Tampa Bay Institute for Psychoanalytic Studies, Inc
813-908-5080

TBIPS Newsletter Volume XIII, Issue 1

Summer 2021

Volume XII, Issue I,
Summer 2020

Greetings from the President

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Dear Reader:

So happy we made it this far. Many of us as still working clinically on Zoom and negotiating missing three-dimensional corporality while enjoying working in our sweat pants. Because TBIPS has, for years, offered training virtually to international and other long distance students, participating by Zoom has been 'old hat' for us.

Many of us breathe easier knowing that several effective vaccines are available, that we have an *experienced* Commander-in-Chief at the helm - and we look forward to greater inclusivity, civil justice, and communion.

TBIPS starts a new class this Fall when introductory courses in psychoanalysis and development are offered along with clinical case conferences. We are so proud of those who have completed the four- year didactic portion of their training, most recently, Euripidis Gavras and Ageliki Tsikli.

There is, beginning on page 4, a lengthy contribution from two candidates (who are also co-therapists in a group setting) on Somatization in Group Therapy, where one's pregnancy and the other's son's illness has a mutual impact on all. I encourage you to read it in its entirety as it is fascinating.

We wish everyone a heathy, relaxing and rejuvenating summer,

Lycia Alexander - Guerra, MD,
President, TBIPS

TBIPS Newsletter Volume XII, Issue I

Training in Psychoanalysis and Psychotherapy

TBIPS embraces pluralism and emphasizes a comprehensive contemporary view of psychoanalysis and features a multi-cultural and theoretically diverse faculty, including, but not limited to, expertise in Intersubjectivity, Relational, and Self Psychology.

The TBIPS training program represents the most current, up-to-date theories in psychoanalytic thought. TBIPS embraces *pluralism* and emphasizes a *comprehensive* contemporary view of psychoanalysis within the context of a mutually shared and respectfully open paradigm between faculty and candidates. We offer a multi-cultural and theoretically diverse faculty, including, but not limited to, expertise in Intersubjectivity, Relational, and Self Psychology, whose teaching style is student focused with the goal of offering the opportunity for dialogue between varying schools of thought and to engage and encourage candidates to think *critically* about psychoanalytic concepts.

Inquiries Welcome. To Apply:

Contact Lycia Alexander-Guerra at 13919 Carrollwood Village Run, Tampa, 33618 or 813-908-5080; or go to Tampapsychoanalytic.org "Home"

Seminars may be taken individually or as part of certificate programs in psychoanalytic psychotherapy or psychoanalysis

We are always seeking additional faculty to volunteer to teach and/or design TBIPS courses. Contact Dr. Alexander-Guerra at tbinstitutepsastudies@gmail.com to join us in this exciting endeavor.

TBIPS CURRICULUM

TBIPS recognizes that, because many people come to us suffering from the Trauma of childhood abuse and/or other horrific events or from the relational trauma of chronic misattunement and misrecognition, our curriculum must weave into it a deep understanding of child development, attachment, and the effects of trauma. Semesters currently run 16 weeks long. Courses are open to individual students as well as to candidates seeking full psychoanalytic training. TBIPS invites candidates to frequently update the syllabi.

Semester I	FIRST YEAR	Semester II
Intro to Psychoanalytic Concepts I		Intro to Psychoanalytic Concepts II
Practical Analytic Subjectivity I		Development
Continuing Clinical Case		Continuing Clinical Case
	SECOND YEAR	
Relational Concepts I		Relational Concepts II
Developmental Issues: Narcissism and Shame		Developmental Issues: Attachment
Continuing Clinical Case		Continuing Clinical Case
	THIRD YEAR	
Repetitive Painful States		Trauma (8 weeks) and Gender (8 weeks)
Group or Couples Therapy		Practical Analytic Subjectivity II
Continuing Clinical Case		Continuing Clinical Case
	FOURTH YEAR	
Psychosoma		Focus on Psychoanalytic Contributors and Topics*
Hate, Envy, and Destruction in the Clinical Encounter		Electives (candidates design)
Continuing Clinical Case		Continuing Clinical Case

* courses which focus on specific theorists (Winnicott, Ferenczi), and topics (Spirituality, Racism,).

Tampa Bay Institute for Psychoanalytic Studies, Inc.

http://tampapsychoanalytic.webs.net **tbips.blogspot.com**
813-908 5080

Registration Fall Semester 2021

All Courses meet for 16 Wednesdays: Sep 22, 29; Oct 6, 13, 20, 27; Nov 3, 10, 17; Dec 1, 8, 15, 2021; Jan 5, 12, 19, 26, 2022.

Registration deadline is August 1, 2021 and includes a subscription to PEP (psychoanalytic electronic publishing).
Fee: $300 for a single course; $250 per course if enrolled in 3 or more courses.

Introduction to Psychoanalytic Concepts I
Wednesdays 8:00am-9:15am Courses I and II offer a contemporary foundation in psychoanalytic theory and application, beginning with ideas about analytic attitudes, clinical process, and how an analytic relationship is constructed. We will consider the analytic relationship in terms of the mutual impact of analyst and patient in conscious, non-conscious and unconscious realms. We will begin to look at contributions from major schools (Freudian, Ego, Object Relations), reading Freud, Klein and Winnicott, and continue in Spring 2021 with contributions from Relational, Interpersonal, Self Psychology, and Intersubjectivity, reading Kohut, Mitchell, Bromberg and Benjamin, et al. Participants are encouraged to bring clinical examples which we will use to illuminate concepts.

Clinical Case Conference Wednesdays 9:30am-10:45pm This course is designed to support the clinician's work and offers opportunities to integrate clinical material with psychoanalytic concepts, including ethics, and ways to deepen the psychoanalytic process, with a focus on the therapist's self reflection, the clinical relationship, and ways to facilitate what is mutative for the patient. Attendees are encouraged to present case material.

Practical Analytic Subjectivity Wednesdays 11:00am-12:15am In this course we will rethink clinical practice in contemporary terms looking back on the harm and usefulness of classical authoritarian neutrality, abstinence and anonymity and elucidate some of the differences between classical and postclassical psychoanalytic thinking. We discuss such practical issues as starting an analytic practice, setting, frame and fee. With an emphasis on the analyst's self reflection and on ethics we will explore how we locate ourselves in the therapeutic process.

TBIPS FALL 2018 REGISTRATION FORM

_____ **Introduction to Psychoanalytic Concepts I** (16 weeks)
Wednesdays 8:00am-9:15am Sep 22, 2021 – Jan 26, 2022
Fee: $300 for a single course; $250 if enrolled in 2 or more courses.

____ **Clinical Case Conference** (16 weeks)
Wednesdays 9:30am-10:45am Sep 22, 2021 – Jan 26, 2022
Fee: $300 for a single course; $250 if enrolled in 2 or more courses.

_____ **Practical Analytic Subjectivity** (16 weeks)
Wednesdays 11:00-am-12:15pm Sep 22, 2021 – Jan 26, 2022
Fee: $300 for a single course; $250 if enrolled in 2 or more courses.

_____ **PEP** subscription $50 MUST BE RECEIVED BY AUGUST 1, 2021

_____ Late fee $50 if received after (Aug 1) deadline

_____**Total Payment Enclosed** including PEP subscription. Payment to Paypal.
(one course: $300; two courses: $500; three courses: $750)

(refund policy: 85% 7 days before classes begin)

Must Include this page with Payment.

Registration deadline is August 1, 2022. Deadline is for all application material, registration form, and payment. We cannot provide papers through a subscription to PEP (psychoanalytic electronic publishing) unless pay by deadline.

Name_____ Degree____ License #_____State___
Address_____City_____State___Zip_____
Email address_____
Request long distance learning ____(yes)

EMail forms and CV to tbinstitutepsaStudies@gmail.com. Paypal bill and application will then be sent.

CANDIDATE CORNER

Jennifer Schaefer is a Licensed Clinical Social Worker (FL) who received her bachelor's degree in Psychology from LeMoyne College in Syracuse, New York, her hometown. She writes, "Ever since I can remember, I have always wanted to be a part of the helping profession. Then with advice from my psychology professor I decided to step out of my comfort zone and move to Miami, Florida where I graduated from Barry University with my master's degree in Clinical Social Work. My first social work position was with children in NYC as a Foster Care Worker with physically, emotionally and developmentally disabled children.

After a couple years I returned to Florida, a place that always felt like home to me and pivoted my focus to working specifically with seniors and disabled adults. I worked as a social worker for home care agencies as well as hospice while being supervised for my license. I currently work as a contract therapist with seniors on Medicare who can benefit from weekly ongoing psychotherapy and supportive counseling.

My professional and personal life go hand in hand. It was my own therapist- analyst who introduced me to the Tampa Bay Institute for Psychoanalytic Studies about ten years ago. The impression TBIPS made on me years ago could not be forgotten and I am now in my third year of training. My time at TBIPS has been both the most challenging and rewarding experience of my career to date. I have opened my mind to new theories, and perspectives, and, in the process, I have met so many amazing candidates and instructors from across the globe, people who continue to inspire and support me regardless of their level of experience and training. I am excited and grateful to be here, to continue learning, not only for myself but also for my clients and community.

Samples Written by Candidates from the TBIPS Blog *Contemporary Psychoanalytic Musings* at tbips.blogspot.com from their Electives

In **Somatization in Group Therapy**, we start with a brief introduction of the model which provides the theoretical base for the accomplishment of the therapeutic goals in our work with the group. These are the Interpersonal model by Irvin Yalom and Relational Psychoanalytic Psychotherapy. We present the most important points of a Davies' article, searching for answers to the question: why some therapies fall apart from the burden of repetitive self-destructive behaviors of both the patients and the therapists. How the emergence of envious, embarrassing selves at the beginning of treatment blocks the mutual acceptance of toxic introjections but finally allows the analytic work to proceed.

In Part II, we will present the case studies of the personal stories of the two therapists which coincide with the stories of the group members. In such moments, the enigmatic feelings of the therapists and the group members became valuable

analytical data. In Part III, we will explore how the space for new experiences is created.

The group is the place for the repetition of internal conflicts and unbearable feelings of therapists and patients alike. The participants cannot avoid the impact they have on each other every minute. We are interested not only in what is said but also in what is not said. Our bodies, sometimes restrained, other times weak and tired, inform us that something is coming. Based on Davies' article, we will try to show how aspects of our subjectivity - regarding the therapy of the heart problem of one of the therapist's children and the pregnancy of the other therapist, carrying her first child, that is, somatization in our relational stories - helped the group and the therapists realized the difficulties of mother-child relationships. Then comes the realization, how certain interactions with our patients helped us, the therapists, to understand how we can be vulnerable together and how we can stay connected and collaborate in a joined effort to understand what is happening.

Theorists have moved from one-person analysis to more interpersonal models. The **interpersonal theory** developed by Irvin Yalom was strongly influenced by Sullivan's view of the development of the human personality. Even before Sullivan, Winnicott [there is no such thing as a baby] talked about the importance of the relationship: the infant is nothing [would not come into being, or, would not survive] outside the mother-infant relationship. Sullivan also believed that the way we perceive ourselves is the consequence of others' views which have become internalized. We see ourselves through the eyes of significant others, especially the ones in our early lives, and then we interact accordingly. He suggested that the modifications of the beliefs and habitual patterns of interpersonal behavior should be a primary focus of treatment. The group can function as a mirror, so we expect that these internal representations and beliefs will emerge in the group, and that the members can understand their patterns and how they co-create their relationships. This is a model that focuses not only on interpretation and soothing but also on providing new relational patterns.

The main techniques of the model are that we work in the **here and now** of the group and we concentrate on the process and not on the theory or content. At the heart of the model is the emphasis on the **feedback, (how** the person connects with others and their impact on others). and the **interpersonal learning**. Lastly, in this model the group leader(s) is not only an observer but also a participant and so needs to be aware not only of transference but of her/his counter transference as well. The development of therapy cannot happen outside of the relationship, it is a co-creation. The interpretations are at three different levels, the individual, the intersubjective, and the group as a whole, the latter being the main level of interpretation.

Reading **Davie's** article, we will see that in modern psychotherapy the psyche is composed of the interaction of the self in relation to others. All these that we are going to see today are also going to discuss on the second week of our presentation.

Though in the beginning the communication is nonverbal, from the first lines of the Davies article the impact of the therapist on her patient and vis versa is evident. Davies is aware through somatic stimulus that something difficult is coming based on the expressions on Karen's face and via the tension in her own body. Here we observe the first aspect of unconscious communication between the analyst and the

analysand which continue through the interaction. Karen seems to discern sides of the therapist before the therapist's realization. Davies allow herself to surrender to the experience of the here and now, and to an internal dialogue about what is happening during their interaction. She is receptive in the influence of the unconscious of the patient on her (and the other way around).

We see the focus on the here and now where priority falls on the instant events of the session and on the procedure of transference-countertransference. Davies has in mind the concept of negative transference and its use as a bad object, but she is not concerned with the understanding or the solving of this projective identification which evacuates the badness to the other, and, instead Davies examines her subjective countertransference at the moment of her interaction with Karen. She moves from the psychology of the one (which is the patient pathology) to the psychology of the two, emphasizing the mutual impact and shared responsibility of their relationship. She does this by examining the procedure [process]. Davies wonders what her statement reveals and the numerous factors which emerged due to their interaction. She sustains the capacity to reflect on the experience by being both in the moment and out of it at the same time. In the intersubjective moment they are both constructors of toxic self-states and vulnerable simultaneously, while managing to survive and feel sane and feel loved by the other. These elements are also found in group therapy ensuring cohesion and change for the group as a whole. 'My milk will heal you', Karen says. We can see how the experiential content is as important as the verbal one in an interpersonal meeting thus the patient feels able to heal the therapist. This experience can be the most healing experience of all.

Davies, J.M. (2004). Whose Bad Objects Are We Anyway? Repetition and Our Elusive Love Affair with Evil. Psychoanal. Dial., 14(6):711-732.

-Alkinoi Lala and Fotini Doumoura

In Levine's article we see how her own analysis around her difficulties with her relationship with her younger son opened an analytic space with her patient Susan. How did her relational story facilitate the analytic process? Adrienne Harris has suggested that the analyst opened “access to unbearable affects,” together providing a safe enough environment to reveal Levine’s shame about her relationship with her son. Also, her analyst was able to hold Levine in her mind with acceptance and faith in her and her son so that Levine could contain him - from the inside - and help him put his experience into words.

Levine’s patient Susan also had problems with her own son. Levine initially was not aware of these difficulties because of projective identification, that is, being identified with Susan as a good mother doing the best she could for her son. When Susan revealed that she intended to abandon her son with his abusive father, Levine, by examining her subjective countertransference, was trying to understand this enactment. There was an intergenerational repetition of abandonment, shifting back and forth between the positions of mother and child, trying to create a transitional space of thirdness.

In presenting our case studies of our personal stories, we have in mind what the Barangers' wrote: two persons remain unavoidably connected and complementary - neither member of the couple can be understood without the other.

Alkinoi's Case Study:

My somatization was my pregnancy and I explore my countertransference in the here and now of the group. In this particular week, an enactment emerges which enabled me to reflect on my countertransference and connect with my somatic changes. My relational story hindered, initially, my capacity to engage deeply in the analytic process.

The material comes from the birth of the group (my first ever group) which was around the second month of my pregnancy - something that was not announced to the group members. Only my co-therapist and my supervisor knew. The birth of the group preceded the birth of my daughter, thus I was simultaneously pushing to stretch myself beyond my limits for both of my babies. During this early stage in therapy, the group was made up of two female co-therapists, and one male and seven additional female members. There were many "abortions" due to therapists' anxiety.

The group at these first meetings is occupied with the subject of the omnipotent mother, their mother. The image was clear and vivid: she can do everything but she self-neglected and, at the same time, deprived. There is a split inside the omnipotent mother, inside the group (symbolic children- symbolic mothers) and inside my body as I was sharing it with my baby and my clients. During sessions I was feeling weak with strong somatizations, and with sleepless nights after the sessions. These symptoms were not related to my pregnancy but had to do with the group dynamics and the unmetabolized material of sessions, particularly that we were two novice group therapists.

I had the need to hide this difficulty from the group, whereas with individual clients I was more open and I had self-disclosed about my pregnancy. In the group I had to survive changes, and through projective identification I was identified with the omnipotent mother. Symbolic children were angry with their mother and with me. There were members saying that my interventions were not helpful while others attributed my interventions to my co-therapist, saying how wonderful and empathic she was. They were finding me distant, private, and withdrawn. I was feeling neglected and lonely, tired and discredited, and excluded. The enactment that woke me up, just as Levine wrote about with her client Susan, was when the male member at the end of the session - one day after his name day - complained that no one remembered his name day and complained he was feeling neglected, especially by Foteini. I was really surprised. It nearly pushed me out of my chair. At the beginning of that session I was the only one who acknowledged with wishes his name day, and he had totally forgotten it by the end of the hour.

What was happening that we couldn't connect? What experiences had members placed inside my womb? Was I the Fairbairnian bad object? Although I was talking about my experience, I was not able to communicate empathetically with the members, the children of the group. And the other subgroup of mothers was describing similar experiences in their lives with what I was feeling in the here and now of the group.

Was there a part of me that had dissociated in order to protect my body? Definitely. A subgroup experienced intense somatic symptoms and others in the group struggled with autoimmune diseases and cancer. Did I feel protective of my child? At that time I was not aware of my difficulty to connect fully with my pregnancy. Not the happy side of pregnancy, but the particular side that has to do with more difficult feelings like loss, loss of uniqueness, even envy, as something foreign invaded my body, my life and my relationship with my husband. These were some of the difficulties with this new role as mother and at the same time with becoming a group therapist. There were feelings of shame as I struggled to be a good enough mother for both my baby and for our group, and I was failing. Who needed more support: the group? my baby? or myself? And what would my pregnancy evoke in the group?

According to Fairbairn (Armstrong-Perlman,1991) I was a blur object: I couldn't respond with cohesion and consistency to their needs. A part of me was unavailable. Was I acting as their mothers? How did my pregnancy affect the group as a whole? I could understand that there was a blind spot for me: my pregnancy and my relationship with my own mother had affected the way I was responding to the group. As Bass says: the way we respond to our clients reveals a lot about us and our values. Until the enactment I had been pretending that my pregnancy was hidden and so could not affect the group. Also I had not been aware of my shame - riddled, bad self-representations.

Levine, L. (2009). Transformative Aspects of Our Own Analyses and Their Resonance in Our Work With Our Patients. Psychoanal. Dial., 19(4):454-462.

- Alkinoi Lala

Foteini's case study:

I am going to present how my personal story - the treatment of my son's heart arrhythmia - brought 'arrhythmia' to the coordination of the group. Andrienne Harris noted that our wounds must serve as tools, but sometimes they are obstacles impeding our capacity to engage deeply in the analytic process. Bion believed that two minds are needed to think about the most unpleasant thoughts of the one. But access to the most secret areas demands courage.
What happened in the group happened in parallel process to my personal life: I split my feelings of loneliness and shame from the group's projective identification of me in an omnipotent position.

It was at the end of the third year of a group therapy that Alkinoi and I became coordinators. The group included 11 members and 2 therapists; the sessions took place once a week for 1.5 hours. Before the session from which the present analytic material emerged, the members had empathetically discussed absent parents, somatizations, common traumatic experiences of abuses, fantasies of destruction and projections of aggression. I returned to the group after an absence during which my child had been hospitalized to have his cardiac arrhythmia cauterized. His first episode was at the age of 5; I still remember the strong pulse heard from his chest. I could not offer him any kind of help except to hold him tight in my arms until we took him to hospital. From that day, and for the years following, every time he asked me to go next to him, calling "mama", my body froze until I was certain that he was all right. Feelings of fear, helplessness, agony, and shame invaded me. My son felt the same way, but back then I was not aware of his worry, which was

enacted by bursts of anger and a pervasive fierceness. During that period, I was more concerned with dealing with his behavior than with his inner feelings. I was responding from the ‘outside’ and not from the ‘inside’ - as Levine wrote.

It was especially painful and shameful for me to be able to help other families with similar issues while at the same time I could not find a way to connect with my child. It was not that we did not have moments of love or that I could not see his sweetness. It was extremely hard when speaking of Winnicott’s way to hold him in a continuous and stable way. Seeing motherhood so romantically in our civilization, causes a greater burden to the mothers of our occupation who have to fight with the role of being good enough mothers and the role of being good enough therapists.

Entering the room to start the group session, I noted that I was confused, as if I were in a dream. Some members looked at me furtively. I fantasized that they thought I was exhausted, that they were convinced that I was devastated, and I would not even be “present” at the session. I felt embarrassed and I did not know why. My body was weak. For a long time I remained silent. I couldn't connect, showing that something unbearable was happening. Even before words could explain it, my motionless body echoed that something was coming. A therapeutic impasse and at the same time a moment of deep engagement.

The group members had been informed about my absence at the previous session by Alkinoi, as my son’s hospitalization happened suddenly and I had no time to inform the group about my absence. A special condition that prevailed in the group for weeks, for which the members had consented, is that a mother attended the sessions with her baby. My child’s arrhythmia was synchronized with the ‘arrhythmia’ of the group and my own ‘psychic arrhythmia.’ While I was trying to find my position in the group, I realized that I was in a terrible split. What kind of mother am I? Am I a “good” mother, who gives priority to my real child, or am I a “bad” mother, who is absent for my symbolic children? If I remained in the group, would I be bad for my son and good for my group? In my real life, another child had been left aside, my younger son, and my huge agony was that he might also be exposed to danger or that his personal needs might be left behind.

Nevertheless, at that moment I managed to share with the group a small part of my vulnerability. Idealizing what a mother needs to do to pull through, I pretended to endure, without speaking of my vulnerability, without being perfectly honest or spontaneous. The limits became a blur. How can we invite in our inner selves which torture us from the inside, filling us with self-hatred and self-deception; which trigger repetitions of an unbearable therapeutic impasse, attempting inappropriate forms of heroic rescue? What are we willing to risk: allow ourselves to affect and to be affected instead of remaining closed, fighting with our fears of being strange and defective? Or remain near the subtle details of our own experience and use them in an analytically sensitive way? Up till the moment I returned to the session, after my son's problem of arrhythmia had been resolved, I was not fully aware of the degree of difficulties concerning the relationship with my child. Even in my own therapy, individual and group, I experienced feelings of shame in revealing how difficult it was to deal with this situation, how angry it made me feel, worrying if my therapist would judge me as a bad mother. Unconsciously, I was terrified of my own hostility and destructiveness. However, in this session, even though my intent was to connect with the group members, I was detached, without showing my weak mark.

-Fotini Dourmoura

New relational patterns for the group as a whole

Alkinoi: I explain how I came to understand how my relational story influenced the group material and how I was able to communicate and find attunement with the members. I managed to become a new object for the members and eventually a better mother and therapist.

Ehrenberg, in her article *Working at the Intimate Edge,* writes that we must consider why particular qualities or sensitivities of either patient or analyst are activated at a given moment and not at others. Central to her position is the recognition that analyst and patient cannot avoid having an effect on each other. Sometimes disclosing our confusion or specific feelings of puzzlement can be useful. Asking questions - Why are we fighting now? How did we get into an argument? - and tracking when either patient or analyst becomes more frightened or less, more open or less, etc, can help to engage in a collaborative exploration with patients about what is developing interactively and can become a medium to deconstruct toxic developments in the effort to figure out what is going on. She describes this kind of process as an effort to work at the intimate edge. She looks not only at the interaction but also at how she might be participating in it. Working this way does not involve mutual analysis or wild analysis, but it does require that the patient and the analyst deal with each other, and their strengths and vulnerabilities, in real time and in real ways. Accepting responsibility for our contribution allows the opportunity to discover how deeply affected each can be by the other. This emotional involvement can be constructive. Such experiences are not there to be found but, instead, are intersubjective creations, and they are never static. Each participant then 'owns' something not owned before.

On The Analyst’s Emotional Availability And Vulnerability

How do we understand what happened here, in the patient, in the therapist and in the interaction? It was a truly therapeutic moment; it was not understanding, it was not insight. It had to do with the experience of the moment. What was the experience of the moment? It was with the analyst's inner experience, the degree of emotional availability and vulnerability, the level of what we ourselves are willing to risk emotionally in relation to our patients. Sometimes we permit, and other times we preclude, emotional contact. We listen differently and are present differently. In our silences as well as in our words, our willingness to receive our patients' thoughts and feelings - not being afraid, but being willing to be vulnerable to her/his impact and still survive, being sensitive to whatever we feel, no matter how bizarre it may seem - becomes the basis of the analytic work. Being closed and open as an authentic reaction, not because we think it is the correct thing to do or feel. Whether we find ourselves defensive, detached, angry, unemphatic, constitutes important analytic data about what is going on interactively if we are able to use them in an analytic way. Simply saying, 'I find myself feeling detached and I don't understand what is happening and I am concerned about this' is very different from being detached as an assumed role or merely enacting our countertransference

detachment. To pretend to feel what we think we should feel - trying to be a good object - is different from
being a real object.

The challenge is to stay close to the most subtle aspects of our own experience however threatening they seem. For some patients, the opportunity to experience a toxic interaction can become a revelation instead of remaining locked into feeling 'weird' or 'defective' and may allow the patient to feel safe for the first time. Ehrenberg's supervisee shared her puzzlement with her patient without analyzing it, without blaming the patient for doing this to her. This enabled the patient to feel that she was not as alien as she had come to think. Ehrenberg suggests that this kind of emotional communication - to allow oneself to touch and be touched without the protection of "psychic gloves" - becomes the key to the most profound kind of analytic possibility.

Alkinoi's Case study:

Looking back at the material [see post of May 19, 2021] I can recognize that my difficulty to connect with the foreign object that invaded my body, and at the same time my difficulty to contain group members whom I was experiencing as foreign objects, were crucial assumptions that I had to admit and accept if I was to own my badness, as Davies wrote.

My supervision and my personal therapy as parallel processes to the group therapy, came to side light my blind spots. They helped me identify with my own unconscious material and my own relational story, and interpret them for the benefit of the group. Through my own dreams, that were analyzed in my individual and group therapies, I managed to connect with the difficulties of having a baby. I comprehended not only the absolute happiness ,but also the unbearable feeling of narcissistic injuries: my fear about if I would be able to raise her properly, my envy that I would lose the uniqueness in my husband's life and heart, my anxiety regarding my availability as a group therapist and my ability to become a group therapist. Finally, the shame that it was me that was able to get pregnant and not my patients (most of the members were women, some facing fertility issues, many had had abortions or wished to get pregnant).

Admitting my own difficulty, a new inner space was created for the group members. My pregnancy was evident now, present in the room, and the members were examining my experience. Mothers in the group found space to talk about their dreadful feelings during their own pregnancies. A domino of self-disclosure about abortions and miscarriages started as the group felt safe with the therapeutic process and with the two therapists who were bringing our own subjectivity into the sessions.

A subgroup, though, was very anxious about where I would be after giving birth, when I would come back and If there would be still space inside me for them. They fantasied that I would never come back, others, that when I left to give birth, they would take my chair out of the circle. The male member, who was very traumatized by his psychotic mother who had abandoned him when he was young, announced that he would stop therapy at the end of the season, but he couldn't connect his decision with my pregnancy and the here and now of the group. This subgroup experienced anxiety in a persecutory way.

In the group many patients had grown up with psychotic parents. My somatization evoked the sense - described by Davies in her article - who is the insane, the psychotic? Is it also me? This subgroup could not explore this and for some patients it was traumatic. Something that we were only later able to understand came beautifully to a session and to our consciousness from a dream. (Inside the projective identification I could not understand it at that moment.) Two years after my pregnancy, and one year after the pregnancy of one of the members during sessions where she was now coming with her baby boy, there came into group a dream in which babies are monsters that are overly aggressive and fatal. It was a very crucial moment as were finally able to talk about who owns the badness. We had to admit our inability to connect with this part as a way to protect them from the presence of the baby and the traumatic persecutory memories that the baby boy's presence evoked for the group.

Using the theory of action (Ehrenberg) and being honest with my countertransference, first with myself, and then examining it with the members, enabled a new relational pattern about which we had been previously unaware. This experience of emotional communication left me able to touch and be touched in a way that shaped me not only as a therapist but especially as a mother.

Ehrenberg, D.B. (2010). Working at the "Intimate Edge". Contemp. Psychoanal., 46(1):120-141.

-Alkinoi Lala

What had happened in the group happened in parallel process to my personal life: I split my feelings of loneliness and shame from the group's projective identification of me in an omnipotent position. Now we will see how we managed to reinterpret the enactment and how an intersubjective space for new experiences was created for the group as a whole.

Foteini's Case Study:

What happens when something unbearable for the analyst interacts with something unbearable for the group members? It is a moment of encounter in which the group projects to the therapist a deficiency of coordination, a moment when the inner personal will be the womb that will engulf the intersubjective.

The cauterization (medical term: of the heart, to correct the unstable cardiac frequency) of the group arrhythmia seemed to be the therapeutic challenge where bad representations, of the analyst and of the members' selves, were in discourse without detachment and without fear of somatization and fragmentation. Examination of projective identifications, happening in a parallel process, began. The first process concerned the feelings of agony, pain and frustration which the mother has to keep in control and she also has the responsibility of planning the intervention. These qualities my child projected on me, inviting me to occupy an omnipotent position and having to feel loneliness at the same time. On the other hand, the group members, my symbolic children, reflected elements representing a motherly figure devastated and disconnected, a motherly figure feeling ashamed and shrinking, fearing being attacked by her children because of her absence.

It seemed that the group needed to communicate the aspect of the not good enough mother. The mother who can be absent without guilt thus integrates the split and facilitates the transition into a depressive position. The group members sought an object of identification and explored, at a symbolic level, who was being abandoned, whose needs where forgotten. Ehrenberg (1995) supports that the challenge is not to surpass our own annoying feelings, but to recognize that they are part of the analytic procedure. If we see ourselves being defensive, or reluctant, this is an important analytic fact, indicative of what happens interactively, aspects that intervene between the need of the patients to mourn for idealized objects and the need of the analyst to mourn the limits of his/her therapeutic omnipotence.

Until that moment of the session in the group, in which I returned after the cauterization of my son's arrhythmia, I was not fully aware of the degree of difficulties concerning the relationship with my child. I had been a false self of a mother who does not admit her exhaustion, whose body is tired and who may have been persecuted by her child's attacks and enactments. After the session, I discussed the session with my co-therapist, as we do after every session. We had the belief in common that we had cracked open and then closed a door; that is, we did not encourage the cauterization of the group's arrhythmia, an arrhythmia we belatedly understood as members and therapists may be mutually traumatized, mutually vulnerable without the need to deny the toxicity of the one or the other in order to maintain the sense of psychic integrity.

It was at the beginning of my acknowledgement of the extent of my frustration and anger towards my son that I became more able to feel a greater sense of authenticity and aliveness. This, in turn, enabled the group to shift from seeking approval to a search for recognition of a true self. In the session that followed, the members' interactions allowed the unfolding of material that shed more light on the emotionally suppressive mother-child condition. The confession of a member that admitted to how disorganized she feels by the presence
of the baby in the group, (as reminder there was a baby present at the group with the consent of the group members), created more space to talk about the possibility that a child may cause threatening feelings for its mother, might persecute her or even remind her of her inadequacy.

My own personal story met the stories of the group members, causing a resonance (Foulkes,1990) with the experience in the moment - my willingness to perceive the members' material, to be susceptible to their impacts - revealing what happens if we go deeply and fight analytically. With continuous supervision, my co-therapist and I realized that we had gotten into regressive states of shame and guilt which could not be articulated. We realized the need to open a safe enough space where the mother-child dyad would be able to embrace all their aspects of vulnerability allowing for autonomously reclaimed ability to bear to be bad together without threatening persecution.

The personal story with my son incited me to connect more truthfully with the group members, discovering the boundaries of my resilience and realizing that something like this can happen without it being dangerous. The group projected the aspect of a mother who might be exhausted shattered and angry. My resonance with this psychic state, and my realizing, through the supervision, the usefulness of my weak point as a tool of analytic work, allowed the emergence of emotionally difficult experiences of the members concerning their own mother-child relationships. Their experiences of frustration and exhaustion and their denial of the omnipotent position led to exploration of more liberating ways of relationship for the group members, leading not to disorganization but able to include detached shameful aspects of self. It seemed the heart of the group is less threatened by arrhythmia and is steadily regulated allowing for the creation of new perspectives in the analytic work. On a personal level, my therapy, my supervision and the continuous education facilitate the relational coordination of my multiple roles. As Ehrenberg writes: each participant does own something not owned before. This is something we keep even after the experience is over and it becomes a kind of 'private property.' I am different both with my family and my group.

Ehrenberg, D.B. (2005). Working at the "Intimate Edge" Intersubjective Considerations—Comments on "A Case Study of Power and the Eroticized Transference-Countertransference". Psychoanal. Inq., 25(3):342-358.

- Fotini Doumoura

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FILM

DIFFERENTIAL EMBODIMENT

With the growing inclusiveness of diverse gender, race, etc, three short, independent films - *Limbo*, *Limit* (Javard Daraei), and *Ready for My Closeup* - at the presentation from Tampa's Sigmund Freud Film Festival (the brainchild of Rodrick Colbert) viewed at the Tampa Bay Psychoanalytic Society on May 15, 2021 gave occasion to think about "differential embodiment" (Shildrick). All three films reminded me of the works of Margrit Shildrick. In The Broken Body (co-authored with Janet Price), Shildrick questions the assumption that the 'disabled' are disqualified from sexual subjectivity.

Limbo is a whimsical, surprising, somewhat disturbing, very short film in which two characters' prosthetic limbs become separated at times from the rest of their bodies during their 'hook up.' What if *Limbo* is about metaphorical pieces and parts, like multiple selves, always striving toward wholeness?

Shidrick additionally questions whether polymorphousness - both in the literal body and in its desire - is perverse, a question that serves as a countervail to the Freudian idea that fetishism is an attempt at resolution of castration anxiety in the little boy where a lost limb and a penis can stand for and restore, respectively, the lost penis. [Contemporary thinkers might locate this anxiety in early attachment relationships and to self image rather than with the 'horror' of anatomical difference.] Shildrick notes "the impossibility of a fully developed, invulnerable self."

Shildrick and Price write, "slippage between what is possible for them and what is required of them...women can never finally answer to the discursive requirement of femininity but remain caught in an endless cycle of body fetishization." Even the TABs (temporarily abled bodied) "fail to contain or express their ideal standards."

In *Ready for My Close-up* an aging actress and her son go to drastic measures to reclaim (surgically) her youth.

"All women are positioned in and measured against an inaccessible body ideal, in part determined by a universalized male body[*]" which "further marginalizes the already marginalized."

[*in *Ready for My Close-up,* he is "my goofy manchild son"]

In *Limit*, a young man desperately seeks help from strangers but his grunts and the film's ominous score cause suspenseful suspicion in the audience. Vulnerability is reconfigured not as a weakness but as the possibility of becoming.

Shildrick and Price remind us that "disabled and ill people - those whose bodies are deemed as broken are labeled as other - are forced to negotiate a set complementary to those of able bodiedness… [their] performative acts - corporeal signs, gestures, claims and desires elicited in embodied subjects - serve no less to produce effect of identity, coherence, control, and normativity."

Become part of the healing.

To volunteer as a clinician- psychotherapist through Veterans' Family Initiative, please call 813-908-5080.

To make a financial donation to help cover administrative costs, send your check tax-deductible contribution to:

T-BIPS; memo: VFI, and mail to: VFI, c/o TBIPS, 13919 Carrollwood Village Run, Tampa, FL, 33618- 2401

VETERANS' FAMILY INITIATIVE (VFI):

An Outreach Program of TBIPS

The mission of VFI arose from the need to help address with family members of veterans some of the difficulties with re-connecting as a family after separations and long absences, and in dealing with possible disabilities or illness of the veterans.

VFI (Veterans' Family Initiative) is one of the community outreach pro- grams of T-BIPS (Tampa Bay Institute for Psychoanalytic Studies). This pro bono/ low fee program was established to serve family members (spouses and children) of veterans who served in Afghanistan or Iraq by offering low to no cost mental health psychotherapy services. Volunteers are licensed psychologists, mental health counselors, social workers, and psychiatrists like you from the Tampa Bay area who have volunteered their time to talk with veterans' spouses, children, couples, or family.

Volunteers provide psychotherapeutic services to family members who are interested in talking to a mental health professional and who are not already in therapy. The mental health clinician meets with a spouse, child, adolescent, couple, or family, on a weekly basis for little or no fee. All particulars are negotiated by you and the patient.

Volunteers do not work for or act on behalf of TBIPS, and TBIPS is not responsible for overseeing your work or its outcome. TBIPS' limited role is to connect potential patients with volunteers, and to coordinate and support the independent clinicians (by arranging peer consultation groups) who have so generously offered their services for the benefit of veterans' families.

As it will be helpful in the development of this program to learn what services families find most useful, VFI asks the volunteer therapist to report to VFI demographics (such as a child's age or that a spouse was seen). No names or other confidential information will be reported.

Treatment is strictly confidential, except as required by law to report elder or child abuse, domestic violence or any imminent danger to patients or others.

Mobius Strip Logo

Ehrenberg wrote that the analytic dialogue, including intersubjective experience, where transference is not separate from countertransference, requires "something like turning our experience 'inside out'—opening … the 'internal boundary' of the relationship and explicating our experience from inside. "

TBIPS chose as its logo the mobius strip (a common symbol for the interconnectedness of things and for infinity) because its inside and outside are inextricably connected. Just as the inside and outside worlds of human experience are contextualized in one another, the past always contextualized in the present, the present in the past, and foreground experience always embedded in background relationship and meaning, so, too, the analytic dialogue has no 'inside' and no 'outside.'

TBIPS offers:

TRAINING Psychoanalytic courses and certificate programs offered.

DISCUSSION GROUPS for the latest literature in the field of psychoanalysis: **Relational Psychoanalysis Study Group**: Relational literature, relational intersubjectivity, Object Relations, Attachment theory, Infant research, and many others discussed on the second and fourth Fridays of the month, September through June. **Self Psychological and Self-Intersubjective Psychoanalysis Study Group**: Colleagues discuss the latest articles in Self psychology and self (Systems theory) Inter- subjectivity on the first and third Fridays of every month, September though June.

SERVICE
Veterans Family Initiative (VFI): Inspired by the American Psychoanalytic Association's SOFAR program, VFI offers pro bono or very low fee treatment to families of veterans of the Afghani and Iraqi conflicts. We have over a dozen dedicated and generous mental health clinicians around Tampa Bay from amongst our ranks who volunteer. You may volunteer, too.

THE ARTS bringing a psychoanalytic perspective to the arts and to issues of human experience.
Film Series: TBIPS proudly co-sponsored community outreach Film Series: 2008-09: *Women in Crisis*;
2009-10: *Fear of Difference: Diversity of the Holocaust Experience and 2010-2011: Developing Passions: On Sex, Relationships and Happiness 2013-14: Children and Trauma*
2014-15: "The Return of the Repressed" Horror films
2015-16: "On Aging"

Theater: Group outings to performances of interest, followed by dinner and discussion.