could get some idea of what they had to deal with; their emotional experiences, as chronic pain often causes emotional as well as physical distress; and how their pain had affected their lives, including their view of themselves. Very often, tears would well up when I mentioned the last topic, and patients would say how relieved they were to be asked such a question (one many had never yet been asked). In that context, no one balked at being asked about emotional responses.

This development in turn affected my supervision. I eventually encouraged trainees at the clinic to focus less on gathering concrete information at the first session and more on making an emotional connexion with patients and decreasing the stigma they often felt about being referred to a psychologist. I encouraged practicum seminar students to likewise focus less on gathering details and more on attending to the patient’s distress in session; the coherence of the patient’s narrative (see attachment research for more on that variable); and indications of personality style and organisation, especially based on their experience of the patient. I found that the latter, combined with hearing the actual verbal expressions of the patients in recordings, often provided the most informative “data.”

As I shifted to a more psychodynamic orientation, I also began to pay more attention to my own emotional and intuitive reactions to practicum seminar students’ accounts of their patients; in particular, I attended to the impact of the patient on the student. Hugh Davis, at UF, had told me that was what he attended to in his supervision of my cases with him. I was puzzled at the time, but it has come to make a great deal of sense to me. I use the term “intuition,” but I think of it in terms of “processing out of awareness” rather than something magical.

dld: to what degree has your orientation influenced your teaching of non-therapy courses, such as psychopathology or psychopharmacology?

SK: A great deal! As I mentioned above, I have assigned McWilliams’s text for many years now (and I give her credit for prompting an interest in psychodynamic theory and practice in many students) for my Abnormal Psychology course. I also assigned empirical studies of transference (and an article describing a social psychological conceptualisation of transference) and counter-transference. When I took over the Personality & Psychotherapies course, influenced by the course I took in graduate school where we read original writings, I assigned readings by Freud, Fairbairn, Klein (for a couple years), Winnicott, Kohut, and Hoffman.

I suspect some students found my assignment of psychodynamically-based articles in Psychopharmacology to be quite unexpected. These included articles by Nevins, Mintz, and Busch and Auchincloss on both the motivations of medication prescribers (other than empirical support for the meds) and the meaning of medications for patients, based on the authors’ psychodynamic perspectives. I was open to including articles on these topics from other orientations, but I could not find any…If any readers of this interview teach this course, I encourage them to explore those writings and incorporate them in their assigned readings. It was very rare for a student to say that he or she had talked with a patient (or supervisor, for that matter) about meanings of medications or had heard a provider do so.
Kvaal - Downing Interview continued from Page 12

dld: with your retirement from Roosevelt University’s PsyD program, what are your thoughts about the curricular changes that you were able to institute, specifically with respect to maintaining the transmission of psychoanalytical theory and practice? Are there other faculty available to tech and mentor students who are interested?

SK: I believe I had an influence while I was an active faculty member, through my coursework and through informal conversations with students, but I was disappointed when, in response to ads for open faculty positions on more than one occasion, we received no applications from psychodynamically-oriented candidates [this was my experience as well – Interviewer note]. I thought that, by encouraging qualitative research, we would be able to overcome the publication requirements for tenure that might have made some hesitate…but, alas, no. I believe the Program desperately needs a psychodynamically-oriented tenure-track faculty member, especially given that many students subscribe to that orientation after being exposed to the orientation through McWilliams’s text and in the Psychoanalytic Psychotherapies course (taught for the past few years by an adjunct professor). I have been thinking for some time of restarting the collaboratively run Psychoanalytic Reading Group, given how much many students (a few cohorts rotated through it) appreciated it at the time. A faculty member once encouraged us to change the name to something less “analytically” sounding for students’ vitae, but the students in the group soundly rejected that suggestion. They were reading about psychoanalysis and were not embarrassed to admit it!

dld: and, regarding this last note, the survey research which I have done along with students over the years has indicated that such an ‘admission’ is not interpreted negatively by internship directors of clinical training; in fact, they encourage open discussion regarding the matter of students’ emerging theoretical orientations – of whatever type. thank-you, steve, for agreeing to be interviewed on your professional life and journey, particularly as it pertains to your growing interest and practice of psychoanalytical theories. as always, it has been an unmitigated pleasure. and, I look forward to our continued discussions.
It is an honor to serve as a student representative to Section I of Division 39. Psychoanalytic theory and practice is fundamental to my world view and professional identity. In a time where these ideas are facing much misunderstanding and denigration, I feel as though it is of paramount importance to increase accessibility, enhance understanding, and share information regarding this truly transformative work—a mission that I intend to support through my role in both Section I, and the many other psychoanalytic initiatives and organizations of which I am a participant.

My name is Alicia MacDougall. I am an advanced doctoral candidate at Antioch University New England, and I am on my pre-doctoral internship at SUNY Upstate Medical University. In addition to serving as student representative to Section I, I currently serve as co-chair to the Division 39 Graduate Student Committee, am a 2020 APA Leadership Development Fellow, a member of the Psychoanalytic Specialty Council, where I am on the Training Committee developing the Guidelines and Standards for Education and Training in Psychoanalysis, and am the co-student coordinator for Antioch University New England’s Society for Psychoanalytic Psychology. Other roles in which I offer a psychoanalytic perspective include membership on the Children and Families COVID-19 Task Force, and my work on the Graduate Student Education Grant received by Antioch University New England for enhancing training in the field of integrated primary care.

My professional identity has developed through following my curiosity, as well as my enthusiastic approach to critical inquiry and learning. This identity is deeply influenced by individuals such as Bion, Benjamin, Bollas, Winnicott, Searles, Bromberg, Ogden, and more. My clinical observations and activities have informed my proclivity towards working with non-normative forms of consciousness and my abiding interest in psychosis—as well as dreams, neurological disorders, dissociative episodes, and other forms of consciousness as responses to traumatic incidents. These interests have inspired my forthcoming book “The Relational Interpretation of Dreams: When It’s About More Than Your Mother”.

Though trained in a scholar-practitioner model, my involvement in substance abuse, cancer, and cardiac health research in hospitals such as Yale University School of Medicine, and Harvard Medical School Beth Israel Deaconess Medical Center have instilled the sensibilities of a scientist-practitioner. These experiences have grounded my recognition of the importance of evidence-based practice in hands-on experience—a key component to increasing understanding of psychoanalytic practice. In my role as student representative to Section I, I truly look forward to contributing my curiosity and drive to Section initiatives as well as expanding accessibility to, and knowledge of, psychoanalytic theory and practice.
ROUND ROBIN NEWSLETTER: INTRODUCTION OF
REBECCA MOUSSA

My name is Rebecca Moussa and I am currently completing my third year of graduate-level studies in the Doctoral Clinical Psychology Program at Antioch University New England. I am both excited and honored to be joining Section I as a student representative. I have a passion and desire to expand my knowledge of psychoanalytic theory and practice as well as to continue to spread that knowledge and information, which I hope to do through my role in Section I and the other psychoanalytic organizations I am currently a part of. I am an active member of the Graduate Student Committee for the Division of Psychoanalysis, the co-student coordinator of Antioch’s Society for Psychoanalytic Psychology, and a co-student coordinator for Antioch’s Psychoanalytic Society for Dreams.

My interest in psychoanalytic psychology began during my undergraduate studies. I completed my undergraduate degree in Lebanon where I was mentored by two psychoanalytically informed psychologists who fostered my interest and curiosity. This interest has continued to grow throughout my graduate studies with different professors, supervisors, and classes continually deepening and broadening my professional and personal identity. Psychoanalytic theory and practice continues to play a major role in shaping my professional identity and is fundamental to my worldview. I have a wide range of clinical interests and aspire to work with diverse and underserved populations across the lifespan. My time in Lebanon and my Lebanese identity has fostered a continued curiosity in the use of language, particularly on the unconscious activation and dissociation that occurs through our use of language.

As I continue to grow and develop in both my personal and professional identity, my passion around psychoanalysis continues to grow as well. In my experience, many do not have a solid understanding of psychoanalysis and its principles, resulting in derision or stigma out of misunderstanding. I hope to continue to deepen and broaden my knowledge of psychoanalytic theory and practice to challenge and change this stigma through the spreading of knowledge and information. I look forward to contributing my curiosity and passion to Section I, as well as the opportunity to work with and grow from other individuals who share this passion through the exchange of ideas and collaboration on different projects.
CALL FOR PAPERS

Society of Psychoanalysis & Psychoanalytic Psychology – Section I – Psychoanalyst Practitioners
The Round Robin Newsletter, Special Edition: Looking Back, Looking Ahead
Submissions Due: September 21st
https://sectionone.wildapricot.org/round_robin

You are invited to submit a paper for possible inclusion in a special issue of “The Round Robin” Newsletter, a publication of Society of Psychoanalysis & Psychoanalytic Psychology, Section I (Psychoanalyst Practitioners). This special issue of “The Round Robin” Newsletter will be titled: “Looking Back, Looking Ahead,” and will be composed of two parts. You are invited to submit a paper for either, or both, parts of the special issue publication.

As Psychoanalysis embarks on a new decade of vibrant existence, Section I is commemorating the occasion with a call for psychoanalytic practitioners of all levels to reflect on the state of the field, and on their place within the field. Part One of the newsletter will include diverse thoughts from practitioners on the topic of what initially drew them to the psychoanalysis. Part Two asks for statements from practitioners about the direction the practice of psychoanalysis needs to take in order to remain a developing, engaged, and relevant part of the practice of psychology.

In order to present a broad and diverse collection of voices, the Section I Board of Directors envisions that each part of the Newsletter should contain a paper of 1,000 words or less from a graduate student, an early career professional, a psychoanalytic candidate, a clinician who practices from a psychoanalytic viewpoint, and a trained psychoanalyst.

When: Submissions are due by September 21, 2020
How: Papers can be submitted to Kyle Kermott, Psy.D. at drkermott@gmail.com
Who: we are looking for papers from the following:

- Graduate students
- Early career professionals
- Candidates of psychoanalysis
- Clinicians who utilize psychoanalysis in their work
- Certified Psychoanalysts

Where: “The Round Robin Newsletter: Looking Back, Looking Ahead” will be published online in the fall. For more information on the newsletter, please click here.

Topics of Interest:
The special issue will include two parts. You may submit a paper on either topic (or both).

Part I – Looking Back
Please submit a paper describing your personal history regarding psychoanalysis. Possible papers might include such topics as (these are suggestions; your paper does not need to answer these questions):

- What originally drew you to psychoanalysis?
- What have you found/do you find to be enriching about psychoanalysis?
- How has psychoanalysis changed yourself and/or your practice?
- What sets psychoanalysis apart from other theories of mental functioning or clinical practice?
Call For Papers continued from Page 8

Part II – Looking Ahead
Please submit a paper describing your personal view of the future for psychoanalytic practice. Possible papers could include such topics as (these are suggestions; your paper does not need to answer these questions):

• How can psychoanalysis and psychoanalytic practice remain relevant?
• What changes does psychoanalysis need to make in order to grow with the post-modern world?
• What is psychoanalysis missing?
• Where has psychoanalysis failed patients, clinicians, society, etc; and how might these failures be addressed?
• Why continue to study or practice psychoanalysis or psychoanalytic psychotherapy?

For questions please contact Kyle Kermott, Psy.D. at drkermott@gmail.com
For more information about Section I, please visit our website at: https://sectionone.wildapricot.org

David L. Downing, Psy.D., ABPP
President
Section I – Psychoanalytic Practitioners
Society for Psychoanalysis and Psychoanalytic Psychology
Division 39
American Psychological Association