

Bulletin of The Dallas Psychoanalytic Center

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NEW CHAIR JOAN RAFF

The Dallas Foundation for Psychoanalysis would like to announce the selection of Joan Raff, L.C.S.W. as the new Chair. Ms. Raff, who has been a long time advocate of the Foundation and its mission, is looking forward to building upon the previous and capable leadership of Marc Litle, M.D., to serving our community, and strengthening relationships within our and between different area organizations.

The DFP, which is a non-profit organization supportive of the Dallas Psychoanalytic Center and bridge between the Center and the larger community is focused upon providing preventive and educational programs which increase knowledge, insight, self-awareness and compassion regarding a wide range of mental health issues. To this end, the Foundation coordinates programs, lectures, and consultations for public agencies, schools, religious organizations, and the Dallas area community. The DFP is also interested in integrating and applying psychoanalytic ideas and concepts in collaboration with other disciplines. Some of these include literature, neuroscience, film, architecture, religion, mindfulness, and the arts. Another area of importance is increasing community mental health awareness concerning infant mental health, child development and parenting. It is with joy that the DFP continues in these efforts.

The Center and The Foundation have planned many collaborative and diverse programs for this year which will weave literature, writing, music and art into the educative aims of the various programs. All events are free and are open to the public. Please join us!

Our first event is Founders' Day on **October 24, 2009** with Fred Griffin, M.D. He will discuss "The Clinical Use of Imaginative Literature: Creative Reading and Creative Writing" at UT Southwestern 9:30 to 11:30 a.m. in the North Campus, Seay Building, NC 8.212

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DR. STUART TWEMLOW on BULLYING in SCHOOL SETTINGS

By B. James Bennett and Sarah Rabb Bennett

A major change has taken place in the classroom this new century. The child's innate capacities to move forward developmentally are more often hindered by his social and emotional needs. Nowadays teachers are pressed into confronting behaviors and attitudes that block a child or group – attending to or taking interest in what the teacher is presenting; children's emotional issues are coming into the class in an unprecedented way.

Teachers now must be psychologists, counselors even parents in their approach. Their ability to be good teachers and connect with the child demands new creativity based on their understanding of the child's emotional status. A child's cognitive and psychological development requires a teacher reflect on a child's internal experience and how this affects his participation in class, the playground, school and even home life.

Gone are the days when teachers and administrators were mostly concerned about chewing gum or passing notes. Students, their families and school personnel are frightened by the climate that engenders violence on school campuses.

Dr. Twemlow discussed his long experience in various and varied schools where he was consulted on issues of the power dynamics of bullying that were dominating and disrupting the environment. He has been involved in researching and implementing programs aimed at addressing the underlying factors such as the Bully-Victim-Bystander roles exhibited by all the members of the school community. He described how not only students but also teachers, administrators and staff can play each of these roles in shifting dynamics. He gave examples of the bully who doesn't think of other's feelings,

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TAMING “WICKED PROBLEMS”

By Anna Brandon, Ph.D.

Horst Rittel and Melvin Webber, Berkeley professors, coined the term “wicked problem” in 1973 to describe social problems that had no solutions “in the sense of definitive and objective answers” (Rittel & Webber, 1973. *Dilemmas in a General Theory of Planning*. *Policy Sciences*, 4, 155-169). “Wicked” conveyed the sense of malignancy, aggressiveness or downright trickiness and these two social planning experts believed the term described problems for which there was no good solution. Rittel and Webber posited that the increasing pluralism of society prevented objective definitions of equity and made the distinction of any certain undisputable “public good” a quixotic ideal. As a clinical researcher (and an academic candidate), I can’t think of a better way to describe the problems we all face in providing mental health care. Although there have been brilliant accomplishments in the treatment of the mentally ill, now, more than 35 years after the term was coined, mental health professionals are truly confronted by several wicked problems, perhaps the worst of which is depression (predicted to have the second highest cost of all illnesses to society in the next decade). The wicked problem of depression presents even in the face of record numbers of antidepressant prescriptions, “evidence based” psychotherapies and the decreasing stigma attached to mental illness.

Rittel and Webber identified ten distinguishing properties of wicked problems and propose that they require different paradigms for approach. I think they capture the perplexing nature of mental health treatment and support changing paradigms for treatment.

Ten Characteristics of Wicked Problems

1. There is no definitive formulation of a wicked problem. Rittel and Webber pointed out that to define a problem usually the solution has to be in mind ahead of time, which is possible with ordinary problems. The sink doesn’t drain because there is something stopping it up, so you snake it out and it drains again. The ongoing development and refinement of the multi-axial diagnostic system is a good example of how intractable the problem of defining mental illness is and locating where in the human biopsyché the trouble really lies.

The revered medical model has proven incompetent for dealing with the problem, and even our psychosocial theories have been insufficient. For example, what is depression? If it’s just not being “happy,” is the cause biological, social, interpersonal, psychological or spiritual? We know it incorporates all of these, but we don’t know what the determinants of any of these components are or their impact in pairs or groups.

2. Wicked problems have no stopping rule. In mathematical equations, the scientist has an answer that is unequivocal. The formula has one solution and one solution only (or so it seemed in all my stat exams). Where does depression end and euthymia take over? When do we tell a patient, “You’re happy enough now, I think. It seems that we’re done here”? When do we know what we’re doing works? We don’t do well at this, as demonstrated by the relapse rates.

3. Solutions to wicked problems are not true-or-false, but good-or-bad. When a patient doesn’t improve or takes his life, it isn’t simply that the treatment didn’t work. The treatment had a terrible outcome. By the way, what is the desired outcome? Life normally includes happy and sad events—when a patient says, “I just want to be happy again,” or “I want to feel the way I used to feel,” is it realistic to think we can help them reach that goal? Life transitions change individuals and previous states may be unattainable.

4. There is no immediate and no ultimate test of a solution to a wicked problem. With biological infections, both patient and doctor know fairly soon if the right antibiotic is being used. With the wicked problem of mental illness, we may not know the full consequences of treatment for some time. The consequences are almost impossible to predict and impossible to plan ahead for. The best we can do is to create contingencies. The patient may recover from symptoms of depression and promptly realize that her husband was a good part of the problem. Now she may have the psychological strength to begin the process of separation and divorce, but what about the children?

5. Every solution to a wicked problem is a “one-shot operation;” because there is no opportunity to learn by trial-and-error, every attempt counts significantly. Psychotherapy leaves tracks. My heart always skips a beat when a patient says, “Remember when you said...” I say things unintentionally sometimes, without thinking I’ll be remembered (or quoted) later. Every patient counts; every session counts. Someone is seeing me with the expectation that I am going to help and, once you launch a string of words, they cannot be reclaimed. That isn’t to say we don’t learn by trial and error, but we have to recognize the risks when we do so. Being familiar with evidence based treatments informs us what works for “samples” of individuals who are more alike than not alike, but decisions for treatment approaches still necessitate individualized plans of action.

6. Wicked problems do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan. Ordinary problems have a limited set of possible solutions. Rittel and Webber used chess as an example—finite sets of moves with an accompanying finite set of rules. Research on depression struggles with the limited number of designs that can be used to find out if a treatment works or not and the unlimited number of reasons why psychotherapy might work (or not work). It isn’t just about coming up with the funding for a respectable randomized double-blinded controlled trial of psychodynamic treatment and a no-treatment condition. For one thing, you can’t blind anyone to the condition of administering or receiving psychotherapy or analysis (unless the patient has recently relocated from outside Earth). For another thing, it isn’t particularly ethical to identify someone as suffering from depression and put them in a no-treatment or wait-list control group (although it’s done). One of the challenges to holding psychotherapy to the same empirical rigor of pharmaceutical trials for the treatment of depression is that inconstant humans bring an inexhaustible set of variables to a study even if the clinicians are using a manualized approach and the statisticians are accounting for confounders.

7. Every wicked problem is essentially unique. Wicked problems have no precedents; each one is unique. Doesn’t that sound a little bit like the unique set of

therapist and patient? Mental illness isn’t like simple illnesses such as tonsillitis or even complex illnesses such as HIV/AIDS.

8. Every wicked problem can be considered to be a symptom of another problem. Ordinary problems are self-contained; wicked problems are entwined with other problems. The example of poverty comes into play here. Poverty is more than a lack of resources—how did the individual or group find themselves with no resources? Sounds like depression and relationship dysfunction to me. Or a society that prizes independence above interdependence. Or a media that cares more about selling looks than promoting health. We could go on and on here when we look at what depression could be a symptom of in today’s society.

9. The existence of a discrepancy representing a wicked problem can be explained in numerous ways. The choice of explanation determines the nature of the problem’s resolution. Wicked problems have so many stakeholders they can be described a million different ways. At the American Psychological Association annual conference in Toronto this week, I strolled down the aisles of the APA store and vendors. How many different types of psychotherapy are there for the treatment of depression (not only is that our topic, I defy you to count them if we throw out the indication in this discussion)? And yes, less than five are considered “evidence-based.” The empiricism demanded by the scientific community and managed care has us stuck, because the limited means of supporting or refuting hypotheses cannot account for the richness or the complexity of the problem of treating depression.

10. The planner has no right to be wrong. When you tackle a wicked social problem, the goal is not to find the truth, but to improve some characteristics of the community or the world. The usual immunity to blame scientists enjoy as long as they play by the rules of hypothesis testing isn’t enjoyed by those researchers planning approaches to wicked problems—we are liable to some extent for the consequences of treatment our patients face.

Strategies for Wicked Problems

Rittel and Webber pointed out that, in the absence of an overriding social theory or an overriding social ethic, there could be no clear determination of whose values or beliefs would be right or best serve the ends of all. However, in regard to social or “wicked” problems, they warn that to reconcile social values and individual choice by leaving all decision-making to the experts may make rationales explicit but not improve outcomes. In other words, managing wicked problems means involving all the stakeholders in accepting the malignant nature of the problem and collaboratively developing a strategy. This sounds a little bit like some fascinating research findings about treatment outcome. One group found a high association between treatment outcome and patient preference strength—in a group of 60 participants meeting DSM-IV criteria for depression who were randomized to antidepressant medication or interpersonal psychotherapy, the strength of their preference for the treatment they were assigned to was more predictive of good outcome than whether or not they received the treatment they preferred (and participants had a stronger preference for psychotherapy than pharmacotherapy). (Raue, P.J. et al. 2009. Patients’ Depression Treatment Preferences and Initiation, Adherence, and Outcome: A Randomized Primary Care Study. *Psychiatric Services*, 60 (3), 337-343.) It looks like one paradigm shift that addresses the wicked problem of mental illness is sharing treatment decision-making with the patients.

Another important component of managing wicked problems is defining the identity of those in the fray. What are the values, competencies and aspirations of the patient for recovery? Rather than defining recovery as an absence of symptoms, what does recovery mean to the patient? Even funding agencies are sensitive to the necessity of recognizing individual factors in designing treatment approaches. The NIMH Strategic Plan released earlier this year identified four objectives investigators seeking funding should address in one form or another. Strategic Objective 3, “Develop New and Better Interventions that Incorporate the Diverse Needs and Circumstances of People with Mental Illnesses” explicitly promotes the aim to develop personalized interventions as key in future research. (www.nimh.nih.gov/about/strategic-planning-reports/index.shtml)

In a perfect world, we sift through all the alternatives for action and choose one to begin with. With wicked problems, focusing on action may mean just considering those solutions that are realistic. In pharmacotherapy, I see psychiatrists assess what the patient might be able to afford rather than what might be the newest or ideal preparation. The same decision-making comes up with psychotherapy—if the patient can’t pay out of pocket and the insurance provider has a 20-session cap, we have to see what we can do in 20 sessions. It may mean meeting weekly in the acute phase of illness and titrating the visits over the balance of the year so the patient has ongoing support through recovery.

Since response is highly individual, the wicked problem of mental illness requires solutions that incorporate ongoing feedback from the patient and significant others. Trial and error isn’t failure, it’s part of the process. Scanning the context in which the patient lives and acts is an important mechanism for predicting relapse and acting preventatively. This is where psychotherapy holds advantages in patient care that medication management alone cannot match.

Allan Schore, in a presentation at the APA, presented his belief that we are in the middle of another paradigm shift from theories based on “explicit, analytical, conscious, verbal, rational left hemisphere to implicit, synthetic, integrative, unconscious, nonverbal, bodily-based emotional right hemisphere.” (Slides to this engrossing lecture are available at www.allanschore.com) I think his presentation reveals the type of approach to problem solving that Rittel and Webber call for in dealing with wicked problems—an appreciation of the exquisite complexity of the challenge and the curiosity and tenacity to move through the layers.



threatens, harasses friends and enjoys their pain. The victim, who gives in easily even if he/she doesn't want to, see themselves as failures and have trouble standing up for themselves, not letting others know what is wanted or needed. And, the bystander who enjoys watching fights, may encourage the bully to fight and walks away dismissing the problem as not important. He stressed that successful schools nurture those individuals who help the bully/victim/bystander find alternative means of communication and action.

Dr. Twemlow referred to his work developing the CAPSLE program, "Creating a Peaceful School Learning Environment: A Training Manual for Elementary Schools." (Complete review: www.backoffbully.com) His research found that most anti-bullying programs do not work, either because programs are mandated without broad agreement amongst participants to implement and/or a lack of recognition of underlying fundamental factors causing the climate of bullying. For effectiveness, all members of a school community are valued participants from the principal to janitorial help. Some of the more successful programs involve individuals who do not seek personal acknowledgement; their reward is a well functioning accepting community. He gave an example of an individual in a community who had spent much time cleaning the trash on the banks of a river that ran through the town. When the town learned of his self-less endeavors he refused recognition stating that he did his part because it was his river, *taking ownership* he was satisfied with a clean river; that others enjoyed the fruits of his endeavors was an added effect but not the fundamental reason for his work.

Dr. Twemlow spoke of how the awareness of the social and emotional needs of children, when addressed by all members of a school community, have taken failing schools to new levels of academic success. Each school has unique strengths, weaknesses and their own individuals. It is not that individual schools become models for others in a cookie-cutter fashion, but when their uniqueness is fostered that the climate of bullying can shift.

Dr. Twemlow invited the audience to consider their own school and community setting to develop a core group of dedicated individuals who would seek to shift the thinking from struggles for power as a way people gain their

pleasure to one of achievement based on a child's age appropriate mastery of social and emotional milestones. Through this paradigm shift the climate of learning in a specific school can succeed.

THE "AHA" MOMENT

By Gerald Melchiode, M.D.

How often have you had the experience of trying really hard to solve a problem or remember a name and the harder you try to focus your attention the more difficult it is to come up with the answer? Then sometime later while you are daydreaming the solution or name pops to mind. I came across an article in the Wall Street Journal on June 19, 2009 that presented the neuroscience behind this phenomenon. In Robert Lee Hotz's "A Wandering Mind Heads Straight Toward Insight" he pulls together the latest findings. Our brains are more actively engaged when we are daydreaming than when the brain is involved in more methodical thinking. More areas of the brain are associated with complex problem solving in this wandering state; areas which researchers believed previously were dormant. EEG revealed distinctive gamma wave activity from the right hemisphere as well as high frequency of neural activity from the right frontal cortex along with a dampening of alpha waves from the visual cortex. Our most creative thinking "is the product of neurons and nerve chemistry outside our awareness and control."

What does this have to do with psychoanalysis? First of all, free association is the fundamental rule. The analyst asks the patient to say whatever comes to mind, the instant that the thought or feeling occurs, without censoring. The word "free" in free association refers to freedom from the analyst's direction and freedom from the patient's intentionality and concentration.

Secondly, the couch is used as part of the technique in order to facilitate the type of reflective reverie, described by Hotz, in which the patient's mind wanders and makes connection never before seen. Concentrated, focused attention hinders the process and leads the patient and analyst to something that is already known. It is only through the wandering mind that we can arrive at new insights about ourselves and increase our self understanding.

Dr. Griffin will discuss ways that he has made use of reading and writing imaginative literature to generate analytic and self-analytic processes for these uses. See the article on page 7 for more details on the event.

Saturday, **November 7, 2009** is a presentation of Ricardo Ainslie's documentary on kidnappings in Mexico "Ya Basta" at the McKinney Ave Arts Center (The MAC) from 6 to 9 p.m. Dr. Ainslie, psychologist-psychoanalyst and professor at UT Austin, has been studying communities in crisis for several years. He tells the stories of these communities through the medium of documentary films and books. "Ya Basta" is a powerful documentary film about the explosion of kidnappings in Dr. Ainslie's hometown of Mexico City. Beginning in the early 90s, kidnapping became a financially lucrative enterprise executed by sophisticated criminal groups who knew there was little risk of prosecution. Although the wealthy were the obvious initial prey, these crimes soon targeted the very poor in all neighborhoods of the city. Dr. Ainslie's documentary developed and filmed over several years, includes interviews with many victims and their families as well as with perpetrators. His goal has been to share what he has seen with a broader audience, hoping the exposure "might become part of the national dialogue in Mexico and help the country move toward solutions".

The screening of "Ya Basta" will be followed by a panel discussion, including members of the sponsoring psychoanalytic organizations and Dr. Ainslie. This event is a collaboration with Dallas Psychoanalytic Center, Dallas Society for Psychoanalytic Psychology and Dallas Society for Psychoanalytic Social Work

Tuesday, **December 8, 2009** is Daniel Stern, M.D. He has written extensively on early child development. His books include: "The Interpersonal World of the Infant," "The Motherhood Constellation," "The Birth of the Mother," with Nadia Bruschiweiler-Stern, and more recently, "The Present Moment in Psychotherapy and Everyday Life." He is an internationally sought after speaker who is able to capture the complexity of the human condition with clarity, compassion and reverence. His presentation is "How infants see the world and how the Arts collaborate to move us" and will be held at the Texas Scottish Rite Hospital Auditorium from 7 to 9 p.m. This presentation is co-sponsored with the Zero to Three National Conference and the Dallas Psychoanalytic Center.

Wednesday, **December 9, 2009** is Dan Stern "Affects of arousal: A separate category of emotion? A greater role for the arousal centers and some clinical implications" at Grand Rounds at the Medical School from noon to 1 p.m.

Sunday, **January 30, 2010** is an Ethics Workshop: "The Myth of the Wounded Healer". With a discussion of Andrea Celenza's book, "Sexual Boundary Violations", presented by David Hershey, M.D. and Ron Schenk, Ph.D. at UT Southwestern Medical School, Seay Building, NC 8.212 from 9 a.m. to noon.

Wednesday, **February 17, 2010** is Kathryn Zerbe, M.D., Psychoanalyst from Portland, Oregon who has written extensively on eating disorders. Her presentation: "Beyond the Body Betrayed: Integrating Cognitive and Psychodynamic Therapy in the Treatment of Eating Disorders" is at UT Southwestern Grand Rounds from noon to 1 p.m. Dr. Zerbe will also review the most common transference/counter transference reactions of therapists working with eating disorders, and how clinical outcome must be based on more than symptom control alone.

Thursday, **February 18, 2010** is Dr. Kathryn Zerbe, a professor of Psychiatry at Oregon Health and Science University specializing in Eating Disorders from 7-9 p.m. at Hockaday. She has authored several books including "The Body Betrayed: Women, Eating Disorders and Treatment" and "Integrated Treatment of Eating Disorders: Beyond the Body Betrayed". Dr. Zerbe, will present "What's Your Best Friend Not Telling You? Eating Disorders in adolescence, adulthood, middle age and beyond." Dr. Zerbe will use slides of the artwork from the museums in the Dallas Fort Worth area to illustrate her ideas on eating disorders. Using local art that is accessible to audience members and their families may help them communicate with each other about difficult matters between them. She bases her presentations on her two books on eating disorders: "The Body Betrayed: Women, Eating Disorders and Treatment" (1993/1995) and "Beyond the Body Betrayed: Integrated Treatment of Eating Disorders" (2008). Clinical examples illustrate how multifaceted the eating disorders are and that treatment must take into account cultural, biological and psychological/psychodynamic perspectives.

Wednesday, **April 14, 2010** is Fred Griffin, M.D. He will discuss Grand Rounds: "The Psychotherapeutic Process: Some Integrative Models from Neurobiology and Neuroscience." at UT Southwestern Medical School, noon to 1 p.m.

Saturday, **May 15, 2010** is the Harlan Crank Symposium "Psychoanalysis and Writing." with Elena Lister, M.D. Dr. Lister will present her findings on the Columbia Psychoanalytic Institute's writing program.

CLINICAL USES OF IMAGINATIVE LITERATURE: CREATIVE READING AND CREATIVE WRITING

By Fred L. Griffin, M.D.

Some many years ago I made what was for me a most remarkable discovery, one that changed the very course of my life. Changed the course of my life? This may seem an exaggeration. Or worse, a cliché. But it's true.

I discovered the value of spending time with works of fiction.

Reading (and later writing) imaginative literature has opened up for me a universe that has extended my capacities to more fully comprehend the shapes, textures, colors, and rhythms my patients are attempting to convey about their intrapsychic and interpersonal worlds. "Living with" works of fiction (or having them live within me) has prepared me to better join with my patients to discover/create language sufficient to communicate emotional experience. I think of this as sensibility training.

Certain creative writers have become valued "consultants" in my clinical work and their short stories, novels and poems have also become useful resources in my efforts to explore psychoanalytic conceptual problems, for which psychoanalytic terminology and models are not always adequate to the task. In my thinking and writing, I have come to create "conversations" between clinical experience, works of fiction, and psychoanalytic writings that generate analytic and self-analytic processes much like those that happen in the analytic situation (Griffin 2005).

Of course, I have read works of fiction throughout my life (although previously, I must admit, not extensively). But it is one thing to read imaginative literature early in one's life and to read it after years of immersion in clinical work and after decades of reading psychoanalytic literature—both of which have shaped the ways that I perceive the world. Working with patients, over time, has helped me to understand that much of the process of psychoanalysis and psychotherapy has to do with finding the right words to capture and convey

human experience. As William Faulkner's character, Annie Bundren, famously said, "Words don't ever fit even what they are trying to say at." So I have been on a long search for words that "fit"—language that is commensurate with what it feels like to be the human being with whom I am working in psychotherapy or analysis, at this particular moment in time.

And I should add, it is different to become engaged with a work of fiction when one is motivated to explore something within himself or herself—and not merely to complete an academic assignment or seek a way to "escape." For reading fiction came to be a necessity for me.

A Collapsed Imaginative Space

Here's how it came about. Some time ago, as a consequence of my reactions to a personal loss, for a time my capacity for creativity became significantly constricted. I became less attuned to my patients' and my own inner experience and my own internal world seemed to lack enlivening rhythms, color and complexity. Fortunately this condition was temporary, but during this period I felt a bit more like a two-dimensional character in someone else's world than a three- or four-dimensional one in my own. After hearing an interview of the writer Wallace Stegner on NPR, my wife made me a gift of a volume of his short stories, thinking that it might somehow "help." As I began the read, I found myself drawn into the worlds Stegner created in a way that I started to feel again more like a complex "character," and my sense of aliveness began to return. Reading his works, became a daily practice. This was not merely a place of sanctuary. It was a kind of preserve in which I felt that I was being reconstituted, one in which I was developing new capacities to organize in my mind what had happened to me and finding new contexts and original language through which to describe my experience—and the emotional experience of others. Reading fiction became a foot in the door that restored an oscillation between my conscious, preconscious and unconscious life. These acts of reading were transformational.

Being curious about how this process worked, I searched the analytic literature for articles on the therapeutic and self-analytic uses of reading fiction. The scant literature I found was not illuminating to me. I began to read other works of fiction, poetry and literary criticism, and I sought out psychoanalytic writers who seemed to write in a more experiential fashion, who used language that moved me, convincingly, into the clinical or theoretical matters that were their subjects. As it turned out, I learned mostly from experimenting with the use of imaginative literature in a clinical situation and, importantly, writing about that experience—in order to learn firsthand about the benefits of acts of creative reading, as I came to think of it.

Creative Reading

My first opportunity to learn more from my own clinical experience came while working with a seriously depressed patient, Mr. D, whose dark, enraged moods and suicidal potential generated powerful reactions within me (what we analysts call countertransference), creating a force-field between us that threatened to destroy the analytic space of awareness and reflection between us and collapse the creative space within me that was necessary for me to find words to reach him. I made a series of interpretations—insights intended to convey what I thought was going on with him. As I now reflect upon that time, these were desperate attempts on my part to find a piece of meaning that he could take in and they did not fit the emotional place in which he had arrived. My language fell dead on ears that could not hear such words. And his depression worsened.

Somehow, in my own state of worry and helplessness and without conscious intention, I found myself musing about a short story written by the physician, poet and imaginative writer, William Carlos Williams. The story “The Use of Force,” a piece of thinly-veiled autobiographical fiction that portrays a physician’s frustrated attempts to treat a potentially seriously ill child. By making use of the story as a “consultant,” I was better able to identify the nature of my countertransference and to become freed from its inhibiting forces.

In a paper that I wrote about this experience, I describe in detail how this process worked for me (Griffin 2005).

In brief, it had to do with much more than the similarity of story lines of two doctors (the fictional one and myself) attempting to force treatment on a patient. This story memorializes a physician’s efforts to both own an entire range of loving and hateful feelings for his patient and not allow either his impulses or the defenses against them immobilize him. There was something about the way that the story was constructed that demonstrated to me that the author—in the very act of writing the story—was attempting to do a piece of psychological work.

In turn, the nature of the emotional forces between doctor and patient reminded me of a passage from the writings of the psychoanalyst, Wilfred Bion, regarding the mechanism of projective identification (a primitive form of communication in which feelings and impulses are transmitted along unconscious channels primarily by actions and reactions, and not by words). Bion discusses what he terms the analyst’s containment of the patient’s forceful feelings and impulse, through which it becomes “possible for him [the patient] to investigate his own feelings in a personality powerful enough to contain them.” In his inimitable words, he describes what happens when containment fails:

If the infant feels it is dying, it can arouse fears it is dying in the mother. A well-balanced mother can accept these and respond therapeutically: that is to say in a manner that makes the infant feel it is receiving its frightened personality back again, but in a form that it can tolerate....If the mother cannot tolerate these projections the infant is reduced to continue projective identification, carried out with increasing force and frequency. The increased force seems to denude the projection of its penumbra of meaning.

Bion’s words providing me a conceptual model for what I was experiencing with my patient.

And now (initially unwittingly) I had brought a short story and a piece of psychoanalytic literature together into a kind of “conversation” with my clinical experience. As a consequence, I was able to restore an imaginative space within myself in which I could reflect upon what was happening between me and Mr. D and invent language that was able to convey what it was like to be him at this moment in his life. In part, the short story assisted me in exploring more deeply the roots of my

countertransference and thereby released me from the forces within me that had temporarily made me “not strong enough” to absorb, digest and metabolize Mr. D’s terror and desolation. In the end, I found my way out of the tortured world with my patient and discovered words with which I could communicate with him about his suffering, meaningfully, in language that made him feel that I understood him.

Creative Writing

Somewhere along the way I decided to move from creative reader to creative writer: I attempted to write my own story, one about the time following my loss that I have described. My first attempt was a piece of creative nonfiction: I would write something of the facts of what it was like for me to lose for a while my sense of liveliness and creativity. But I simply could not do it. I think this attempt to write directly about it failed, because it was too painful to get close to the memory of the actual happenings of this time in my life. So I decided to write myself in fiction.

My approach was to write a piece of autobiographical fiction: I wrote about a personal analysis, in which I “gave” my constricted psychological/emotional states to a patient, while my attempts to become aware of, and reflect upon, what was happening inside me were represented by a psychoanalyst attempting to work with a patient, Mr. M. The patient in the story I wrote spoke of his feelings in a muted and colorless fashion, which both conveyed Mr. M’s lack of emotional aliveness and generated a kind of deadness in his relationship with his analyst. One day as Mr. M spoke about a short story that he had read (a work of fiction about the Holocaust written by Arnost Lustig), his analyst detected a shift in the energy that he conveyed in the session. The shape/form of the story that I wrote and the language that I found (or that found me) created a text that I could use to generate a self-analytic process.

The process of writing about my experience and reading the text I created became a powerful medium for self-inquiry. I found that the words I had chosen led to a wealth of associations, which became nexuses between forms of experience that had arisen early in my life and those which were shaped by later (inner and outer) experience during the time of my loss in adult

life. It was in the act of writing that these unanticipated words generated a new form of experience for me (a more integrated experience of previously disconnected aspects of myself). We may listen to these words and connections within our own minds, but seeing (and hearing) them on paper opens a creative space. I became the author who created a medium in which I, the reader, could read myself. I was then involved in a form of true analytic experience.

A complex process unfolded, which I demonstrate in the paper I wrote about it (Griffin 2004a). Much like the imaginative writer seeking his “voice,” I found words that evoked feeling states and accompanying sensory impressions that rang true to my life’s experience. I created a form of self-analysis that is a way of talking with, and listening to, myself much like the conversations that we all have within ourselves as they may be evoked by dreams.

Further Clinical Conversations between Psychoanalysis and Imaginative Literature

I have had additional opportunities to make use of the complex and emotionally capacious universes created by imaginative writers as they assist me in solving clinical and conceptual problems. Last year I was asked to write a review of a biography of Ernest Jones (an important person in the history of psychoanalysis) for a psychoanalytic journal. Although the biographer had provided much fascinating and detailed information about Jones and had created a coherent story of his life from it, I felt that there was much missing in the development of his character.

In the course of doing research for the essay, I discovered something that the scholar, biographer and psychoanalyst Elizabeth Young-Bruehl wrote about the “the biographer’s empathy with her subject,” which, she says, involves something other than the conventional notion of empathy, which is

‘putting yourself in another’s place’...rather [in writing biography, it has to do with] putting another in yourself...[becoming] mentally pregnant...with a person, indeed, a whole life—a person with her history. So the subject lives on in you, and you can, as it were, hear her in this intimacy.

I thought that something had interfered with this biographer's living-in process, resulting in a relative loss of intimacy with her subject.

At the time that I began working on this project, I had just completed reading Marcel Proust's novel, *In Search of Lost Time* (which you may know by the title, *Remembrance of Things Past*). As I read the biography, a particular passage from Proust (a metaphor depicting reckless ambition) came to my mind, for it captured something of Jones's personal psychology. This language, in turn, led me to a paper written by the psychoanalyst, Hans Loewald, which—in conjunction with my own ideas about who Ernest Jones was—allowed me to begin to incubate in my mind a fuller portrait of this man's character.

My musings about the metaphor from Proust, about the larger context from which it was taken (a novel in part depicting the psychology of double-ness, or duplicity, and a man's efforts to become a more integrated, authentic person), and about the language and concepts from Loewald led to a new synthesis—a kind of procreative act—that allowed Jones to “live” inside me and made it possible to “hear” him and create my own ideas about his personal psychology. The essay that I wrote on this subject describes this process of cross-fertilization (Griffin 2009). It will be published later this year. During the past year or so, in addition to Proust, I have been reading a number of Modernist writers—Faulkner, Woolf and Joyce—all of whose focus is the interior, subjective experience of their characters. The ways that their texts generate states of consciousness and construct entire universes of minds provide language and conceptual models that may assist us analysts in our attempts to conceive how internal and interpersonal worlds are structured. They also depict how a process may unfold that is much like the psychoanalytic process and that often involves the search for an original voice, demonstrating along the way internal shifts from more primitive ways of viewing the world to more psychologically mature perspectives and back again. These texts hold rich potential for clinical conversations.

Consider, for example, the “inner noise” made by the characters in William Faulkner's novel, *The Sound and the Fury*, and the characters' efforts to listen to them-

selves. Each of the first three chapters embodies a unique voice, consciousness and personal psychology of three brothers, in turn—beginning with Benjy, the more primitive of the three, the one whose cognition is limited to blindly feeling everything, a child-man who looks at the world through a lens of inchoate experience, a partially formulated and barely articulable experience.

And Virginia Woolf, from *To the Lighthouse*, writing about the protagonist, Mrs. Ramsay's falling quietly into her deepest being:

All the being and the doing, expansive, glittering, vocal, evaporated: and one shrunk, with a sense of solemnity, to being oneself, a wedge-shaped core of darkness, something invisible to others...and this self having shed its attachments was free for the strangest adventures. When life sank down for a moment, the range of experience seemed limitless.

Or the structure of the second section of the novel (“Time Passes”), describing the change in the once vital, seaside family vacation home after the First World War and the deaths of Mrs. Ramsay and two of her children. The following language creates a metaphor for the emotional emptiness of one's interior space after suffering loss, being rendered desolate, and now possessed by a world inhabited more by the signs of absences than alive with presences:

What people had shed and left—a pair of shoes, a shooting cap, some faded skirts and coats in the wardrobes—those alone kept the human shape and in the emptiness indicated how they once were filled and animated...had held a world hollowed out in which a figure turned, a hand flashed, the door opened, in came children rushing and tumbling; and went out again.

My current project involves a paper in which I am trying to work out something more of a conceptual, than of a clinical, nature. I once worked with an analysis whose description of an enduring memory from childhood—as a kind of three-dimensional space living inside his body—challenged my capacities to envision what he spoke of and made me question certain time-honored psychoanalytic constructs regarding memory and the internal representational world.

Here too I find myself turning about *In Search of Lost Time* (the novel is, after all, 3,000 pages long, thereby providing much “material” to be moved by, to access,

and to reflect upon). The dimensionality of the language used by Proust to portray states of consciousness and memory as he speaks about the protagonist's "descent into the self" at the opening of the novel is providing me with fresh metaphors and stimulating new ways of thinking about, and articulating, the analytic experience that I am trying to wrap my mind around. I have been able to put aside psychoanalytic idioms and constructs that, standing by themselves, tend to reduce my capacities to write my way into understanding more about this patient. The tentative title of the paper is "In Search of Lost Time in Psychological Space," and I hope to complete it by early 2010.

Lastly, I have also made use of creative reading and creative writing in teaching, and writing about, the emergent field of narrative medicine, in which medical students and practicing physicians read and discuss stories and essays written by physician-authors (Griffin 2004b, 2008). In addition, they write about their own clinical experience and discuss these narratives in a group setting with their colleagues, thereby allowing them to see themselves with their patients on the printed page and to invite others to comment on what the physician-author has not yet been able to perceive. Furthermore, this sensorimotor process of writing often helps them to metabolize the secondary trauma that results from working with terribly ill, traumatized or dying patients.

The Limitations of Turning to a Book

Although the analytic processes of creative reading that I have generated—privately, outside of time spent with my patients—has expanded my capacity to better imagine my way into my patients' emotional worlds and explore certain conceptual problems in psychoanalysis, I must not allow the "voices" from works of fiction or psychoanalytic writings to invade the consulting room and drown out (or over-write) the patient's original story that is unfolding. In the analytic situation there is only one "author" to be listened to, the analysand. It is the psychotherapist's or psychoanalyst's role to accompany those who come to them for assistance and to join with them in finding the words that "fit." In addition, nothing substitutes for beginning a session freshly, unencumbered by any other language or theories and listening for what is being spoken at the moment.

And while the self-analytic work I have been able to achieve through creative writing has benefited immensely from my "relationship" with imaginative literature, turning to a text to help us "read" ourselves has its limitations. There is nothing that can substitute for the experience of turning to another human being—a psychoanalyst or a psychotherapist—to set in motion an analytic process that will help us fathom our inner world and create new perspectives of understanding about who we are and how we relate to ourselves and to others.

With the exception of the 2009 essay (in press), the following articles are available upon request from Tricia Oman at: Patricia.Oman@UTSouthwestern.edu.

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PSYCHOANALYSIS AND THE MIDDLE WAY

By Larry Thornton, M.D.

Some time ago, a patient spoke about the man she would eventually marry: “I like who I am when I’m with him.” For much of her life, she felt disconnected and unreal. She wasn’t sure who she was. But with this man, she felt solid. Rather than floating insubstantially in the air, she felt connected to the ground. She was aware now of the light coming through the kitchen windows; dishes felt firm in her hands. “I like who I am when I’m with him.” She was different when she was with this man.

This made a great impression on me, first because she herself was so moved. Not only had her sense of herself been transformed by this relationship, she also noticed new things about the world. This seemed more than just romanticism. Her experience suggested that our sense of self does not exist apart from our involvement with others.

What is this “self” whose way of being is to be with others? The more I reflected, the more confusing the issue became. What seemed to be most evident, this experiencing “I”, this sense of being “me”, was hard to pin down. Definitions and concepts became slippery and unclear.

On initial examination, the independent “I” seems a self-evident truth. That we are separate and distinct seems clear to common sense. Our experiences are ours alone. Only I feel the pain in my leg. Only I feel the breeze on my face. To be confused about these matters is a kind of madness.

Similarly, it seems a matter of self-evident common sense that the chair I am sitting on, the floor beneath my feet, and the music playing as I write are all separate, distinct entities with stable, definable natures. Whatever relationship I have with them is between distinct beings. The self, on this view, seems distinct, knowable, and accessible to intuition.

Psychoanalytic investigations have found, though, that this sense of self is not a given. It is, instead, a developmental achievement, the outcome of processes involving mirroring, acceptance and frustration, as well

as the synthesis of affects, perceptions, cognitions and adaptations (Tyson, 1990). The outcome of these (and other) processes results in the awareness that one is separate and distinct.

The patient’s statement, “I like who I am when I’m with him” points to another aspect of self experience. Emphasized here is the observation that this seemingly separate thing can be changed by a relationship. The work we do each day is predicated on this notion that a relationship can be transforming.

On the one hand, the self appears to be a distinct thing with its private subjectivity and its own distinct nature. But on the other, it’s being is more mobile, more dependent on relationships and history.

Accounts of the self are regularly narrative in form (Bonnycastle, 1996)) From this point of view, our sense of self arises in and from the stories we tell about ourselves, the stories others tell us, and from the narrative forms our cultures make available. These stories have a listener in mind, and ways in which they wish to be heard. The sense of self conveyed in stories necessarily involves the presence of another, either as a listener or another character in the tale. Here, the self is pictured as an actor playing various roles, always involved with other actors. As an actor, the self’s way of being is multiple, temporal and interactional.

Bromberg’s notion of multiple self-states in dialogue with one another provides another useful frame. In his view, we have many senses of who we are; these are regularly in motion, sometimes smoothly, sometimes in dissociation, depending on our past and current situations (Bromberg, 1994).

The self, in these models, comes in and out of focus. First it is one thing, then it is many. It is now a structure, now a feeling, now a character in a shifting set of stories. What seems most near, this “I” that I am right now, is elusive, emerging in multiple guises, wearing different faces. Each model captures some aspect of our experience, some aspect of how we are, without ever coming to rest with the fixity of a final truth.

Let me illustrate this perception with an analogy: a picture made up of other pictures. Take for example a recent campaign ad for Barack Obama. What appears at first to be a somewhat grainy photo of the candidate, proves on closer inspection to be made of many smaller pictures: Obama giving a speech, Obama with his family, an American flag waving against a clear blue sky. What we see here depends on what we look at. Neither the larger nor the smaller images are more primary or more real. When we attend to one particular image, the other images disappear. They are not there in the same way as before. In whatever way we might say that they still exist, as images, they do not. As images, they exist only when seen. That is, their existence as images depends upon an interaction with the viewer.

So too do our multiple ways of being come in and out of focus. The person we are in a given moment depends on who we are speaking to, what we want and fear, what recently has happened, and what happened long ago. These various ways of being have a certain regularity of features, similar to how Obama's face appears because of how the smaller pictures are arranged. But this regularity only emerges from the interaction of the pieces. Without this interaction, the larger regularity isn't there. So too, our regularities come into being based on relations we have had, those that we are having, and those we have within ourselves.

The perception that our way of being is dependent and relational is central to Buddhist thought. This is especially evident in the work of Nagarjuna, a monk living in India in the second century C.E. His approach to being speaks directly to the conundrum we find in searching for the self: that this seemingly evident, distinct being of common experience emerges only in dialogic moments with other equally relational selves.

Nagarjuna's major work is *Mulamadhyamakakarika* (The Fundamental Wisdom of the Middle Way). It is a lengthy poem "composed in very terse, often cryptic verses, with much of the explicit argument suppressed, generating significant interpretive challenges" (Garfield, 1995). Writers in this tradition, it is said, prized eliminating a single word more than most men prized the birth of a son (Della Santina, 2002)! But through a rich commentarial tradition, Nagarjuna's

thought comes to have a bracing, transforming clarity.

Let us return to how we typically conceptualize the world. Here, objects are distinct and different, with clear qualities, clear boundaries and clear beginnings and ends. The chair we sit on occupies a distinct space. It seems separate from our perception of it. Similarly, the writer of this sentence is not the reader. We each have our own personal history, thoughts and feelings, and unique birth and death. All the things in the world, ourselves included, seem self-evidently to be objects with essential, definable differences.

But Nagarjuna shows that this common sense view carries a number of deeply problematic assumptions about the nature of reality. If things were, in fact, essentially distinct, experience would be impossible. His point is quite simple, and it rests upon the observation of change. It is an inescapable aspect of our lives that things come and go. Feelings flare and dwindle. Objects break and decay. In the classic Buddhist formulation, we all must face these three great changes: sickness, ageing, and death. Upon seeing these, the sheltered prince Shakyamuni left home and began the wandering life that led to his enlightenment.

It is Nagarjuna's central argument and vision that for change to be, things cannot have separable, distinct, and definable existences due to their own inherent natures. If they did, they would simply be what they are



perpetually. For things to change, for them to function, for them to work in the world at all, they cannot be what they are solely because of themselves (Garfield, 1995).

Change, as we can easily see, is not random. Specific conditions give rise to specific states. This process is referred to in Buddhist thought as dependent origination. This concept is of such central importance that the Buddha said that “one who sees dependent origination sees the entire Dhamma, and one who sees the Dhamma sees dependent origination” (Majjhima Nikaya 28, quoted in Bodhi, 2005). (Dhamma: teachings, truths, the way things are). Dependent origination holds that whatever at the moment happens to be, happens to be so due only to conditions. When certain conditions prevail, matters are a certain way. When these conditions change, matters are different. This simple perception has important implications regarding the seemingly self-evident experience that things have essential differences.

To illustrate dependent origination, let's return to our chair. From the point of view of dependent origination, the chair comes to be because of the trees that gave the wood, the ore that gave the metal for the nails, the plants and chemicals that gave the fibers for the fabric, the intent of the maker, and the desire of the one who sits. Also required are the culture that uses such objects to sit on (as opposed to stools or floor), that does not need the wood for fuel, and that has aesthetic traditions giving the chair its form. Without these, there is no chair.

For Nagarjuna, this means that the chair has no essential being. By essential being, he means no fixed, inherent nature that doesn't rely on anything else to be what it is. He argues that if the chair had inherent being, not relying on anything else for its being, it would exist eternally, without ever needing to come to be or ever passing away. Because it would be what it is only because of its own inherent, essential being, it could only persist indefinitely as it is.

This is a critical point. For Nagarjuna, this is what our tendency to reify entails: a view of ourselves and of things in the world as fixed and eternal entities incapable of any interactions or change. This clearly contradicts experience.

To say that things have no essential being is not to say that they don't exist. It is to say that they exist conventionally. By convention, we may for the moment refer to the collection of conditions as a chair based upon our current needs. But “(t)here is no fixed boundary between the existence of a seed, the tree to which it gives rise, a piece of wood from that tree, and a table fashioned therefrom or between the existence of an intact table, a broken table, wooden parts, ashes, earth, the nutrients for a seed, that seed, the sapling to which it gives rise, and another tree” (Garfield, p. 199).

Similarly, there is no fixed boundary between a person's flesh, the biologic functions of that flesh, the proteins that constitute it, the molecules that constitute those proteins, the atoms that constitute those molecules, and the weird subatomic world that constitutes those atoms. Nor is there a fixed boundary between these physical aspects of our being and the emotional, relational, and historical features of ourselves. Based on the needs and concerns of the moment, we may conventionally refer to a weak muscle, an abnormal enzyme, or a changed base-pair in a strand of DNA, or we may speak of a trauma, a loss, a fantasy or a great and passionate love.

None of these has any fixed, essential being apart from conditions. It is as if the larger picture of Obama was but a smaller part of yet another picture, and the smaller ones were made of even smaller ones, and so on in both directions without end. Each picture exists, in Nagarjuna's view, conventionally, insofar we choose to abstract and delimit them from the mass of other possible groupings. The individual pictures may be empty of inherent existence, but they do exist, and not in some inferior, lesser way. To say that something exists conventionally is not to diminish it. Nagarjuna shows that phenomena can only exist conventionally. Things, because they are dependently arisen, are necessarily conventional. This is the path between reification and nihilism. This is Nagarjuna's Middle Way.

Psychoanalysis and Buddhism share the aim of alleviating suffering. Both do so by paying meticulous attention to the moment-to-moment movement of our thoughts and feelings. They are both more than a just set of propositions and ideas. They are supported by a disciplined practice. Immersion in this practice is

needed before the richer significance of these ideas reveal themselves.

Freud showed that we do not have a fixed essence, but that we are formed by our relationships (Freud, 1917, 1923a). These relationships are, in Nagarjuna's terms, conditions that shape who we are. The therapeutic relationship is another condition in the being of both the patient and the analyst. Neither are fixed entities. Both are changed by the encounter (Andresen, 1991).

Buddhism teaches that our suffering arises from mistaken judgments that things have fixed and enduring natures. One manifestation of this is our tendency to ascribe permanent, indelible qualities to ourselves and others. For example, assertions such as "I'm so bad" or "He is so narcissistic" are said as if they refer to some unalterable essence in the person. Similarly, we easily take affects, drives and fantasies as if they were separable existents apart from the person who "has" them. From Nagarjuna's perspective, these are only conventionally separable. There is no "anger"; there are rather moments of angry being. This is not to play with words. It reflects a perception of the particular self-form as arising momentarily, and it suggests important implications for our conceptions of drives and affects.

Buddhism also teaches us to be watchful of our tendency to reify. Simultaneously, there is a recognition that we cannot help but speak and act conventionally. There may not ultimately be some separable entity called "anger" or "Mr. Z.", but conventionally, we may speak of certain people who are angry at a certain time. Nagarjuna asks, along with psychoanalysis, what are the specific conditions whereby this angry moment comes to be right now? Why this particular association, this particular dream, this specific forgetting? Psychoanalysis can be seen, in this light, as the empiric study of the psychological and developmental conditions that contribute to our specific ways of being.

Our lack of a fixed and final nature lets new experiences alter who and how we are. Here, Nagarjuna and psychoanalysis find common ground.

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