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ETHICS: DIAGNOSING PUBLIC FIGURES FROM AFAR

Interview with Mark Smaller, Ph.D., LCSW

Interviewed by Barbara Alexander, LCSW, BCD and Amy Eldridge, Ph.D.

(Edited slightly for readability)

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Welcome to ON GOOD AUTHORITY. I'm Barbara Alexander. You are listening to or reading an interview with Mark Smaller, Ph.D. and past-president of the American Psychoanalytic Association. This interview is co-conducted with Amy Eldridge, PhD.

One of the characteristics of all humans is the ability to ask "Why?" and to try to understand our world and the people in it. That, to me, by the way, is the purpose of gossip—establishing and transmitting social norms. So, to a greater or lesser extent, when we see or read about unusual behavior—sometimes spectacularly unusual behavior, we try to find a framework in which to understand that behavior. Only natural. And we are all entitled to our opinions. Right?

Anyone can be "an armchair psychiatrist." However, when it comes to mental health professionals, another standard exists. By virtue of our training in diagnosing and assessing behavior, our opinions tend to be held in a higher regard, with greater believability and gravitas. That would suggest that we take care in making our opinions about people and their behavior, especially if that opinion is expressed publicly in the media, be it news media, books, radio, TV, or social media outlets such as Facebook, Twitter, etc.

Our codes of ethics, in one way or another, admonish us not to publicly express opinions about people whom we have not directly evaluated in person.

By the way, violations of our professional ethics codes are nothing to sniff one's nose at. Whenever we've renewed our memberships in our professional organizations, we've all signed an agreement to abide by these rules. Infractions could lead to losing those memberships.

So what, you ask? Well, that could lead to, losing our malpractice insurance and having to pay more for that malpractice insurance, or even being ineligible for that insurance. And worse, these infractions sometimes get reported to our state or national licensing boards and that is not something anyone wants to experience. That potentially leads to loss of license and/or malpractice suits.

So be careful expressing those professional opinions, especially on social media sites like Facebook and Twitter, where it's too easy to lose our inner censors! We all have our first amendment rights, of course. But as you will hear in this interview, there is a difference between one's opinion as a private individual and one's professional opinion.

Here are some examples of these ethical codes:

Section 7, which appeared in the first edition of the American Psychiatric Association's Principles of Medical Ethics in 1973 and still in effect today, says:

"On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper consent for such a statement."

The Ethics Code of the American Psychological Association supports a similar rule. In 2016, American Psychological Association President Susan H. McDaniel published a letter in *The New York Times* in which she stated:

"Similar to the psychiatrists' Goldwater Rule, our code of ethics exhorts psychologists to 'take precautions' that any statements they make to the media 'are based on their professional knowledge, training or experience in accord with appropriate psychological literature and practice' and 'do not indicate that a professional relationship has been established' with people in the public eye, including political candidates. When providing opinions of psychological characteristics, psychologists must conduct an examination "adequate to support statements or conclusions."

In other words, the ethical code of the American Psychological Association states that psychologists should not offer a diagnosis in the media of a living public figure they have not examined.

Next, the code of ethics of the National Association of Social Workers, in section 4.06 on Misrepresentation, states that social workers should make clear distinctions between statements

made and actions engaged in as a private individual versus as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

In other words, any public statement a social worker makes has to clearly be as a private individual. Not exactly a prohibition against publicly diagnosing, but drawing a line as to what is a personal vs a professional opinion.

Furthermore, if a social worker were to evaluate a public figure, social workers' codes of ethics have strict confidentiality rules prohibiting posting any identifying or confidential information about clients on professional websites or other forms of social media. Section 3.04 on Client Records states that a social worker cannot disclose what he or she has learned without client consent, and section 1.07h states that social workers should protect the confidentiality of clients when responding to requests from members of the media.

Now, referring back to the Goldwater Rule of 1973, at that time, diagnosis was driven by analysis of patients' unconscious. Today, diagnosis is often linked to observable traits, making evaluation at a distance plausible. So this muddies the waters considerably.

But, there is another side of this issue – as always. What about the Duty to Warn? What if a mental health professional, observing the traits and behavior of a public figure, concludes that this person is potentially dangerous to some individual or groups of individuals? Then, does this mental health professional have the ethical, moral obligation to speak out? To write letters to editors? To warn the public, whether or not this professional has personally evaluated the public figure?

Here to help us clarify this issue is Dr. Mark Smaller, past-president of the American Psychoanalytic Association.

Dr. Smaller, Ph.D., is a psychoanalyst who works with adults, adolescents and children and practices in Douglas/Saugatuck in Southwest Michigan. He is Founding Executive Director of Project Realize, an in-school high school treatment, training and research program at Morton Alternative School in Cicero, Illinois.

Dr. Smaller is the former Director of the Neuropsychoanalysis Foundation in New York. He serves on the Board of Trustees of the Neuropsychoanalysis Foundation, the American Psychoanalytic Foundation; and The Executive Committee of the International Society for Neuropsychoanalysis in London. He is a former board member of the Institute for Clinical Social Work, Chicago, and the Chicago Institute for Psychoanalysis.

Dr. Smaller is a recipient of the 2008 American Psychoanalytic Association Distinguished Service Award.

NOW TO OUR INTERVIEW

ALEXANDER: Welcome to On Good Authority. This is Barbara Alexander speaking. We are going to be speaking now with Dr. Mark Smaller, and this interview is going to be co-led with,

Dr. Amy Eldridge, so we will get used to her voice, and of course, Mark being a guy, has a different quality to his voice. Dr. Eldridge is going to begin with an overview to why we decided to do this interview.

ELDRIDGE: We decided to have this interview because of the current controversy in the mental health field which is related to the controversial political situation that we are living in. There is a history to this issue which culminated in the Goldwater Rule, which prohibits psychiatrists from rendering professional opinions about public figures. The American Psychoanalytic has been in the center of it, but it certainly goes and extends to all mental health professionals, although somewhat differently according to each of their ethical principles.

So, Mark, thank you for being here. We always look forward to speaking to you and hearing from you. Can you tell us something about the history of the Goldwater Rule? What led to it? What it is? And who it applies to?

SMALLER: Sure. It's great to be here and to speak with you about such an important topic, both in terms of mental health professionals' responses to social and political issues and also regarding the history of psychoanalysts, psychotherapists, other mental health professionals speaking about public figures.

So the Goldwater Rule emerged following the election process between Barry Goldwater and Lyndon Johnson. What had happened at some point, right before the election, in that election cycle, a group of psychoanalysts spoke out and made comments -- and I think those were published in Time Magazine -- about the mental health of Barry Goldwater, and in their speaking out, they made it clear that there was something about his personality that made him, for example, potentially dangerous should he be in charge of nuclear codes of the United States of America.

Well, after the election, Goldwater ended up suing not the American Psychoanalytic, but I believe, Time Magazine and another publication that had published this article and Goldwater won the lawsuit. Essentially the bottom line was the court ruled that unless you have face-to-face contact with someone, it's not only unethical, but illegal to make these kinds of diagnoses. and ruled in Goldwater's favor.

Now, it's important to contextualize this, and by that I mean, at that time most psychoanalysts of the American Psychoanalytic Association were psychiatrists, many of whom, probably most of whom were also members of the American Psychiatric. The Goldwater Rule was actually adopted by the American Psychiatric Association and other professional organizations, like the American Psychological Association. I believe even the National Association of Social Workers and other groups began to rely on this so-called "Goldwater Rule," and in many ethics statements of various professional groups, it is stated that it is unethical to make diagnostic statements about a public figure if you've had no contact with that public figure, and that's how things sort of stood for all these past years until the last election cycle for president.

The American Psychoanalytic Association, as all professional associations are, is a non-profit association and the position of the association of the president at the time, (this happened right

after I was no longer president). Harriet Wolfe (who became president) took the position that we can't really take a political position; that goes against not only our bi-laws, but also is against our legal standing in terms of being a non-profit 501C3. An association can lose its your non-profit status if it takes a political position.

ELDRIDGE: Okay. Thank you, and I'm going to attempt to clarify a few issues and perhaps extend the conversation. So, recently the Goldwater Rule was part of the American Psychiatric and technically only applies to their members. It was adopted by the American Psychological Association in very similar language. Nonetheless, we have a controversy. The Goldwater Rule recently changed to prohibiting professional opinions on the subject of a public figure's mental health, or was it simply narrowed to prohibiting professional opinions in addition to diagnosis?

The whole area is muddy. What is a professional opinion? Does it include anything that a professional says about a public figure? And can a professional offer an opinion as a person rather than as an expert? So, let's clarify what that all means. Can you speak to what a professional opinion is, Mark?

SMALLER: That is where the waters get very muddy. Certainly, I think that making a diagnosis of anyone, whether he or she be a public figure or not, would, in my mind and certainly the position of the American Psychoanalytic and most other organizations, would be I think grossly inappropriate. How can you make a diagnosis of somebody if you haven't actually sat down in a room and over some extended period of consultation made that evaluation or diagnosis? I think most mental health professionals would agree with that.

I think where it gets much more ambiguous is: can you offer an opinion about a public figure -- <u>an</u> <u>opinion,</u> not a diagnosis, but an opinion that includes or is based on your professional expertise? So, for example, speaking generally, someone who has fragile self-esteem, narcissistic vulnerability – if someone who has those kinds of internal dynamics, what one might expect or possibly see or observe in behavior is somebody who makes unrealistic claims about him or herself, goes through significant periods of depression when he or she feels attacked or injured by those around. So, you could offer that kind of description of a dynamic of somebody with, for example, narcissistic vulnerability. And, I think the most you could say is --- the most one could do comfortably in my opinion as a professional, is to offer that kind of view and whoever is reading or responding to your publicly expressed point of view -- they may or…they may decide or choose to apply that to that public figure.

Now in saying that (chuckling) I haven't read specifically the American Psychiatric's Goldwater Rule, but I think even in the original Goldwater Rule, even offering that kind of point of view was on the edge of diagnosing. You're not saying it; you're saying somebody who has this particular dynamic could be sort of classified or diagnosed with this particular diagnosis, but you're sort of not saying it. And I think that it's very ambiguous but I think many of my colleagues, both in the American Psychoanalytic Association and outside are sort of taking advantage of that ambiguity and offering opinions that pretty much sound like diagnoses.

ELDRIDGE: But, it gets even more complicated because some are saying now, given our state of electronic record, that there is enough evidence in video and in written word to diagnose, to adequately come up with a diagnosis. Clearly that's against the Goldwater Rule, but I wonder what you think about that.

SMALLER: Prudy Gourguechon, who again had been president at the time where the American Psychoanalytic Association's position on this years ago has made clear that it would be unethical to diagnose somebody, or even to offer certain kinds of opinions about public figures.

She had an op-ed piece in the Los Angeles Times some time ago. What she did is that she went and looked at the military manual that describes characteristics and levels of competency for leadership in the military. There are these leadership guidelines that the military puts out in a standards document of the United States Military. I think that's one way of then looking at guidelines that can be used to evaluate somebody's leadership capacity. That's very different than offering a professional opinion based on or loosely associated to a diagnosis.

ELDRIDGE: I agree with you. I think that's very different because that's then measuring a leader against standards of leadership that are published as opposed to from afar, applying diagnostic criteria.

SMALLER: My concern as a psychoanalyst is that if this is not carefully considered, thought about, reflected upon, it would be very easy for any kind of mental health professional to offer an opinion about somebody who, for example, might be perceived as politically very liberal, but somebody could make so-called professional opinions in a way that might make me as a sort of politically liberal person, uncomfortable, so I think that it's a very legitimate concern. I want to say though that -- and this is something that I as a psychoanalyst, as a clinical social worker have struggled with over the last couple years: I think that we might get ourselves into trouble in terms of offering professional opinions that can be construed as diagnoses.

However, I think that psychoanalytic, psychodynamic mental health professionals, certainly can be experts in terms of, for example, group and social dynamics. There is something to be said for understanding something that happened in this country over the last couple of years. Obviously it had been building before then and I think we know something about groups who feel ignored, groups that feel marginalized. We know individuals who feel marginalized, ignored, not responded to, and who develop all kinds of angry, if not rageful feelings.

Psychoanalysts have been writing about this for many years, certainly since World War II and Nazi Germany and how that all came to be and how even the Holocaust came to be. We know something about how groups behave and function when they're not responded to, marginalized and ignored. A charismatic leader can come along who makes that group of people that has felt so consistently marginalized -- a charismatic leader can come along and speak to the concerns of that group, even making unrealistic statements about a current social, political situation, or about him or herself, and obviously that group is going to gravitate towards that charismatic person, even if the direction that that leader is going could be potentially dangerous or destructive.

I think there is something to be said about offering psychoanalytically informed understandings of individuals and groups. I think that's something that we can offer the public, and I think we should be offering the public because the public is hungry to understand something about what you were saying earlier, Amy, about the current state of such polarization and divisiveness. We know something about how group dynamics work and I think we need to be present to offer the public a view about those kinds of issues.

ALEXANDER: Just in terms of all mental health professionals, not necessarily psychoanalytic… is it unethical? Is there a moral imperative to speak out? Is it ethical…can it be ethical and not moral, moral and not ethical? I mean is there… sort of a little dialectic there that I'm wondering if you could address?

SMALLER: I'm going to go back to what Harriet Wolf, current President of the American Psychoanalytic has stated, and I think it speaks to my point of view as well. I think that one has a very personal, if not moral responsibility to speak out against social, political situations that actually go against individual values, personal values, but also against professional values. Speaking again as a psychoanalyst and also as a clinical social worker -- you know, social work is a profession similar to psychoanalysis -- but social work is a profession unique among many professions that has evolved from a set of values as well as based on the foundation of the uniqueness of an individual. It has evolved from those kinds of values, and if, as a professional, I feel that the value of the individual is being either ignored or exploited in some really potentially destructive way, I think I do have a responsibility to speak out. I think that the President of the American Psychoanalytic was suggesting that people have to speak their conscience. If they feel that something is going on socially, politically, that puts people at risk -- oneself or others at risk, we do have a professional, as well as moral obligation to speak out. So I think one has to do that. I think it needs to be done on an individual basis, and I think it complicates things to do so as a professional association.

Now – in saying that, in the American Psychoanalytic Association we have taken positions when we feel, for example, that there are aspects of the Affordable Care Act that are being taken apart in some way and that we feel is potentially harmful to our patients and their access to mental health services. We are going to take a position about that

ALEXANDER: I want to change the subject just slightly, Mark. Now, as therapists -- let's get into the direct therapeutic relationship. So, it could happen, and it probably does happen very often, that somebody in our practice will have a very different point of view politically than we do, and could be very provocative or insistent. Whether you're a liberal therapist or a conservative therapist and you're talking to somebody of the other school of thought, how do you handle that? Do you try to sidestep the whole issue? What are your thoughts about that, Mark?

SMALLER: That is a great question, Barbara and I had hoped that we were going to get into that, because I think it certainly speaks to a familiar experience for me, and I'm sure of many of your listeners. I think that there are many issues that emerge in the clinical setting that have to do with likenesses and differences between the patient and the therapist or the analyst.

The first thing I would suggest in terms of how one handles that is, in the words of my very first social work supervisor, oh so many years ago, who used to say in response to complex questions, and he used to smoke this cigar and in the midst of the smoke, he'd say, "Well, it really depends," and I remember thinking to myself, "I'm paying University of Chicago tuition to get this kind of response, 'Well it depends!'" And yet probably one of my first, and most important professional lessons was… "It depends."

I think how one handles this depends on the context in which those differences make themselves known in a clinical moment. Depending on whatever else might be going on, there may be times that the issue of a political difference between the patient and the therapist is an issue that needs to be understood, discussed, sort of flushed out and then responded to by the therapist, without necessarily getting into so much of a discussion about those differences.

However, in this current sociopolitical climate, I think this kind of issue probably has come up much more frequently in the clinical setting, and I think it still has to be handled extremely carefully, but sometimes the acknowledgement of those differences as opposed to not speaking about them -- the acknowledgement of those differences can be very useful and lead to not only a fruitful political discussion, but also a very important clinical kind of discussion that's going to hopefully facilitate an outcome that moves the treatment forward. There are always going to be so-called reality issues, differences, likenesses between patient and therapist, and also transferential issues that just need air time and an opportunity to be discussed and understood.

ALEXANDER: Any way you could give a hypothetical example of that, so that if I come in and I'm seeing you and I'm saying, "How can you possibly be a supporter of this person?" "How can you possibly -- how can I be talking to you when you have such a… a different world view than I do, and how can I think that you're even in the same world that I'm in?" So what do you say then?

SMALLER: So, nine times out of ten, or maybe slightly less, there are going to be those kinds of differences expressed in a treatment and especially an in-depth treatment. There may be many issues about which I might have a very different opinion than my patient, and my patient may know it. Whether it's political or social, those kinds of issues need to be addressed and the more they're discussed openly, and sometimes with full disclosure on the part of the therapist, what you often will find is that those pretty hot topics that seem to have only to do with what's going on today, have a long history to them.

So, for example, I do have a patient who recently made his position, his political position, very clear to me and it was very different than mine. This was a patient who had supported and still supports the current president. But after some long discussion about it, it becomes clear both to my patient and to me that one of the reasons that this patient is particularly attracted to this particular president and through the candidacy was that what he likes about him is his directness, that he will express a point of view without any hesitation, which is in complete contrast to this patient's father growing up who was often very disappointing, traumatically disappointing because that father would never come to the defense of this patient as a child, would never take a strong position. He turned out to be a father with whom this patient just could not comfortably identify, and it was the source of tension in that relationship throughout his childhood.

Again, what's important about that…is it the political difference that's important? Or is it most important that he and I sort out something about the meaning of this particular current situation, the meaning that it takes on to him, and based on what's going on between us in the present in the transference, and also in the history? And that was a very useful and good clinical discussion.

ALEXANDER: Well, how would a patient know the therapist's point of view? I mean it could be that the patient could be going on about their opinions about the election or about anything, and they notice that the therapist is pushed a little bit back in the chair, has raised an eyebrow, has started to fidget or done some physical thing that's given away the therapist's discomfort with it.

SMALLER: There are all kinds of ways in which therapists may communicate his or her political position, social position… all kinds of things, without even being aware of it, right? You and I know this. In this particular instance, this patient became very aware of my political position because he happened to see me driving down the street years ago and I had an Obama bumper sticker on the back of my car. So he knew where I stood, at least at that time politically, and even at that time before the more recent discussion -- we used to have on the surface all kinds of political discussions -- but really they had something to do with some issues that had originally brought this patient for help.

But, you know, whether you disclose or not, there are ways that you communicate your discomfort and that needs to be addressed and usually once it is, is a very fruitful clinical discussion.

ALEXANDER: Mark, I want to approach this from a slightly different angle. We've talked about what to do, or how to handle it, when, a client, patient, comes in very agitated or they're very upset about certain public figures or certain political or social conditions, and they come in and they're really going on about it. We've talked about what to do, how to respond. Now, what about not responding at all? In other words, the therapist would just not say a word about it, just not respond… just sit and wait? It might… it's almost like the old, analytic, blank screen situation.

SMALLER: It depends on the context in which maybe such a reaction of a client or patient comes up, whether it's about a political figure they're having a reaction to or any kind of social issues. You certainly want to listen because how a particular patient at a particular moment in time experiences reactions to the world around them is going to very much be determined by who they are and their particular, for lack of a better way of saying it… subjectivity.

So, somebody comes in and they're concerned about an issue having to do with racism. Either they've witnessed something or they've been the object of some kind of racial bias behavior. You certainly want to listen to hear what meaning that experience takes on to that particular patient, and it may be different, so… you're always listening.

Can I imagine that I would never respond or that I would, in some psychoanalytic caricature of the old analyst, just sit and be silent? It's hard to imagine that. I'd certainly want to

acknowledge somebody's very real experience, but it seems to me that if I'm doing my job, I'm going to try to tease out what that particular experience means to that particular person at that moment in time. It's going to be different, because how I might experience being the object of somehow feeling or being bullied in the workplace -- based on my history, my experience -- it's going to be very different than someone else's, and it seems to me our job is to tease out the uniqueness of that person and their experience.

ALEXANDER: Because let's say you don't respond at all, that would just seem to me to complicate that -- would add another layer of problem.

SMALLER: Absolutely. I think one of the most important, contributions of Heinz Kohut and then it was later more fully developed by Howard Bacall was this idea of "optimal responsiveness." That term emerged in reaction to what classical psychoanalysis used to refer to as "optimal frustration:" it was inevitable that the analyst would do or not do things that would frustrate the patient and the job of the analyst and the patient was to collaborate about the nature of that frustration.

Optimal responsiveness is much more experience-near. It's really about how you're going to respond to a particular patient in a way that makes them feel just that: responded to! Some patients, for example, might want or need me to be particularly quiet. Maybe their history has to do with intrusive care-takers, so my being quiet is something that's optimal, if you will, for them. Another patient though may experience the silence on my part as indifference or boredom, based on whatever their history was with indifferent parents or parents who were particularly unatuned. So, as one sort of lives, if you will, in the treatment or the analysis with a patient, you learn what is optimally the best for that person, what facilitates their growth, and certainly what facilitates the movement forward of the psychotherapy or the analysis.

ALEXANDER: Oh that's really interesting, that's very helpful because the client could think, "Well, my therapist isn't responding to me because he doesn't agree with me." Or… "My therapist isn't responding to me because… he does agree with me and he doesn't want me to know." Or, "He doesn't agree with me and thinks I'm stupid, thinks I'm being ridiculous," etc. There are so many different ways that not responding could be interpreted, and that's not the point. I don't think that would be the point of a regular, nonanalytic, psychotherapy.

SMALLER: I think also you raise a good point because some patients may want to know what is my political view, and with some people, it might be (chuckles) again, optimally responsive to share that. With somebody else they might experience that as being intrusive; they actually don't really want to know that, they might be curious about it, but not necessarily ask. Again, it depends on the person, it depends on the particular moment in time in the treatment, but I will say that under political situations where there are such strong feelings expressed on both sides of a continuum of sort of more liberal to more conservative, I suspect that those kinds of issues are coming up much more frequently in psychodynamic, psychoanalytic treatments and how they're handled, how they're managed by the therapist or the analyst is a complex kind of thing. There are no easy right or wrong answers. These are not black and white situations, but complexity, I think is important.

And I think any good psychotherapy or good analysis always demands an acceptance of complexity and sort of teasing out about what's going to be the most therapeutic to a patient and how you respond, how much you share or don't share, disclose or don't disclose really depends on that individual treatment.

ALEXANDER: By complexity, you mean… what?

SMALLER: By complexity, I mean one patient because of some historical experiences, historical traumatic experiences, may want or need me to share something about my political views about a social issue. With someone else, depending on their history, it might be inappropriate, it might be experienced as intrusive and potentially interfering with the treatment moving forward. So, in the words of my very first social work supervisor, it really depends, and it depends on context, the person, where the treatment process is, and the therapist or analyst's job is to be very clear about that and try to tease out what's going to work for one person at that particular moment in time.

ALEXANDER: If the therapist seems hyper-interested, much more… "OH, HELLO," wakes up in a sense, or pays a lot more attention to these comments either in the positive or the negative side, what might that say to the patient.

SMALLER: Well, again, it really depends, I mean, if suddenly the therapist is quite active or responsive in terms of a political discussion, that's going to be a communication to the patient. Let's say, if it's in the context of the therapist previously being more quiet about these kinds of issues, but let's say the therapist has a lot of feelings about that particular social or political issue. He or she is going to respond in a way that obviously says something to the patient. Now, in that moment, it may be unclear what it's communicating to the patient, but if one is listening, analytically, therapeutically, within a few sessions, you're going to hear what meaning that took on to a patient.

So, for example, I have a patient who felt particularly traumatized by the election of our president, and because there were attributes of him that felt to her so similar to what her very physically and verbally abusive father was like for her growing up. When I shared with her at some point that I had similar concerns in sharing a political view. on the one hand she experienced that in a way of feeling great relief that she could openly and freely talk about her concerns and what was really some of her trauma experience even currently.

But at the same time, as the treatment moved forward, she also said that sometimes she was aware that the focus on other people's bullying-like or abusive-like behavior was also a way for her to not think about some of her own anger and how she, at times, could be very unreasonable towards people, that she traced that to this kind of identification with this very abusive father and, in reaction to that, sometimes she could be unreasonably angry in a way to push people away. So, that emerged, but it wasn't the end of the story with just that sense of relief that she felt we might be on a similar page socially or politically, but it was also used in a kind of protective or defensive way.

ALEXANDER: Dr. Eldridge has raised a point about the duty to warn.

SMALLER: Again, I think that as we were discussing before, how one feels about that individually -- if one feels that a leader or a public figure is potentially dangerous to others, in this case. We are familiar with this clinically when we decide a duty to warn if we hear a patient talking and it sounds like there's a clear risk of either harming themselves or others. I think that in this kind of situation, obviously making the case that somebody, a leader, is potentially a danger to others, might be a more complicated process, but if one feels that one can make the case for that and has a rationale about that, I think one has to step up and make that case, and in doing so, fulfilling a duty to warn.

Obviously, there will be some who disagree with the case that is made because the argument will be, "Well, is this a political case that you're making? Or is it a case based on your professional expertise?" The problem, for example, with a psychodynamic or psychoanalytic perspective, is that often, it's not a perspective that necessarily can predict destructive or potentially destructive behavior. But, better to err on the side of being overly reactive in this regard, than to not react at all.

I mean the example is psychoanalysts did not speak up as Hitler came to power, and maybe they should have, although one sort of doubts, even if they had, whether that would have done much, and also, the Nazi regime and certainly Adolf Hitler was very suspicious, and very much against anything that had to do with psychoanalysis, and many of those psychiatrists who did not speak up were psychoanalysts.

ELDRIDGE: It's an interesting issue because the duty to warn is very specific, that you have to know a specific, imminent threat and who it's directed to. It's a slippery slope, it seems, to try to make a case that we have a duty to warn according to what a clinical duty to warn is. This seems to be more of an ethical feeling that the ethics call for us to override the restriction on political discourse that some professional organizations dictate in the interest of the harm, in their minds, that is being done, from their minds, to people. So, I think I understand that.

SMALLER: Yes, I think that it becomes a much more complicated task to make that case. But, again, if one is speaking from one's personal and professional sense of conscience and one feels that they can at least make some kind of case, I think one has a responsibility to at least put it forward.

ELDRIDGE: How do we handle it when the people consulting with us want to know what to do or how to handle what they perceive as danger

SMALLER: One aspect of what many people and certainly our patients have in common-- there is a certain level of helplessness that emerges, and it's a traumatic level of helplessness that can then be particularly disruptive, even in regards to day to day functioning, and I think our job as clinicians is to try to be a witness and acknowledge that kind of helplessness, and then it may have a history to it in terms of that individual. But I think also we can work with a patient to develop ways to sort of manage and integrate and cope with that, whether it's to become, for example, more politically involved because if you feel like you're doing something to effect a change, it's obviously going to make you feel less helpless. It may be just a process of talking through that sense of helplessness, and if that's done in a responsive

and empathic kind of milieu, even that will help that level and have it be reduced so that that level of fear and helplessness is no longer so disruptive.

ELDRIDGE: So, it's addressing the clinical issue not the political issue? Even though it's about the political issue.

SMALLER: I think you sometimes can and need to do both, and you have to acknowledge the reality. There is a certain level of social/ political helplessness that many people are experiencing these days. I think that's a reality and I think that needs to be acknowledged, and also, that political/social reality takes on a very particular meaning to every individual. What it means to me, may be something different than what it means to you or others based on our own personal subjective histories and so we want to take into account all of that as we're doing our clinical listening.

ALEXANDER: Well, Mark, in the few minutes we have left, is there anything you'd like to add, any thoughts you have that we haven't gotten to?

SMALLER: I really would want to underscore something about mental health professionals responding to all kinds of social, political issues. This is certainly not true of the profession of social work but certainly in the profession of psychoanalysis. Up until maybe the last 25 or 30 years, there had been a great deal of reluctance of psychoanalysts to be responsive to these kinds of issues and offer, I think, useful and helpful perspectives about these issues. I would encourage mental health professionals at every opportunity that they have whether it's speaking to the media, writing letters to the editor, speaking with community groups.

We live in a world that is in need of, and can make use of our expertise and, just as importantly, what's going on in our communities, whether it's a local community or a national or international community, is that we as mental health professionals have a lot to learn from our communities, a lot to learn both in terms of how we can be an effective voice in those communities, but also understanding community issues, social issues, in a way that can enrich our respective fields, whether they be social work, psychoanalysis, psychiatry, psychology. The more we do that, the better. I think there's a need for it and I think there are opportunities to speak out in all kinds of ways and hopefully mental health professionals will take advantage of those opportunities.

The signature of my personal email is "Psychoanalysis and diversity, now more than ever!" These kinds of issues -- speaking about them, now more than ever.

ELDRIDGE: Excellent.

ALEXANDER: Well, I agree totally, Mark, and thank you again for sharing your thoughts with us. Amy, anything?

ELDRIDGE: I want to echo what you're saying, Barbara. I think this has been a really timely and fruitful discussion that's left me with a lot to think about.

SMALLER: Me too! And I want to thank both of you for inviting me. I've already formulated at least two more potential op-ed pieces.

[laughter]

ALEXANDER: Thank you!

ELDRIDGE: Signing off!

CLOSING

This concludes our interview with Mark Smaller. We hope you have learned from this interview and that you enjoyed it.

Dr. Smaller can be contacted through his website, www.markdsmaller.com.

I must say here that the views expressed by our speakers are theirs alone and do not necessarily reflect the views of On Good Authority. Until next time, this is Barbara Alexander. Thank you for listening.