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ROUND ROBIN
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The Psycho-Politics of Evidence-Based Practice and the Assault on Our Mental Health and Mental Health-Care System

Allan Scholom, PhD

In this issue:

There's hardly a term in social science, political discourse and the scholarly professions where there is anything like clear definitions. Definitions are basically parts of political structures. A definition doesn't mean anything unless it's embedded in some theory of some explanatory scope. They have a strong ideological component.

—Noam Chomsky (2015)

My purpose in analyzing evidence-based practice is to contribute to the developing perspective that psychoanalysis offers a methodology and a morality that can and should be directed toward the understanding of how individual dynamics and social forces interact. The history of psychoanalysis has been saturated with a splitting off of the personal from the societal. This began with Freud, who in his early years believed it was necessary for the survival of the psychoanalytic movement. But whereas Freud changed his mind later in his life, believing that psychoanalysis might have more to contribute toward addressing social problems than as a method of treatment, in recent years we have only begun to connect the individual to the social. Among the consequences of this splitting has been a marginalization of psychoanalysis both professionally, in our theory and practice, as well as in our relevance to the world our patients live in (Tolleson, 2009). Consequently, this paper is meant as a call to consciousness in the psychoanalytic world as well as for our citizenry more broadly.

The term evidence-based practice (EBP), is defined as the integration of the best research evidence with clinical expertise and patient values, although in practical terms the empirical aspect dominates. It sounds like science, with rationality and common sense embed-

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Editor's Column

This issue of *The Round Robin* concerns itself in the main with two different influences of politics on our field.

First, in a well-researched essay by Section I president Allan Scholom, we learn about the national trends in healthcare away from the single-payer model that works so well in every other industrialized country and how those trends resonate with tendencies in the field of mental health that move away from psychodynamic models of treatment. His essay helps us make connections between the drive to reduce mental health treatment to easily measurable numbers and the drive to reduce health care to what is convenient for private insurance companies.

Second, we have an article by me about how six psychoanalytic societies responded in the weeks and months after the unexpected election of Donald Trump as president. I thought it would be interesting to learn how societies reacted since at least half of the country and very large percentages of the analytic community were in profound shock.

Finally, no politics here, there is a section devoted to remembering Allan Frosch, a very popular and respected analyst at IPTAR, who also was an avid reader of *The Round Robin.*

Richard Grose, LP
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Psychoanalytic Societies and the Trump Victory

Richard B. Grose, LP, Editor, *The Round Robin*

Psychoanalysis takes place in a culture that provides both analysts and analysands with some sense of what is normal and what can be expected in the world they both inhabit. The oft-repeated goal of a psychoanalysis is to help the analysand to function better in the culture that he or she lives in. The unexpected election of Donald Trump on November 8, 2016 represented for many an earthquake that suddenly put in question previous assumptions of American culture and politics, such as assuming the need to provide reasons and evidence for policy choices and requiring a minimum level of civility for political discourse. Because the United States is a nation that owes its very existence to an agreement on rules (the Constitution), the abandonment of basic rules of political life as represented by Donald Trump has hit many people very deeply.

I became interested in learning how psychoanalytic societies responded to this earthquake. So I wrote to ten societies, some in New York City and some not, and I heard back from six. Here is how these six societies responded to the election.

Boston Psychoanalytic Society and Institute (BPSI)

My respondent was Joseph M Schwartz, PhD, licensed psychologist, who is the chairman of the Board of Trustees. From his letter I learned that the annual BPSI members' meeting took place on November 19. During the breakout groups, which were standard procedure for such a meeting, the members spoke about the election, and a consensus arose about the need for further discussion. A special community meeting was held on December 13, which broke up into four discussion groups: talking with children and adolescents about their fears; responding clinically to patients; understanding the forces that led to the election result; and considering BPSI's response to the larger community.

By the time of the community meeting, the leadership had realized that there were both students and members who had voted for Donald Trump. As Dr. Schwartz put it, "Though they represented a small minority (as best we could determine anecdotally), we made an effort to assure that all voices would be welcomed so that we did not re-create a microcosm of the national election process where at least one of the prime casualties was a lack of curiosity about what animated people of differing perspectives."

Contemporary Freudian Society (CFS)–DC

My respondent for the Contemporary Freudian Society-DC, one of the two branches of this society, was Michael Krass, society director. He is a member of a study group that was preparing for a regular presentation at the January meeting of APsaA. Mr. Krass wrote: "Our study group's monthly meeting in November fell on the Monday after election day. We arrived at our meeting … in varying states of shock, disbelief, dismay, deflation, suspiciousness, hopelessness, and helplessness. And feeling to varying degrees parentless, in the hands of abusive parents, abandoned by our parents to the hands of abusive others, [feeling] that we were parents who failed to keep our children (our actual children, our patients, the younger generations) safe."

The group decided to organize its upcoming APsaA presentation around viewing the election as "an impingement on the analysts' containing function," and to present case material that would illustrate the analyst's struggle to keep the focus on the patient's inner life, "with the explosive impact of the election continuing to reverberate in the analyst's mind." He mentioned the intensity of the discussions around the presentation as the participants needed a place to vent their fears and anger as well as to consider the stresses that the political situation was exerting on their work. He continued, "There was a great deal of laughter, maybe more off-color jokes than usual, as we attempted to master the primitive anxieties that had been stirred up and that were looking for a place into which to settle down."

Contemporary Freudian Society (CFS)–New York

For the New York branch of the CFS, my respondent was Andrea Greenman, PhD, chair of the Organization Consultation Committee. Dr. Greenman began, "In the first week following the election, it felt like 9/11 all over again. The shock, outrage, disbelief, and worry overwhelmed any sense that we could go-on-being as usual in our daily lives." Every encounter among colleagues was about this, and many patients and supervisees reacted with tears, some-

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Psychoanalytic Societies

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times loud sobbing, reflecting "unimaginable distress and rage."

Colleagues discussed how to deal with these feelings in sessions, whether it was best to share their own feelings with their patients, whether that would distract from treatment issues, and whether that would affect the transference. She reported a general consensus emerging that without wanting too intrude to actively into the discussion, neglecting these powerful feelings also felt like an omission, and therefore for many a resolution lay in simply acknowledging that we too felt shock and disbelief, and were concerned and disheartened at the election, in order to move back into a place where the patient's perspective was in focus.

In response to all of these discussions, the Board of Directors of the CFS-NY scheduled a Members Forum for three weeks after the election. The forum was not held, however, because too few people signed up for it, the general feeling seeming to be that people had been talking about nothing else and further discussion would be at best useless and perhaps a painful rehashing of the collective trauma. In the weeks that followed, some patients were reporting that it was hard to take individual concerns and pleasures seriously against the background of such a "dangerous and unpredictable social upheaval."

Dr. Greenman concluded by mentioning the pull toward political activism of one form or another. While acknowledging the importance of activism, she wrote about the unique place that psychoanalysis offers to process and understand the irrational forces in individuals and groups. She emphasized the need to preserve the spaces where people can think and talk together so as to "enable us to maintain our moral and therapeutic vitality through a difficult time." She concluded with thoughts about the possibility of bringing psychoanalytic wisdom into the public arena for those who can take comfort in guidance from it.

The Institute for Psychoanalytic Education (IPE), Affiliated with the NYU School of Medicine

My respondent was Herbert Stein, MD, director of the IPE. After beginning by saying that most IPE members responded as one might expect from a group of New York professionals, "with great concern for the future at a range of reactions," he went on to say that special meetings were organized for the faculty and for the students to discuss the effect of the Trump victory. He reported on the meetings for faculty, of which there were two, neither of them very well attended (seven at one, and five or six at the other).

The faculty meetings reflected mainly the specific problems that certain patients were bringing up with regard to the election as well as problems that the faculty themselves were having in their own reactions. They also mentioned the increase in hate acts in the community and the responses to them, as well as the difficulty in maintaining neutrality in the face of this traumatic event that involved more controversial reactions than 9/11 or Hurricane Sandy, for which the community had a clear shared reaction.

Institute for Psychoanalytic Training and Research (IPTAR)

My respondent was Nancy Einbinder, LCSW, president of IPTAR. Ms. Einbinder reported that IPTAR called a meeting on November 27 to discuss the reactions to the election, and twenty-five people attended. She summarized the conversation as including talking about people's own disorientation, their feelings of shock immediately after the election, and in some cases an impaired ability to work. Patients with a history of trauma were feeling victimized and fearful. They discussed how these patient reactions interacted with analysts' reactions. She noted that by the time of the meeting some of these feelings were diminishing, but some felt there was an ongoing sense of dread both in analysts and in their patients.

They discussed opportunities for political action, signing petitions, going to marches, and donating money. The general sense was that it had been important to meet and that it had helped those present as an emotional support. The wish was voiced to have another meeting, and one was held on February 26. Ms. Einbinder characterized the meeting as "a very open, heart-felt conversation."

IPTAR: The Newsletter *ROOM 2.17 A Sketchbook for Analytic Action*

My respondent was Hattie Myers, PhD, training and supervising analyst at IPTAR. Dr. Myers reported that after the November 27 meeting she thought that "it might be useful to establish a 'virtual' space within IPTAR—a space entirely dedicated to publishing essays of a clinical, theoretical, political, or philosophical nature—and poetry, art, photography, music, cartoons, and announcements." She sent out a call for those at IPTAR interested in doing this, had a first meeting with a small group, and with the help of a talented graphic designer and a professor of design the group created the newsletter *ROOM* in two months. The link to *ROOM 2:17* (the numbers designating the date of release) is http://iptar.org/publications-2.

Michigan Psychoanalytic Society

My respondent was Kehinde Ayeni, MD, the president of the society. Dr. Ayeni began her letter by saying that the society had not issued any formal public statements regarding the election because of the number of people who voted Republican in Michigan in the election, and they did not want to alienate anyone who might come to them for help. She said that there had been informal group meetings among analysts, ad hoc, centering on thinking about how to continue to help individual patients deal with the election and on trying to understand why people voted against their own interests.

She wrote that it was well known

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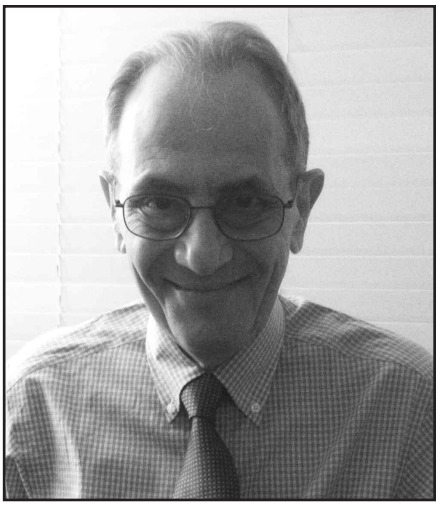
Four Remembrances of Allan Frosch, PhD

Allan Frosch, psychoanalyst, teacher, training analyst, and supervisor, and twice president of his society, died on October 28, 2016 at the age of 78 after a ten-month struggle with cancer. His career at IPTAR (Institute for Psychoanalytic Training and Research) and elsewhere was distinguished, but more than that, he was uniquely beloved and respected within IPTAR and beyond for his warmth, intelligence, and honesty. Below are four remembrances of Allan Frosch, two from colleagues and two from analysands. One of the latter is mine. — Richard Grose

Sheldon Bach

In this age of totally strident narcissism, when some people live in golden penthouses and spend their days glorifying their own image, Allan Frosch was a humble man. Humble but not weak, for I have seen him fending off a room full of people while fighting for an idea of which he was the only proponent. He believed in good causes and he believed in people, and anyone who met him, even for the first time, knew that they had encountered a good man.

Allan and I worked together on cases for a few years, and it was a true collaboration in which each of us learned a lot. Apart from his empathy, his intuition, his interest in new ideas, and his enormous desire to help, the one thing about him that stood out most of all for me was his dependability. You could count on him, and you knew without having to worry about it that if Allan was seeing a patient, that patient was in good hands. Since so many of the people we see today have been fragmented by discntinuity and trauma, Allan's dependability was therapeutic and his presence was healing.



Allan Frosch, PhD

Allan was twice president of IPTAR and he was one of the founding fathers of the IPTAR Clinical Center, both daunting tasks that he sustained with his usual calm resolve. For years he was always available to sit on a committee or to perform another task that needed doing. Later in his professional life he became more interested in finding his own unique voice, and he published almost a dozen cogent, lovingly written papers. Many of these papers seem to me to have a moral or ethical quality that one finds only in the best writing in our field, and they all seem to point to a widening vision for psychoanalysis and a plea for open-mindedness in our analytic community.

In one of his last papers, "The Sacred and the Profane," Allan uses the concept of quantum entanglement as a metaphor for the relationship between patient and analyst. In quantum entanglement, two particles that have interacted or been intimately connected will continue to influence each other even long after they have separated. Allan compared this to many situations where, long after an analysis has been completed, the analysand may no longer be thinking much about the analyst, but she will still continue to feel that he is always with her. And I think that this is how many of us feel about Allan. We knew him and we grew to love him, and we became intimately involved with him. Although we are now separated by a great distance, we remain entangled with him forever.

Sheldon Bach, PhD is Adjunct Clinical Professor of Psychology at the NYU Postdoctoral Program for Psychoanalysis, a Fellow of IPTAR, and a Training and Supervising analyst at the Contemporary Freudian Society. He is the author of several books including *Narcissistic States and the Therapeutic Process, The Language of Perversion and the Language of Love, Getting from Here to There, A Handbook for Students of Psychoanalysis* and, most recently, *Chimeras and Other Writings*. He is a recipient of the Heinz Hartmann Award for "outstanding contributions to the theory and practice of psychoanalysis."

Joan Hoffenberg

I have not wanted to face this loss. Part of what made Allan Frosch remarkable was that each person he

Allan Frosch

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came in contact with felt a level of intimacy and intention that made the relationship feel special and unique. I would like to spend a few minutes on Allan's place at the Institute for Psychoanalytic Training and Research (IPTAR).

I think that Allan and I are the only two IPTAR members who served as ICC director, dean, and president. I think I unconsciously identified with him and internalized his ethic for service. Not only did I follow him, but often I worked alongside him—observing, sharing, planning.

He was the person I turned to when I needed advice, when I needed someone to talk something out with, when my professional life was keeping me up at night. He was calming, never alarmist, always available.

In many ways Allan represented the best in IPTAR: he was thoughtful, insightful, truthful, intelligent, analytic, and committed. Allan was a man of integrity, and those around him knew that.

He graduated from IPTAR in 1992 and became a Fellow (Training Analyst) in 1998. While he was on the faculty elsewhere, IPTAR was his analytic home.

His view that a psychoanalytic attitude was relevant for all of our clinical work permeated his thinking and teaching. He saw psychoanalysis as being along a continuum and did not make a hard distinction between psychoanalytic psychotherapy and psychoanalysis. This belief touched the lives of his many students, analysands, and supervisees.

Allan's career at IPTAR always involved teaching. From 1995 to 2005, he taught the seminar on Latency and Adolescence in the adult analytic program. Then began to teach a course that he reshaped in keeping with his ideas about psychoanalysis; from Analyzability and the Psychoanalytic Situation the course became the Seminar on Developing Analytic Process. In this way Allan was able to help candidates recognize and develop their analytic skills with any patient and to help them deepen the treatment.

In 1994 Allan along with Audrey Siegel became the first directors of the IPTAR Clinical Center (ICC). He held this position for six years, during which the ICC became a vital part of IPTAR, providing clinical experience, control cases, and free supervision for our candidates.

Allan was also a member of the research team (with Norbert Freedman, Neal Vorus, and me) that studied and then wrote about the efficacy of treatment at the ICC. Our finding that frequency and duration made clear differences in outcome was one of the first outcome studies for psychoanalytic psychotherapy and is often cited. He went on to research effectiveness in the work with children at the ICC as well.

Allan was Dean of Training from 2000 to 2002. He also served two terms as president of IPTAR: 2002-2004 and 2006-2008. He accomplished much in these four years as president:

- He led a process of finding new office space, culminating in IPTAR's acquisition of the offices on West 97th St., where the institute was until last year.
- As a way of making psychoanalysis more relevant, he conceived of and brought into being the Arts and Psychoanalysis Committee. It was designed to bring the couch into the streets and place IPTAR at the vanguard of a current trend to highlight what psychoanalysis has to offer to diverse disciplines. He saw this group functioning as an umbrella under which visual arts, film, music, and literature could be explored through a psychoanalytic lens. The regular exhibitions in IPTAR's conference room are one ongoing result of Allan's vision.
- Noting the lack of diversity in analytic communities, Allan created the Diversity Committee, whose task it was to work within IPTAR on recruitment, admissions, curriculum, and programs to encourage and facilitate dialog with reference to otherness and difference.
- Allan began IPTAR's first diversity scholarship. Named in the memory of Enrico Jones, the first African-American professor of psychology at Berkeley and an eminent psychoanalyst and researcher, this scholarship is designed to encourage people from underrepresented groups to enter psychoanalytic training at IPTAR.
- Allan saw the need for connection to the expertise of individuals who had an affinity to psychoanalysis but were experts in fields that we analysts were not. To this end he and his colleague Joe Cancelmo gathered experts in branding, finances, real estate, group development, funding, and other fields with whom they met regularly. Members of the Advisory Board were instrumental in helping IPTAR acquire its new East Side campus.
- During his second term as president, Allan pushed for IPTAR to develop a program to assist candidates who did not come from mental health fields to become licensed in psychoanalysis under a new law in New York State. The program was approved in 2006, allowing hitherto unlicensed members and candidates to receive the credential of Licensed Psychoanalyst.
- In the final year of Allan's presidency IPTAR was granted permission by the United States government to train non-immigrant foreign students. This program transformed IPTAR. Today we have candidates from Turkey,

Joan Hoffenberg, PhD, FIPA, is a graduate of IPTAR, a Training Analyst and Fellow. She served as Director of the IPTAR Clinical Center for 6 years . During that time she and her colleagues organized the conference following 9/11 "Terrorism and the Psychoanalytic Space" and edited the book that followed it. She served as President of IPTAR 2012-2014, and since 2014 has been Dean of Training there. She was a coauthor of the book, *Another Kind of Evidence*. Dr. Hoffenberg is in private practice in Brooklyn.

Korea, France, Italy, Israel, Taiwan, Canada, Peru, Argentina, Mexico, and Switzerland, among others, and can provide treatment in many languages.

When we last spoke on his birthday, October 16, 2016, we talked about how he had touched so many people's lives, how he had influenced the shape of IPTAR, and how ironic it was that it took something like his illness to give people an opportunity to say how they feel about him. He worried about the future, but he knew that his time was very short. We both felt that this was probably the last time we would talk.

Allan's death leaves an unfillable space in my life. His is a voice I carry with me. He has touched a generation of analysts who also carry him with them, and for this we are all grateful.

Claudia Heilbrunn

I began looking for an analyst after a less-than-ideal ending with the analyst I was planning to see when I began IPTAR's adult analytic training program. My then supervisor referred me to Allan Frosch, with the words: "I think you'll like him. He's a real mensch." She was right. Dr. Frosch was a real mensch: a person of high integrity and honor. He demonstrated this on the first day we met. Whereas other analysts I met with since my last treatment had ended asked me the name of the analyst with whom I ended treatment, Dr. Frosch didn't ask who it was. In my mind, he didn't need to feel superior to that person or to have that particular tidbit of gossip.

His integrity was also clear in what I saw as primary tenets to which he remained true: each patient is different, so no one way of thinking - no one theory - will do for all; the analyst must consistently look at himself to understand what is happening in a treatment; there are no rigid rules in psychoanalysis (excluding, of course, those that protect the patient (e.g., rules forbidding gross boundary violations)), and analysis occurs when the analyst thinks analytically about the patient.

Dr. Frosch's lack of rigidity helped me enormously not only in my personal treatment, but also in my training. That first day of treatment, when asked "How are you?" he answered my question and asked me the question in return - something I was told I was never allowed to do. I felt instant relief that there was no one set of rules I had to follow. When I was told by a supervisor to do something that did not feel right, he encouraged me to follow my instinct, not blindly, but after sorting through my perceptions about my patient and increasing my awareness of why a certain course of action seemed better than another.

When Dr. Frosch was very ill, I asked him how he could sit and listen to my problems, when what I was going through seemed to be so trivial compared to what he was experiencing in his fight for continued life. He answered, "It's an honor to be here with you." And I believe he felt that it was. Listening to people who were suffering and helping them to feel better - which, he told me, was the true aim of psychoanalysis - was, for him, an honor. I cannot think of anything more that I would want of an analyst than someone with integrity, intellectual autonomy, and the capacity consistently to reflect on himself, who feels honored to help people who are in need.

I can only say that the greater honor was to know, to be treated by, and to learn from him.

Richard Grose

I was in treatment with Allan Frosch for five years, the last nine months of which were under the cloud of his cancer diagnosis. I am writing here about how he handled his illness in my sessions.

Last winter, Allan had canceled some appointments to learn why he was coughing so much. At the beginning of my next session I asked him how he was. He said, "I'm ill." I asked, "Is it cancer?" He said, "Yes." Lung cancer? Yes. What stage? Four. He told me that he would be starting chemo and radiation soon. I asked if he would be able to work while he had those treatments. He said the doctors were encouraging him to work. He said, "It doesn't look good but I'm still here." Later he said, "I guess you didn't sign up for this, did you?"

In the first few months after the diagnosis, he would intervene to point out when I defensively moved away from the topic of his health. He answered all my questions about his scans and doctors' reports. Being able to ask about anything meant that I was anxious before he met with his doctors, but it also meant that he wasn't going to hide anything medical from me, and this, I now know, was extremely important to me. Among other things, his openness allowed me to express my hatred for his disease and my anger at him for being in its clutches.

Around the beginning of the summer, I asked about immunotherapy, and he said the doctors had held off on that because the results of the chemo and radiation were turning out to be better than originally thought. I took this as welcome permission not to think about his illness, and during the next several weeks he didn't interrupt my concern with my own life. That ended when I again mentioned immunotherapy and he said he was going to start it soon. I understood that to mean that he was likely in the last stage of his illness.

In succeeding weeks I was upset at not knowing if the current session would be the last one. In response he said that if he needed to end the treatment, he would try to give me as much warning as he could. In the end it came down to one phone call of less than five minutes in which he told me that he couldn't continue and gave me the name and number of somebody I might consider working with. I then tried to express in a couple of sentences the depth of what I thought he had given me, and he responded warmly. And that was that.

During these nine months I would sometimes ask myself: What is the point

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Claudia Heilbrunn received her BA from Columbia University and her MA from the University of Pennsylvania. She is an advanced candidate in IPTAR's Adult Psychoanalytic Program.

Allan Frosch

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of going through this when the end is not far off and seems inevitable? But after Allan died and I was able to think a bit, I realized that somehow while enduring the pain and uncertainty of this time a shift had occurred in me regarding a deep-set tangle of feelings about an inter-generational unconscious relationship to death in my family. I now think that Allan helped me most by staying open and connected to me while he was in this struggle for his life. His work with me in these last nine months of his professional life not only helped me but also gave me an indelible and inspiring experience of how a profound devotion to psychoanalysis can take even a losing struggle with death itself and make it a crucial part of a therapy.

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The Psycho-Politics of Evidence-Based Practice

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ded in it. After all, who could be against using evidence and thereby science as a basis for judgment, action, or practice? EBP dominates the landscape in the health-care world as essentially valid and valuable. In mental health it has become synonymous with cognitive behavioral therapy (CBT), which has become code for the short-term treatment approaches that most easily fit the flawed empirical requirements that constitute scientific evidence today. Those who do not practice so-called EBP are left vulnerable to treatment denials, audits, and lawsuits on a practical level (Walls & Scholom, 1998; Shean, 2015). Depth-oriented longer-term therapy as is embodied by psychoanalysis has been especially damaged, as have training programs offering psychoanalytic approaches. Experientially, there is a stigma, shame, defensiveness, and marginalization that haunt those in the psychoanalytic, humanistic/existential, and family systems clinical worlds.

The reality of EBP is, however, quite another matter. In a recent analysis of the empirical literature, Shedler (2015) has found that "evidenced-based therapies are *ineffective* for most people most of the time." In a related review, Johnsen and Friborg (2015) have found that CBT is half as effective as it used to be in treating depression. This is even more striking in light of Shedler's conclusion that "evidenced-based therapies are weak… their benefits trivial… and even the trivial benefits do not last." In essence the grounds for widespread acceptance of CBT were never there to begin with.

Furthermore, there has been a great deal of empirical support for psychodynamic treatment (Shedler, 2010), as well as a long history of psychotherapy research prior to the EBP era, which demonstrates the general effectiveness of psychotherapy. In fact, psychotherapy, including psychoanalytically oriented approaches, has historically been one of the most research-supported treatments in the health-care world. In this sense, the effort by the CBT proponents of EBP is an attempt to rewrite, if not eliminate, the research-supported history of the general effectiveness of psychotherapy.

So we are left with a critical question: How and why has the EBP movement come to dominate the health-care landscape? To understand the matter, we must turn our attention to history and begin with the broader social and economic forces that set the stage for the situation. Until the 1980s health care was essentially a "ma-and-pa" operation, with services provided by private practitioners, stand-alone hospitals, and medical centers, some with a religious affiliation. In the 1980s health care, the largest industry in the country, which currently accounts for over 17 % of GDP, essentially became the target of a corporate takeover because of its potential for great profit (Scholom, 1998, 2013). Health insurance, the pharmaceutical industry, and large hospital chains came to dominate the health-care world as it galloped toward oligopoly.

The overarching result has been that the United States has the most expensive health-care system in the world, costing about twice as much in GDP and per capita health care as nations with single-payer or non-market-based systems (as is the case in all other first-world and many third-world countries). The current U.S. system is ranked worst in the world among developed countries (Commonwealth Fund, 2014). Americans suffer poorer health in almost all categories compared with citizens of all other industrialized countries, and this downward spiral has continued since the 1970s (Institute of Medicine, Woolf & Aron, 2013). The United States is ranked 70th out of 132 nations worldwide in health and wellness (The Social Progress Imperative, 2014). In reality, Americans get fewer services, including outpatient visits, hospital days, and surgeries, for far greater cost with far worse results.

How can this be? In essence, it is the costs of the for-profit/market-based system that are responsible. These include administrative costs (about 30% going to the health insurance industry versus less than 5% for Medicare), excessive profit (due largely to drugs costing more than twice what other countries pay), and profit unrelated to health-care service delivery (for stockholders, advertising and marketing, debt repayment from mergers and acquisitions, and executive compensation).

The bottom line is that in health care, the market does not work effectively. Nor does it work humanely, as health care is a privilege of wealth and not a right for everyone. Thus, the market *is* the problem. This is reflected in exorbitant profits for many corporations not directly providing health-care services (Scholom, 1998, 2013). To illustrate, since the passage of the Affordable Care Act (ACA) the stock prices of the four major health insurance companies have more than doubled.

Set against this backdrop, EBP serves an important function as a vehicle to curtail services and thereby increase the profit of the health insurance and

drug industries while also cutting government costs. Actually, one of the prime objectives of the ACA is to eliminate the fee-for-service system and replace it with a capitation model wherein a fixed amount is given to provide services for an individual regardless of actual need. One way this is done is through "accountable care organizations," which are a new version of HMOs.

The popular term often used regarding capitation is "value over volume." In reality, this shifts financial risk onto practitioners; the incentive is to provide less service under the guise of "accountability." Essentially, this is code for austerity, or people getting less. Under the rubric of "medical necessity," a term created by the health insurance industry to control cost and increase profit, services that are not deemed to be evidence based can more easily be denied.

Thus, EBP (as in short-term therapy) provides a "scientific" rationale or cover for providing less service while garnering greater profit. Because Americans do not receive more services (in fact, they generally receive less, but do pay more for those services they do get) compared to people in other countries, the current fee-for-service system is not the problem. The free market is the problem in health care—too many entities making too much money while contributing little or nothing to delivering services.

Whereas 75 % of Americans believe the U.S. health-care system requires fundamental change (Commonwealth Fund, 2014), the public debate centers on the role of big government and not the limits of the market. How is this so despite these facts? Put another way, how is it that we continue to act against our own best interests by allowing to remain in place a system that is harmful to us? The situation is not unlike one we see as practitioners when patients arrive at our offices knowing something is wrong with them but having little to no awareness of what the real problems may be. We are charged with helping our patients look more deeply into their struggles to facilitate understanding and acting on their own behalf.

Herein lies the potential for the psychoanalytic approach to aid in our understanding the connection of the individual to her or his social world. Layton (2006) has called attention to the unconscious pull to dissociate individuals from their social milieu in the United States. In seeking to comprehend this unconscious pull in the health-care context, it is essential to consider the mythologies that are at issue here. Let us start by taking up those concerning big government and the free market, and elucidate the individual and group fantasies and illusions that permit such myths to go unchallenged.

In reality, Americans get fewer services, including outpatient visits, hospital days, and surgeries, for far greater cost with far worse results.

Regarding big government, the actual size of the government or spending by the government has not changed appreciably over our recent history. This has been the case whether Republicans or Democrats were in power. What varies are the directions one party takes in contrast to the other regarding how resources are to be used and what laws are passed. For instance, when Republicans (generally seen as against big government) push to control women's choice or marital freedom, or determine what children are taught and tested on in school, or decide who can vote, they use big government for their own ends.

Concerning the free market, this too is dependent on the rules made that determine the direction the market may take. For example, when the rules allowing banks to consolidate banking and commercial activities were changed under a Democratic administration (Democrats are generally considered to be more protective of individuals and the environment against the excesses of the market), the stage was set for the economic crisis of 2008. Similarly when the various free trade agreements starting in the 1990s were written favoring corporations without sufficient labor or environmental protections, jobs were lost and the environment degraded.

I cite these examples to illustrate that there is no such thing as "big government" or the "free market." Rather, these things are myths that serve to confuse and mystify the public such that it cannot see its own self-interest. Big government and the free market become potent oversimplifications, illusions, or mythologies used by both parties to manipulate public opinion and perceptions for political ends. They do so largely to preserve their own influence, the status of which is vastly dependent upon serving the interests of those who provide the financial resources necessary to gain power.

From a psychoanalytic perspective, we can endeavor to explicate the underlying fantasies these myths speak to. As to big government, concerns about the dangers of dependency and vulnerability are foremost. We psychoanalysts might remind ourselves how we typically face patients who are afraid of close relationships (for understandable historical reasons) such that being influenced by others is felt as threatening or coercive. Many may seek the illusion of independence or self-reliance as a potential solution. That may find expression in an idealization of the free market as an embodiment of individualism and safety, free of external threat. Of course, the opposite may be true in that some people may seek to be overly dependent so as to avoid the perils of separation and individuation.

To be sure, I am oversimplifying, as the fantasies around independence and dependence underlying the myths of "big government" and the "free market" can take myriad forms in the same person and certainly in a collective sense as well. My point is not to map, in some one-to-one fashion, how a given person or group may travel from fantasy to mythology and back but rather to illustrate that there exist fantasies that make us vulnerable to political mystification.

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Furthermore, we in the psychoanalytic world are uniquely positioned to help with the demystification on an individual and collective level (Scholom, 2015).

We now turn to the rise of neoliberalism taking place over the last thirty-five years. Neoliberalism refers to free market economic fundamentalism, or basically little to no control over corporate power. That is in contrast to traditional Keynesian liberalism, where the government contains corporate excesses and provides a social safety net. It includes a corresponding ideological assault on consciousness and subjectivity (Layton, 2010). A critical aspect of the mystification process involves the creation of a new neoliberal language that generates a neoliberal consciousness, leading us to think, feel, and act in commodified and objectified terms.

To illustrate, "multitasking" becomes a worthwhile end as if doing more than one thing at a time somehow makes us better, more capable people (even if we could do so from the point of view of mental processing, which of course we cannot). More broadly, we tend to think of ourselves as good or virtuous, depending upon how much we can "accomplish" in a given day (Peltz, 2005). Over and above the stress and pressure this thinking engenders, it places responsibility on us to do more while at the same time estranging us from present experience, fostering a splitting off of our inner selves.

Not surprisingly the rise of neoliberal free market fundamentalism corresponds to the rapid expansion of religious fundamentalism throughout the world. A key connection here is belief about innate human sinfulness, undoubtedly the ultimate in blaming the victim or self-hatred. As we are born in sin, it is our individual responsibility to overcome this state, regardless of how the deck is stacked against us by the system. While we in psychoanalysis do believe in personal responsibility, we are also mindful of how historical forces, both familial and societal, powerfully influence the course of our lives.

It follows then that we have come to approach life in productivity terms, embodiments of this free market fundamentalist ideology, or what has been called, "homo entrepreneurs." In essence, our subjectivity becomes commodified. Unwittingly, we become increasingly objectified and objectifying entities embedded in this formative social reality, without our realizing what is happening. Of course, if we don't do this very well, it is our own fault, which becomes a new way of blaming the victim. As we know all too well in our work with patients this is a kind of defensive lie that covers a more painful truth or is disavowed from one (Freud, 1927). In this case, the painful truth is that government has ceased to function as the caretaker of last resort. Instead, it is increasingly merging with and serving the interests of large corporate entities.

The loss of the government as the caretaker of last resort is exemplified in the shredding of our social safety net over the last thirty years (for example, cuts to Medicare and Medicaid, Social Security, the loss of private retirement programs, and price gouging with student loans). In light of this development, we can say there has been a collective trauma visited upon our citizenry, leaving people increasingly on their own. Furthermore, that is considered to be a good thing in that people ought to be more responsible or accountable or sacrifice for the greater good.

This process is known as "gaslighting" (Welch, 2008)—being told that the bad things that are happening to you are not really happening, are not so bad, or are actually good for you. This mystification is a pathogenic process that makes people more vulnerable to being controlled as their grip on reality is assaulted. Thus it becomes internalized as "our" problem—the defensive lie that conceals the deeper truth that it is the larger system that is failing us (Layton, 2010).

This triumph of individualism and illusory control over interdependence and vulnerability represents a shared delusion dominating the collective psyche in the United States today (Layton, 2010). From my vantage point, that is not the approach to living we in the psychoanalytic world would stand for. Our long commitment to transforming "neurotic misery," to seeking authenticity and freedom to choose, exemplifies that we have a great deal to contribute to our society in understanding the neoliberal colonization of our social reality and our psyches.

Perhaps nowhere is this more evident today than in the election of Donald Trump and its relationship to the fantasies of the American Dream and American Exceptionalism. "Make America Great Again" was his successful campaign slogan meant to arouse a fantasy that in essential economic respects has been relentlessly and significantly disappearing since the 1970s. The facts are that 92% of children born in the 1940s made more money than their parents, whereas only 50% born in the 1980s did (Leonhardt, 2016). Given the further declines in median income for families that we have seen since the eighties and the increase in the income disparity between the 1% and the 99%, we can safely conclude that the situation is getting far worse for recent generations.

In the absence of the increasing inequality due to neoliberal economic policies (tax cuts for the wealthy and corporations, privatization and deregulation, cuts to the social safety net, and other forms of income redistribution upward), it would be the case that 80% of children would make more than their parents over the last thirty-five years. In sum, these class warfare policies waged by the 1% against the 99% have had profoundly destructive consequences for our standard of living. The United States is now the most economically unequal of all Western nations and has significantly less social mobility than Canada and Europe.

What is most striking in this situation is that Americans are both unaware of the extent of the inequality in the United States and do not believe that it is as bad as it really is (Fitz, 2015). Clearly, the public is in cultural denial about the vanishing American Dream. As comedian George Carlin joked, "The reason they call it the American Dream is that you have to be asleep to believe it."

Furthermore we have always been told that the American Dream was responsible for waves of immigration to the United States. However, the facts show otherwise, as 30 to 40% of immigrants from Europe before World War I ultimately returned home and many more were unhappy they had come (Zahra, 2015). Surely we must consider that the United States was built upon a legacy of genocide of 9 to 10 million Indians and the death and enslavement of countless millions of blacks (Zinn, 1980).

Add to this the fact that the United States is often seen nowadays as the most war-mongering country the world has ever known with polls taken in other countries revealing that the United States is seen as the country posing the greatest threat to world peace (Perry, 2016). Thus, we can see that there has been a dissociated, disavowed, and denied U.S. history that has been compensated for by the fantasy and illusion of the American Dream and American Exceptionalism.

While there is great deal of understandable fear and uncertainty about what Donald Trump will actually do, it is quite clear so far in light of his cabinet appointments, executive orders, and policy statements that from an economic perspective we will be getting another, likely stronger dose, of these same neoliberal redistributive policy poisons. Undoubtedly it will not be long before the people who voted him in should realize their betrayal. But will they? Or will they cling to the fantasy of the American Dream and American Exceptionalism, because the loss of the illusion is too painful to digest?

This tragically also applies to many, if not most, of the rest of the public, who are horrified by the specter of Trump. We might attribute our fears of Trump to his personality and character, which embodies and applauds our basest destructive instincts. This is certainly fair and understandable on a manifest level. However, I believe that the deeper fear is that the policies he embodies are reflections of a system that is in decline—that the dissolution of the fantasy of the American Dream and American Exceptionalism is far too terrifying to face. Furthermore it is an illusion that for many, if not most, people never was but always dreamed of.

As Freud has said in *Reflections on War and Death* (1918), "Illusions commend themselves to us because they save us pain and allow us to enjoy pleasure instead." However, as French philosopher Sebastien-Roch Nicolas de Chamfort asserts, "pleasure may come from illusion but happiness can come only from reality." It is here that we in the psychoanalytic world have much to contribute in helping people to understand what has been happening to them both on an external political/historical level as well as what this means to them from a personal/internal point of view.

How is it that we continue to act against our own best interests by allowing to remain in place a system that is harmful to us?

In essence our work can help people move from disillusionment to empowerment. While we do talk to our patients about politics undoubtedly now more than ever in the wake of Trump, it becomes ever more important to do so to avoid the danger of blaming the victim (us) for our struggles and recapitulating our trauma by failing to sufficiently address the external forces that are terrifying and harming all of us in real terms.

Furthermore, it is incumbent upon us to speak out beyond the consulting room to help bring about the larger systemic social change we so desperately need. In this regard I do not believe that research demonstrating psychoanalytic efficacy will reestablish our place in the mental health world. The research is already there, and those who blame our declining status on the supposed lack of it are themselves blaming the victim (us) of a system that also oppresses us.

If we are at fault in some way it is in our failure to strongly oppose the forces that are exploiting all Americans. We psychoanalysts have much to contribute in the realm of helping people address their fantasies and illusions. In doing so we make ourselves relevant in ways we have not been, yet can be and need to be. Now is the time to join with our fellow citizens not only to resist the poison pills that Donald Trump is offering but moreover to help set a new course, freer of fantasy and illusion, that meets the real needs of the many in the 99%, not those of the few in the 1%.

Let us now turn to the history of EBP both to illustrate how it happened in the field of psychoanalysis and how we, like most everyone else, have been unwittingly implicated. Although EBP is generally understood to have originated in medicine, these same systemic forces just discussed were at play during the time period that EBP was beginning to hold sway. In both medicine and mental health, EBP is defined as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. In psychology, the earlier iteration, called empirically validated treatment (EVT), later evolved into the definition of evidence-based practice adopted by the Institute of Medicine in 2001 as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values."

The American Psychological Association formally adopted the broader definition of EBP (American Psychological Association, 2006) that includes therapist expertise and patient characteristics in addition to empirically validated treatments empirically supported treatments (EVT/EST). However the APA has offered no oversight in determining whether a treatment can be called "evidence" based by insurance companies or the government, thereby allowing the evidence for psychoanalytic treatment to be ignored. Worse yet, the APA is now developing practice guidelines based on CBT evidence-based treatments that will further limit public access to psychodynamic treatment and

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any depth-oriented or longer-term treatment. To complete the CBT takeover, the APA is actively promulgating the near monopoly of CBT evidence-based treatments in graduate training and internship placements.

It is here we can see the role of our professional organizations as colluding with the broader system, whether government or corporate. That is not surprising in view of the fact that professional organizations are authorized by the government to provide surveillance and control functions over their membership, presumably to protect the public. There are guild interests at issue as well, such that those members who are more aligned with broader political and economic forces will be better served. Thus, those who practice from an EBP framework as with CBT will benefit, as treatment is short term and costs less, which serves the interests of the government and health insurance industry.

It is critical to understand here that CBT fits the neoliberal paradigm economically in costing less and shifting the financial burden to patients and practitioners. Moreover it is consistent with neoliberal ideology that values the triumph, however illusory, of individual control over relationship and interdependence. Put another way, the illusion and fantasy of control over our psyches, embodied by CBT, triumphs over the acceptance of vulnerability and interdependency via self-understanding, embodied by psychoanalysis.

To return to EBP, I would argue that the movement has its strongest foothold in mental health perhaps because psychotherapy is the primary treatment modality and thus easier to effect. In the mid-1990s, under the auspices of the American Psychological Association's Division of Clinical Psychology's Task Force on Promotion and Dissemination of Empirically Validated Psychological Procedures (Division 12, 1993 as cited by Brooke, 2006), the formalization of EBP began to take shape. It started with empirical research—empirically validated/supported treatments—as the sole criterion for a therapy to be considered evidenced based. This resulted in lengthy lists of treatments reported as EVT used by the government and health insurance companies to limit therapy to shorter-term approaches.

There was a successful movement within APA by practitioners of psychoanalytic, humanistic, and family therapy traditions, however, which pushed for the inclusion of therapist expertise and patient characteristics in the definition of EBP beyond just having research evidence as the sole criteria. Part of the stimulus for this response was an attack waged by psychologists in the academic community, as they pushed to make it unethical for practitioners not to use so-called empirically validated treatments in their work. When considering the standard of therapist expertise, it is hard to imagine how manualized treatments as is foundational in CBT could ever constitute expertise and thereby meet this criterion. And yet APA has not assumed any role in assuring the public that the full EBP criteria are being met.

Historically speaking, this failure represented the trend toward collusion with the cost-cutting and service-limiting ideology and actuality of managed care. Within the context of APA politics, there had been a shift in the organization toward a more clinical /professional as opposed to academic/scientific orientation, given the growth of membership in the practitioner community in the 1980s. The division sparked the formation of a separate organization, the Association for Psychological Science, in 1988, as well as a backlash within APA, which spurred the academic community toward the promulgation of empirical research as the exclusive criteria for effective practice.

Worth highlighting is that the Board of Professional Affairs (BPA) and Division 12 consisted largely of academic psychologists during this period. The president of Division 12, David Barlow, was also chair of the BPA and had published an approved manual for the treatment of panic disorder. Thus, he and others stood to gain both professionally and financially from these efforts, not unlike what psychiatric consultants to drug companies do. My point here is that the development of EBP is rife with personal and political influence and not simply the product of scientific progress, particularly in light of the limits of the original studies and of psychological science more broadly as previously discussed.

Let us turn now to other developments in the last thirty-five years related to the top-down, market-based social engineering in health care that similarly embody the neoliberal assault in social and economic reality terms and on our subjectivity. A major thrust of the Affordable Care Act involves a shift from fee for service to a "value"-based approach toward reimbursement for health-care services. This is based on the flawed neoliberal market ideology that blames fee for service as the major cause for our expensive and ineffective health-care system instead of acknowledging that the market itself is the problem—too many entities making too much money while delivering limited or no useful health-care services.

This approach, often called "pay for performance," is now embodied by what is known as the Physician Quality Reporting System (PQRS), essentially a system of classifying conditions that will be paid for and how much will be paid. So a given diagnosis will get a defined level of reimbursement and no more, regardless of the complexity and individual nature of the case. Thus payment is capitated, and legitimate individual needs for service are limited or denied. In fact next year, there will be reimbursement penalties for those practitioners who do not follow these guidelines.

PQRS is based on standards derived from studies now largely discredited (Gourgechon, 2007) yet which are considered to be evidenced based. Rather than questioning the validity of the practice guidelines or more importantly the cost cutting agenda they serve, APA is now offering training for psychologists to comply with the system. Thus, EBP functions under the banner of "accountability, " although what we really have is austerity or people getting less than they need. Lastly, there is no evidence that pay-for-performance schemes improve

quality of care or save money (Snyder & Anderson, 2005.) What we surely do know is that it does increase the potential for profit or cost cutting.

Nowhere is this more evident than in mental health over the last thirty-five years. This period corresponds to the corporate takeover of health care, the largest industry in the United States (Scholom, 1998, 2013) and the rise of free market fundamentalism. During this time spending on mental health services has remained at about 1% of GDP from 1986 to 2009, while total health-care costs have increased from 10 to 17% (Rampell, 2013). Put another way, while mental health spending remained about the same during this period, all health-care expenditures went up by 70%! Despite this, our professional organizations largely stood by and offered little opposition to or even education about this matter, as few mental health professionals are fully aware of the extent of the destructive reality being created. Worse yet is the collusion via EBP with the broader free market fundamentalism agenda. From another vantage point, this is about how science, or scientism, can be used for political and economic purposes (Hoffman, 2009).

It is in the realm of science where we can see a critical fantasy constellation that enables the neoliberal assault to take hold. I will call this the "science as savior" fantasy—that science and technology will provide the answers to our problems in living. All science can ever do is address the material aspects of living. This endeavor of course can be quite profound; however, it can never speak to human aspects of life, as in our relationship to one another and ourselves. Nevertheless, in light of the collective traumas over the last thirty-five years, as exemplified by the loss of the government as caretaker of last resort, we look to science (much as some do to religious fundamentalism) for compensation, if not salvation. As Nebula Award-winning science fiction author Richard Chwedyk (personal communication, 2015) views it, "what we want from science is magic."

We can think of scientism as a way of characterizing science as a belief system, whether good science or bad. As we now know, EBP is based upon almost nonexistent science. At the same time it has been used as a rationale for carrying out the cost-cutting/austerity needs of the government and the profit requirements of the health insurance, hospital, and drug industries. Thus, the "science as salvation" fantasy allows our citizenry to participate in their own exploitation: the defensive, surface-level, less-painful truth. The deeper truth, that we are being undone by the neoliberal system, remains split off.

To complete the picture of how the corporate/government control over health care takes place, we need to look at National Provider Identifier (NPI) numbers and electronic medical records (EMRs). The NPI evolved out of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and was implemented in 2006. First of all, HIPPA was not an act that preserves privacy but rather one that informs people how their privacy could be breached. (we in Illinois, where I live, are protected by state law, which supersedes HIPPA; it allows patients to have control over their health records, necessitating mental health professionals get a release from the patients to allow any health-care information to be disclosed.)

Big government and the free market become potent oversimplifications, illusions, or mythologies used by both parties to manipulate public opinion and perceptions for political ends.

Second, contrary to what we were pushed to do by our professional organizations, we are not required to have an NPI unless we file insurance forms electronically or are Medicare providers or on insurance panels. In essence, this allows insurance companies and the government to have access to our practice patterns and likely clinical orientation. The reality of coercion, treatment denials, therapist audits, as well as violations of privacy by these entities is profound. The benefits for our patients or ourselves are yet to be found.

Similarly regarding EMRs, the notion that such information would improve quality of care and help control costs is simply not borne out (Himmelstein & Woolhandler, 2005) by any substantive evidence. However, there is a great deal of evidence attesting to the enormous costs (in the tens of billions of dollars) of creating electronic records. Moreover, there is the ever-present reality of breaches of privacy and security via leaks and hacking, which have occurred with increasing frequency and scope over the last years. Furthermore, there are hundreds of EMR systems in hospitals, government, and insurance companies that do not and likely cannot ever communicate effectively with one another. But health insurance companies are actively using this information to scrutinize claims and practice patterns and deny care.

How does this all link up? Gourgechon (2007) concludes that pay for performance (P4P) relies on standards derived from evidence-based practice, which cannot be fully implemented without electronic medical records, and I would add without National Provider Identifier numbers. The bottom line is an effort toward top-down social engineering that both serves the profitability of the health insurance industry and allows for hidden austerity measures on the part of the government under the guise of accountability and technological efficiency. The result is that we are all getting less and paying more, which in the final analysis results in income redistribution from most of us to very few of us, or from the 99% to the 1%.

Now we come to the most difficult and painful questions. Why don't we already know this, and what are we going to do with this information now that we know it? We in the psychoanalytic world have a great deal to con-

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tribute to the analysis of these issues and most particularly in the realm of unconscious dynamics. The trauma and resulting fantasies, illusions, and defensive configurations call out for further elucidation and discourse within our walls amongst ourselves and with our patients and with our citizenry more broadly.

After all, we do talk a great deal about the outside world with our patients. But without sufficiently understanding it ourselves, our frame of reference is limited, as is our therapeutic discourse. Whether with our struggles with health insurance, burdens related to job stresses, or familial pressures, the system we live in is inevitably implicated. Without adequately understanding the real in social reality terms, it is harder to parse out the psychic reality of our patients. We then run the risk of indirectly blaming the victims for matters beyond their control (as in not fully appreciating the impact of issues related to inequality, class, race, gender and so on), thereby reproducing the very trauma they come to us for help in sorting out. It is here that we may suffer the same illusions as our patients, by not sufficiently recognizing the external reality of our shared trauma.

In the final analysis, even if you only grant some part of what I am saying, there is an inevitable sense of powerlessness and vulnerability that follows. That is hardly what any of us likes to experience, as our own limitations may collude with therapeutic zeal such that we may be hesitant to fully appreciate that there are forces that strongly influence us beyond our day-to-day reach. The more we are able to grapple with our own reluctance to knowing and the great vulnerability and interdependent need that lies beneath, the more we can be of help. We surely have been victimized ourselves by the neoliberal assault on psychoanalysis over the last thirty-five years, as brought about by EBP and the related denigration of our work.

One requirement in this pursuit is the recognition that psychoanalysis historically has been a dissident force and is subversive toward the status quo. Freud knew this when he spoke of "bringing the plague" to America. He likely believed this more expansively later in life when he realized the potential for psychoanalysis to address social problems. This undoubtedly has played a role in our current marginalization, as the capacity and courage to critique is a threat to the powerful forces being wielded against psychoanalysis and our citizens more broadly. The relative comfort of our class position in society may also contribute to our struggle to bring an expanded social psychoanalytic level of the plague to the United States.

To conclude, another factor may be our tendency to map psychoanalytic ideas onto the world, to understand it in our terms so as to provide us with an illusory sense of power and control. However, it is critical to know that there is a system out there, a social reality in which everything we think and feel and do is embedded and embeds us. It is a system in and around us that transcends psychoanalysis. The more we understand it, the closer we come to the more painful, if ultimately more freeing truth. That is after all what we are meant to do.

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that some of the older analysts in the society had voted Republican, and therefore the society could not speak with one voice on this.

She went on to mention that she and another analyst in that society have been preparing for a symposium in April on the subject of prejudice and all of its many forms, racism, marginalization, gender and sexuality, and religion. In preparation for the symposium they had been holding a series of so-called clinical moments, which explore in depth such issues as racism between analyst and patient, police brutality, LGBTQ issues, and marginalization with the example of the Flint water crisis. In the post-election gathering, the discussion centered on the effect of the election result and its possible meaning for democracy in this country, and especially for "the others," people of color, minority religions, and the LGBTQ community.

New York Psychoanalytic Society and Institute (NYPSI)

My respondent was Lisa Deutscher, MD, vice president of NYPSI. Dr. Deutscher said that there had been no organized meetings or programs immediately after the election, and went on to implicitly explain why not. On the society's listserv right after the election many members had shared their thoughts and reactions, given words of comfort, and shared links to petitions and to articles interpreting the election result. But a few people "commented on the implicit assumption that all must share similar views."

She went on: "I am sure that almost all Institute members opposed Trump, but found those comments sobering. As an institute, we have been working hard in recent years to be more open to different views within psychoanalysis, and perhaps partly as a result of that, I and others want to avoid the idea of any required set of attitudes." So to avoid that impression, a separate list was created for the purpose of sharing information about anti-Trump activities. Dr. Deutscher concluded, "our involvement so far has been more as concerned citizens than specifically as responders in our psychoanalytic role."

In this context, however, a special event was held at NYPSI on February 16 with guest speaker Richard A. Friedman to discuss the Goldwater Rule [according to which psychiatrists are prohibited by the APA from giving professional opinions about public figures they have not personally examined] in the context of the Trump presidency.

A Few Final Comments

Psychoanalytic societies, like individual human beings, are unique. As the above descriptions show, each society had a way of responding to the election that was informed by its institutional cultures, traditions, and memberships. So even though all of the above societies reported deep anguish at the election of Donald Trump as president of the United States, each one processed that anguish differently. For some, public discussions were valuable as opportunities for reaffirming values and the need for action. For others, public discussion turned out to be less valuable, partly because there had been so much private discussion. Some societies made more of a point than others of acknowledging that some members supported Trump,

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respecting those members' opinions while trying to give voice to the profound distress at Trump's election.

But the predominant reaction among all the societies was the same: Trump's politics and rhetoric represent a direct assault on values such as respect for truth, respect for individuals, and the importance of self-knowledge—all of which psychoanalytic work is based upon. The other common reaction was the feeling that important structures and assumptions that held all of American society were under powerful attack, thus putting both analysts and patients equally at risk, and presenting clinicians with difficult technical questions of how much of their own anguish and distress to share with patients.

Finally, speaking now quite personally, I was heartened to read about the unique ways all of these societies grappled with the situation that confronts all Americans who are not supporters of the president. Perhaps our very pleasure and relief in hearing about other people's, other societies', other groups' articulations of profound upset can be taken as not only a sign of health in our corner of American society but also as an indication, through the very act of pushing back, of where the Trump administration's policies—like those of all such governments in the past—are directed, which is to isolate individuals from each other and terrify the population as a whole.

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