Conversation in the Time of the Plague

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A July evening, a suburban garden. You can smell iodine in the air from a nearby lake. On the table fruit and wine. Flowers and glassware. We've had soup. I turn on the dictaphone. The first minutes of the recording are a story about an old apple tree. Although its yield is high, no one wants to eat its tainted fruit – like the irony from the Book of Genesis.

Maciej Duda: I'd like to start our conversation with the trickiest question. Whether we should be talking at all. Should psychotherapists talk about reality, about what is happening "here and now", outside the office? We have a number of books in which authors use psychoanalytic tools to comment on and diagnose the social and political reality, or the history of given nations [Leder; Samuels; Bollas], but the dilemma doesn't go away. Let me start with a quote. I just need to find it in my notes.

Katarzyna Poniatowska-Leszczyńska: The second basic question is the issue of interdependence: does

psychotherapy influence the society, does the society shape psychotherapy, or does either dominate this system?

M.D.: I see psychoanalysis and psychotherapy as cultural thought, a historicized current. I think that if Freud were alive today, perhaps there would be no Oedipus. Perhaps the developmentally crucial myth would be different. And patients would be different. Statistically speaking. There would be no neurotics, just a preponderance of patients diagnosed narcissistically – as in Otto Kernberg's. But probably during the conversation we will take this thesis apart and study it from different perspectives.

Katarzyna Chałupa: By asking if we can talk, are you asking if the therapist should be talking in the context of therapeutic neutrality and disclosure of their views? Meaning, we are between neutrality and involvement.

M.D.: Yes, yes. Oh, I found this quote by Hanna Segal. It was recently cited by Ewa Głód in her text *O psychoanalizie w dzisiejszej Polsce* [On Psychoanalysis in Today's Poland]. The text comes from the book *Czy powrót wypartego?* [The Return of the Supplanted?] [Kobylińska-Dehe], from the section entitled *Between Neutrality and Commitment: Being a Psychoanalyst in Difficult Times*. Contemporary Polish psychoanalysts are wondering what they ought to do, what they could do in this day and age. Is it time to talk, or is it still best to withdraw, to stand aside? And what do we lose by withdrawing, and what do we lose by not withdrawing?

K.C.: Psychoanalysts have recently made quite clear, unambiguous statements.

M.D.: I'm not sure if they're unambiguous. We interpret them somehow as recipients.

K.C.: Well, they've expressed their opinion, though. They openly said what they were against.

M.D.: They certainly expressed themselves, but…

Maciej Paschke: They certainly commented on reality more often than we, psychodynamic psychotherapists, which seems to be in contradiction with what I assumed earlier. Because a psychoanalyst seems less…

K.P.-L.: Hold on, you're already talking while Maciek was going to tell us something else.

M.D.: Just this quotation. I finally found it.

K.P.-L.: You're already offering various arguments and soon what you're saying will be lost because it isn't being recorded.

K.C.: No, no, we're already recording.

K.P.-L.: Oh, OK.

Marta Andrzejewska-Ratajczak: You should have left the illusion so we could speak more freely.

K.P.-L.: Yes, I felt free. [*laughs*]

M.D.: The quotation comes from the text *Milczenie jest prawdziwą zbrodnią* [Silence is the True Crime]. It's a war-related text. Segal says: "We know that as psychoanalysts we should be neutral and not participate in political debates, although as individuals, we may hold certain political views. However, in some situations, this attitude can also become a shield of denial. The psychoanalytic stance is about learning the facts, including the psychic facts known to all people, and boldly naming them. We must confront our fears, mobilize our forces to fight against destruction. People need to hear our voice". [Segal]. It sounds like a manifesto. Segal wrote this in the context of the Holocaust and World War II. Bringing up this topic, I have a question: where are we now? Is this the moment when people should hear our voice? Can the voice of psychoanalysts, psychodynamicists, have any meaning in the public debate, can it help anyone? Is anyone waiting for it?

K.P.-L.: Psychoanalysts have always embraced debate because psychoanalysis has Jewish roots. Hanna Segal was Jewish. Sigmund Freud was Jewish, Otto Kernberg is Jewish. They experienced the agony of the Jewish people and may feel that silence was a crime against them, against their families. Psychoanalysts are most

open to such discussions because the ancestry of psychoanalysis and its development is largely based on the Jewish environment. When you read biographies of Hanna Segal, Margaret Mahler, or Melanie Klein, their nationality is very apparent. This may be the reason why a group of psychoanalytic psychotherapists are broaching this subject. None of them want a situation where everyone only stands by and watches again.

M.A.-R.: It's easier for them to identify with what Segal writes.

K.P.-L.: Maybe that's "part of the reason" why psychodynamic psychotherapists are silent and psychoanalytic psychotherapists have no doubts.

M.D.: This would mean that in Poland we can keep silent because our hands are clean. Because we didn't participate in the Holocaust? That would be a false approach.

K.P.-L.: Polish psychoanalysts aren't silent – they're very active. They work a lot on epigenesis, on trauma. They organize psychoanalytic meetings connected with history, with the Holocaust; they analyze what happened.

K.C.: I browsed the Facebook wall of the Polish Society for Psychoanalytic Psychotherapy (PTPP) and the Polish Psychoanalytic Association (PTP). They commented on every major event. They condemned the death of President Adamowicz as violence and destruction

of the long-standing initiative of the Great Orchestra of Christmas Charity (WOŚP) [Polskie Towarzystwo Psychoanalityczne]. When there were the Women's Strikes, the Constitutional Tribunal's ruling on abortion, they were also quite clear on this subject [Polskie Towarzystwo Psychoanalityczne][1]. I have the impression that from their statements-comments, one can read which political party they are for and against. These are clear signals. They take clear stands.

M.A.-R.: On the PTPP's website, there are translated articles written during the pandemic; texts about what was happening in Italy, voices of Italian psychoanalysts, a description of what they were doing, how they were experiencing it, for example, a discussion of the transition to work remotely. They also reflected on the extent to which they could comment on the issue of anxiety over COVID-19.

M.D.: In their work with patients?

M.A.-R.: Yes, the extent to which it contributes or doesn't contribute to their work with patients. Riccardo Lombardi spoke directly to his patients that he was also afraid of COVID-19 [Lombardi], especially at the beginning. He also had doubts about deciding to work remotely, but at the same time, he pointed out that he and his colleagues in Italy were shifting to work with patients online even before the official government regulations were announced. In doing so, they kept

1 The post from January 14, 2019 was deleted due to aggressive attacks.

up with their patients and the fears that the patients brought to the sessions. He gave an example of a patient who was immunocompromised, at a higher risk. The dreams she recounted in sessions accurately reflected her fears. After discussing them, the therapist switched to remote work long before the official recommendations.

K.C.: These articles were very open, exposing the analysts, their fears and concerns; the fact that they work from home, that it's hard for them to create a working environment because their families, their children are behind the wall, that they're wearing house slippers. There was something very honest about it.

M.P.: I'm curious how this translates into individual work. Graduating from the school of psychodynamic psychotherapy, I had the idea that when working with patients' transference and fantasies, we comment on their reality (life situation) to a greater extent than psychoanalysts do. Now it turns out that they are the ones who relate more to the existing social reality, and we are reluctant to do so. And I'm curious to see how this works for them in their practice on an individual level.

M.A.-R.: And this is what posed a dilemma for them: how much to work with this reality? But I also remember the opinion [Lombardi] that because the fears were more intense with COVID-19, the analysts had easier access to them and could work better, as if paradoxically, it was more beneficial.

M.D.: More beneficial for the patient?

M.A.-R.: Yes. And for the analyst.

K.P.-L.: It opened up some areas of experience that they didn't have access to before.

M.D.: Two expressions appear in one statement, though: "exposed" and "showed" the honesty of the therapists. These are two differently valued words. And that moment we're confronted with: does it expose us or not? What does it mean for the therapeutic process?

K.C.: It also shows the realness; a therapist is a real person, an external object.

M.D.: An example from my office: a patient who tells me that he has no holiday plans abroad because he hasn't been vaccinated. And he doesn't want to be vaccinated. We're sitting across from each other in the office, I've been vaccinated, he hasn't. This isn't a discussion about ideas, but about safety. What should we do about it?

M.A.-R.: Recently, I've had a conversation in my office about the same topic.

K.P.-L.: After talking to a friend who called me saying that so-and-so hasn't been vaccinated, I have this sense that I'm not in a position to tell someone to get

vaccinated or not. I don't know what the long-term effects of the vaccination will be. I myself decided to go into the experiment precisely with the knowledge that this is an experiment, that these aren't vaccines that have been verified in the long term, but I wouldn't be able to say whether it's good or not, because I simply don't know. It doesn't upset me when someone says they're getting vaccinated or not; I'm more curious about why. I think that one day we'll find out.

M.A.-R.: When X-ray machines were invented, for example, they were available in shoe stores so that everyone could take a picture of their feet and see how long their bones were. People didn't know that it was harmful [laughs]. I hope there is no simple analogy to what is happening now.

K.P.-L.: This all shows that we very much want to be experts, that we want to know. In an anxiety-producing situation, we need to know and be sure that we're right. It's hard for us to hold a thought that we don't know, that we decide without being sure, each of us. This inability to remain in uncertainty forces us to categorize what is definitely right and definitely wrong.
M.P.: This also shows a very blatant and powerful attack on authority figures. But most of the medical community weighs the risks based on professional knowledge, and people don't want to accept that. Sometimes they even despise it.

K.P.-L.: At Poznań University of Medical Sciences, the contract of Dr. Herald Wallach, co-author of an article in the journal "Vaccines" encouraging a rethink of the vaccine policy ["The Safety"], wasn't renewed.

M.D.: On what grounds?

K.P.-L.: From what I read in "Gazeta Wyborcza", the university didn't renew the doctor's contract, firmly dissociating itself from the conclusions of the article. They disavowed his claims because it could discourage people from getting vaccinated, and the methodology of the study was questioned.

M.D.: But someone published this article.

K.P.-L.: Yes. That's exactly the point. What do authorities tell us? Do they keep their doubts to themselves and to what extent is this a scientific discussion? If officially there was such a discussion with arguments for and against, it would reassure me. Instead, I hear the university saying: "He doesn't work for us anymore." At this point, trust in these authorities is lost and there is an impression of superior control, maybe state control, maybe political. There should be no such control over the field of science. Methodological errors and misinterpretations can appear on any side. As long as there is dialogue and space for dialogue, I trust that we're talking about science, about the development of science and knowledge.

K.C.: It sounds like removing inconvenient people. If someone has a different view, they have to be removed, and this is a great pity for us, for science, because what's ambiguous stimulates thinking.

M.D.: Can a discussion like this take place between us and the patient?

K.P.-L.: I talked to my patients about whether they wanted to be vaccinated. If they said that they were afraid, I understood that, and we could analyze their fears therapeutically, which didn't mean changing their beliefs regarding vaccination policy.

M.A.-R.: Did you disclose your position?

K.P.-L.: I said that I was vaccinated. I didn't talk about doubts, only about facts.

M.A.-R.: I informed them about the vaccination once I had already had the shot.

K.C.: I did the same.

M.A.-R.: But there is a difference between someone who says: "I don't want to be vaccinated" because they have doubts and time will show what the consequences will be, and someone who doesn't want to be vaccinated because they think that

they'll be implanted with something. This is already an argument that distorts reality. I think that these two sides should be distinguished.

K.P.-L.: You're right. Disinformation and lack of broader information puts the society in such a state that we don't know what's going on. This increases paranoia.

M.P.: Working through such uncertainty is, after all, diagnostic.

M.A.-R.: I agree, these are two different situations. I was referring to this distortion of present reality. Some of my friends can't comprehend or even get angry at people who undermine the very fact of the pandemic, the virus, its harmfulness, or who look for movie extras in hospitals and so on. In some situations, we can observe the workings of reality denial, a defense mechanism that is supposed to protect us from fear. It's as if we're all afraid, but some people can cope with it only by concluding that all this isn't happening, it doesn't exist, it's a lie. That's what I was alluding to, and I think that's what Maciej meant. And the lack of dialogue you're talking about is another matter.

M.D.: It would show that in the public debate, outside the office, we lack a grey area, a safe place where we can discuss without judgment. The metaphor of the office, with its arrangements, therapeutic setting, and rules, catches on. After all, when

we lose the setting, we lose the possibility of a dialogue. It's replaced by action and lashing out.

K.C.: We have no place for dialogue, and we need dialogue to work out an agreement.

M.D.: Psychotherapeutic settings could be models for the possibility of public discussion. Under this premise, there is also a temptation for psychotherapists to say to the public that we like to be right, that we will explain everything from a theoretical position, as if we were outside this reality. As if we were only examining, watching everything from a theoretical tower and explaining the world. Like sacred cows. This is an important aspect of the question of whether we should speak.

K.P.-L.: I did a lot of thinking before this conversation. I knew this question would be asked. I think there is no dialogue between our group and the public.

M.D.: Our group?

K.P.-L.: Of psychotherapists. It goes beyond because there is no discussion between people representing different specialties. It's like debating whether children should go to school at six or seven years old. I haven't heard a discussion about whether developmentally speaking, these children should go to school at six. The scientific perspective was brought into the discussion by Jerzy Vetulani, who said that children

should start school at age five before the neurochemical cleaning of the brain occurs, which is the breakdown of neurons that aren't being used [Vetulani]. He took a position, and we didn't participate in that discussion. We didn't maybe because nobody asked us about our knowledge of children's mental and cognitive development, but maybe it's also the case that we don't share our knowledge. It's not about interpretation or diagnosis, but we don't even talk about what a child at age six looks like in certain developmental stages from our point of view. In a sense, we look down from a tower. We're happy that we know this, we're frustrated that this knowledge isn't being applied socially and politically, but we don't participate in the discussion.

M.D.: There is no psychodynamic Vetulani. Although there is Professor de Barbaro. I remember him from a discussion on Aleksandra Grzemska's book about mothers and daughters [Grzemska]. For example, he spoke publicly about what his feminist daughter taught him. He shared his knowledge, but also exposed himself ideologically, in the context of political changes and protests. It was a meeting on a platform, not a TV discussion, so maybe this isn't a good example, but I want to see it as a moment of sharing and unveiling. Of breaking through.

M.P.: I also think about the influence of psychotherapists on culture, on the society. What is our impact, what is our resonance in the public debate as a profession? To what extent do people think that a psychologist's

position on a given issue is necessary? Even in the context we're talking about now: vaccination and mental health. My conclusion is this: we have little power, for a number of reasons. We aren't particularly resonant.

M.D.: We're not an authority?

M.P.: We don't participate very much in the debate.

K.C.: But we also make sure that we don't participate much. We emphasize that we're neutral; we don't express our views and this can be confusing for the public. Speaking one's views and speaking out on the issues from a developmental perspective are two different things. Just as it's the duty of scientists to share their research results, it's our duty to disseminate certain knowledge to the public.

K.P.-L.: We think that this is a neutrality that we've developed ourselves, and it seems to me that it's a social process. Physicians don't have neutrality, and often a cardiologist doesn't understand what nephrologists do. Psychiatrists don't understand how their patients are affected by their kidney medication. It's a social process, and everyone is hiding behind something. We'll say it's neutrality. Physicians will say they don't have time. Meanwhile, the socially progressive separation of specialties, of available knowledge is replacing exchange. A philologist used to talk with a physicist, Einstein corresponded with Freud. At conferences

there are only psychotherapists, and often only psychotherapists of a particular paradigm. This is more than neutrality, it's withdrawal from dialogue and isolation in the environment of science and practice.

M.A.-R.: At the micro-level, it happens between us, in the office. Before the emergence of the trend to audio-record sessions and play them back as part of observation, one talked about them from one's own perspective. Then the therapist might get defensive, and their responses could be unclear or incomplete to the supervisor. You didn't know exactly what was going on in the office. We don't discuss things with each other, we may exchange advice, but I think we rarely talk openly about our doubts. It's difficult to talk about our work, even among each other.

K.C.: Often teams – not only political committees – are set up in such a way as to confirm something, so that there isn't too much differentiation. At times, it resembles fortresses under siege, we isolate ourselves from different world views.

M.D.: We're inconvenient because we're here to see both sides of a coin? To look for ambivalence?

K.P.-L.: Or maybe it's not about therapeutic neutrality – that it exists – but about the fact that our society is moving in a narcissistic direction? All groups are isolating themselves and speaking their own tongues,

like in the tower of Babel. No one wants to hear another because they would have to listen. When we go to a conference, do we learn anything new there?

M.D.: Rather, we confirm hypotheses and don't listen to those who could theoretically do something new for us. For example, we don't read Samuels, who's a Jungian. In general, I have this idea that it's somehow easier for the Jungians, that they're more open. Samuels discusses politics, economics, feminism, and sees no problems in connecting the different issues. In the context of gender, relationships, and development, he writes about the new fatherhood, the new motherhood, the brother-sister bonds that can rebuild society. He writes this, not by disavowing Freud's claims, but precisely by historicizing them. And he has no problem with that.

K.P.-L.: And we have Jung, who kind of anticipated epigenesis. When Jung talked about archetypes, he argued that we're born with certain patterns that are reproduced in subsequent generations, even though we don't have them in real, individual experience [Jung]. Contemporary epigenesis shows that we can inherit the experiences of our parents and even earlier generations. This is consistent with the Jungian idea that there is inherited material that we aren't aware of but we have it, and that shared generational experiences can create a collective consciousness. We used to believe that we couldn't pass on acquired traits – educationally yes, but not biologically. Today, there is considerable

evidence that experiences and environmental factors cause biochemical changes, and therefore influence gene expression [Dmitrzak-Węglarz and Hauser].

M.D.: Inherited trauma [Wolynn].

M.P.: This is the context of social inheritance.

K.P.-L.: Of epigenetic modification that proceeds dynamically.

M.A.-R.: I wonder what the pandemic will do to us in this context? How will it affect subsequent generations? Just as there is the post-war generation in Poland. To what extent will it intensify the divisions and difficulties in getting along with one another?

M.D.: And what will the COVID-19 pandemic do to kids developmentally? What is it doing?

K.C.: The pandemic didn't give us time to prepare. I think we're yet to see the effects. What was evident after the first lockdown was the concerns reported by parents about anger outbursts, frustration, aggression, phone addiction. You ask what the pandemic will do. Kids need each other less in live contact, and more in online contact, in games. Their isolation has increased. Education isn't just about the challenges of learning; it's a time of getting to know yourself and others, building an identity, socializing in a group.

M.D.: That would be speeding up the process, not changing the trend.

K.C.: Yes, the difficulties had been there, the pandemic enhanced them.

K.P.-L.: I'm puzzled by this neutrality we've been talking about. I'm not sure if it's something we've produced or if what's happening in our society is a vicious cycle. Let's assume that societies, civilizations go through the same cycle, which is similar to biological cycles, just like our cells – first there's development followed by decay, apoptosis. Freud used biological mechanisms when he talked about life and death instincts; he explained it at the level of cellular life. For years I have been passionate about the combination of astrophysics and psychology. I have this fantasy that if we could work together, transfer certain physical processes to mental processes and actions of physical forces, science would go forward. Italian scientists have done this. They analyzed the structure of galaxies in the universe and it turned out that their structure resembles that of neurons in the human brain. The interconnection of galaxies in the universe mirrors the neuronal connection grid. This research shows that the laws governing the development of our brain and the universe in which we live may be the same [Vazza and Felleti]. How much we can learn about the brain and the universe by comparing these processes! It isn't just about neurology and astrophysics, but about a dialogue of different disciplines instead of the tower of Babel. It requires

the commonality of language, of listening; a certain resilience to the frustration of one's ignorance, respect that others may think differently from us and may be right. During a discussion in an interdisciplinary group diagnosing disorders in children, for one phenomenon of disturbed behavior, each specialist had a different idea. A child was reacting with fits of rage while swimming in the pool. Of course, this was a child with a dual diagnosis of the neuro-developmental disorder and psychological behavioral disorder, and I don't want to simplify this diagnostic situation. However, the pool-induced condition was understood by a pediatrician and neonatologist as hypoglycemia and she focused on the sugar curve; a neuropsychologist viewed it as the result of a disorder in the area of sensorimotor integration, while psychotherapists saw the reaction to contact with water as a symbol of the difficulties in the young patient's attachment relationships. One very important thing is the attempt to restore dialogue in social and political dimensions, between science and practice, and even what Kasia was talking about – a dialogue between kids during the pandemic. Maciek, your questions are encouraging us to do that! Another aspect that might be important is to compare social processes to more basic ones: biological or even physical. Maybe social processes are like those related to cells: first growth, development; then the reverse process, a breakdown of structures, destruction – and the cycle continues. Is there a connection between our world leaders and the fact that socially, we seem to be firmly, narcissistically planted in the process, and even

going in the anti-social direction, a certain breakdown of structures? Or is it a cyclical process of integration and maturation, followed by disintegration and destabilization? First, a child is psychotic, which means we have fragmentation, chaos, lack of differentiation between boundaries and structures; then there's fission followed by repression; then we have a healthy structure, and maybe further down the line, the cycle regresses. A reversal occurs. Civilizations climb up this ladder of development up to some point, like the cells in our body or our mental apparatus, and then go down, as maybe we are now. Maybe it's like the Big Bounce concept, which is that the universe expands and then implosion occurs and contraction begins. And here the question arises whether we are the ones creating these leaders and social processes caught up in universal cycles of ebbs and flows.

M.D.: Just like with climate variability, there are cycles.

K.P.-L.: Or the cyclical changes of the Earth's poles.

M.D.: Bollas wrote a book on this subject, *Meaning and Melancholia: Life in the Age of Bewilderment*. He describes what's happening to us now, but he shows it as a result of the civilizational changes of the last two thousand years. There are a lot of gaps in it to fill in, because it's an enormous hypothesis. And if we were to fill them in, a number of variables would take us in different directions and complicate the whole thing. But the pattern exists, and I'll admit, I find it tempting.

K.P.-L.: It's always debatable. I have discussions with my husband. He laughs that maybe it's a matter of manipulation, that it's the leaders who create something, kind of what you said, Marta – chips and top-down control processes. I wonder if this is a mapping of a group process. Is the group leader outside the group? Do they also, as the leader, remain in counter-transference? They can, of course, somewhat modulate the process, but is what's happening the result of a group process?

M.D.: That wouldn't be optimistic. It would mean that we're doomed, we have no choice, we have to repeat the cycle.

K.C.: Like in *Dark*, where we have a wormhole with time dimensions: past, present and future that interact with each other. Watching this series, we can wonder what determines our fate. Are these our decisions or do we happen to be going in circles, and events repeat themselves?

M.D.: Oh, this series calls for a psychoanalytical or biblical interpretation. We're not going beyond the climate of the apocalypse.

M.A.-R.: And this is the voice of the society, of the whole group. We aren't victims.
M.P.: It's quite deterministic.

M.D.: Exactly, completely.

K.P.-L.: The repetition compulsion: we do something anti-social and the structures start to crumble. And once they collapse, like during wars, we start re-building. Until we reach mature positions, well, then we start anew.

M.D.: It sounds like a holistic theory of culture or time. From chaos to order and celebration, to decay and emptiness.

K.P.-L.: Everyone knows Jeff Bezos. The richest man in the world. He left Amazon according to the theory that no company can live forever. He calculated the process of such an organization to roughly thirty years of growth. Bezos left when Amazon had been operating for 27 years.

M.A.-R.: So at a good time.

K.P.-L.: The crew tried to convince him that Amazon was doing great. In response they heard: it doesn't matter because the business structure has its inevitable dynamics, after a period of growth it will start to fall apart.

M.D.: What we have here is an acceptance of decline, but also a certain escape from it. Samuels describes it interestingly in the context of economics and post-growth theory. He shows possible changes in economic patterns. The blocking of massive, inconsumable corporate profits and their social distribution. Samuels sees this as an action based on ethics and empathy.

In this context, psychotherapy can show the different developmental moments of a given organization.

K.P.-L.: There is, of course, the counter-argument that there are people who are ahead of their era, following a different rhythm: da Vinci, Einstein. What about them? I'm also interested in what allowed them to gain a certain metaphysics, the ability to name processes, like Einstein's discoveries that aren't observable. Maybe this is where the interdisciplinarity comes in. The openness to exploration, to looking and listening. Einstein corresponded with Freud. They didn't isolate themselves. This allows us to see patterns discernible only from a meta-level. We can focus on what kind of leaders we have, what kind of authorities we have, and why we have these and not others. In Poland we have similar processes as in the U.S. I read that in Canada they're burning churches. The process is in full swing.

M.A.-R.: Yes, in different countries, in different societies, similar things have happened at similar times. Black Lives Matter, our Women's Strike – it's a similar pattern.

K.C.: I thought about the same thing. The riots and outrage after the death of George Floyd, the various anti-government protests and those against restrictions related to the virus outbreak. Throughout history, we can find revolutions that followed epidemics.
M.A.-R.: For months I've also puzzled over the fact in the COVID-19 pandemic, there was a common trend of buying

up toilet paper. Did you wonder about that? I came across a statement by a psychoanalyst, Professor Don Carveth. He argued that it's a retreat into the anal phase, where the dominant issue is control of the situation [Carveth]. I was wondering why people weren't buying up flour? If they don't eat bread, they will die; if they don't have toilet paper, nothing will happen [*laughs*].

K.C.: It was curious to see this impulse to hoard – like a harbinger of the apocalypse or safeguarding of one's current lifestyle. Undoubtedly, we were in a group process.

K.P.-L.: I just don't know if it's depressive or matter has to remain in dynamics. You can't be stagnant. We can't get somewhere and stay there; it's like with development – we keep experiencing crises all over again. Maybe the matter of the universe and our society can't be stagnant.

K.C.: There has to be a crisis.

K.P.-L.: Bezos said that at Amazon they should work according to the first-day policy, because the second day would be stagnation, but that sounded like the death of an organization: either you grow or you die.

M.D.: This brings to my mind changes in the job market. We no longer work for 40 years in one place, not even in one profession. We need to be flexible, constantly oriented towards the new. How does

the profession of psychotherapist fare in this process? There seems to be more stagnation here.

K.P.-L.: And yet we're still developing.

M.D.: Although we say that we're ghettoizing, that our development sometimes seems to be illusory or somehow limited. And what does it look like in the context of understanding patients – is it changing? Maybe a good field of observation would be our sexuality. The understanding of patients' and therapists' gender is changing, and so is the influence of gender factors on the therapy process.

M.A.-R.: Sometimes I wonder if this isn't a new look at old things. We use new words to describe what has been around for a long time. I once had a discussion with a patient who wondered if she was more masculine or feminine. I thought that if we removed the modern language that helps us describe it well, we'd be thinking about the same processes that continued to unfold in personality development before, under different names.

M.P.: That's interesting in the context of sexuality, because in the context of health, we strive for object choice, for someone to "make a decision" and identify with something, and additionally to know who and what they find sexually appealing. When I say "make a decision", of course, I mean a largely unconscious

process. It seems that today it's different among adolescents, young adults or, even more broadly, in the society. This is to some extent the opposite of the assumption described above. Currently, adolescents in particular are more focused on variability, on the attractiveness of variability and not choosing. I have a lot of adolescent patients; they don't come to me exclusively in the context of sexological themes, but in the course of our conversations they say: "One day, I feel like a girl, another I feel like a boy and that's OK; a lot of my friends feel this way". This variability is very much emphasized.

M.D.: Is this how patients describe non-binary?

M.P.: You could call it non-binary. A fluidity in gender identification.

M.D.: To be clear, I understand non-binary as being outside: neither boy nor girl.

M.P.: In sexology, this concept isn't very well defined, and there aren't many scientific studies, for example, longitudinal, in this field. It's assumed that non-binary identity is the phenomenon of experiencing oneself, so to speak, beyond the simplest division into men and women, but rather towards being more than one sex or no sex at all. In addition, there are concepts such as gender non-conformism or gender fluidity [Pliczko and Mijas]. The topics of gender identity and sexual identity are very dynamically analyzed, this is what's happening

now. Particularly interesting analyses are being carried out in the field of cultural sexology. Patients themselves describe their sexuality in very different ways: some of them say that "sometimes they feel like this, other times like that", and here is the area of variability; others can't feel like this or that, so they "choose" nothing. For me, this all falls under the concept of non-binary. I admit that patients sometimes teach me concepts, especially adolescent patients in the context of what one likes, what one identifies with. I don't even hide it anymore. I tell my patients to educate me because I don't know something.

M.D.: This is an identity question: what does it really mean to them? Though maybe in general, in the context of non-binary, thinking in terms of identity is a backlash, simply conservative. Let's keep asking. You're talking about adolescent patients who see and define themselves in a particular way. Do we have a broader perspective on this phenomenon, for example, what happens after the adolescent crisis?

M.P.: There are no studies, especially ones that take a long-term perspective. But we do have older studies of transgender or transsexual patients. When they discover their transsexuality in adolescence or earlier in childhood, sometimes in the next developmental stages, they no longer identify themselves as transsexual, but more homosexual or heterosexual. This goes down to the level of sexual orientation and this is where things happen. In sexology, there is a lot of talk about the Seligman model.

According to him [Seligman et al.], the most biological, basic level is the level of sexual identity, then there is orientation, then role, and so on. Patients who are unsure in the area of gender identity, the most primal core of sexuality, after some time may experience that the sex assigned at birth is the correct one, but, for example, the sexual orientation is not heterosexual but bisexual. Doubts in one layer of sexuality lead to changes in another layer. It just happens that way sometimes. But also a large percentage of adolescents or children who report that they don't feel female or male, will continue to feel this way and seek, for example, a sexual reassignment surgery. What about those adolescents who now identify as non-binary, what about their future? It seems to me that in Poland there is still no such research, no such recap, no understanding of the entire process.

K.P.-L.: I look at my daughter's environment. Most of her girl friends think that they're bisexual. My daughter often asks me: "Is there something wrong with me, Mom, that I think I like boys?" It's apparent that homosexuality is attractive in teenage groups. I tell her that this is a developmental time, an age when we're all homosexual. We have a homosexual developmental phase. Except we didn't use to think about it. Girls sleeping in one bed and holding hands didn't use to have any sexual meanings, technical terms or definitions.

M.D.: We would put it between homosocial and homoerotic meanings.

K.P.-L.: I observe young patients, but also kids my daughter's age; many of them feel bisexual. They experience strong internal conflicts. They turn to self-harm, and on the other hand, they narcissize it, for example, they ship guys with guys.

M.D.: What does that mean?

K.P.-L.: They pair them up. And they primarily ship homosexual couples, which is evident on the various forums where they meet. This simultaneously creates a lot of anxiety and excitement for them. Internal conflicts that are normative can create perspective faster: "Since I have these thoughts, impulses, I'm probably like this".

M.P.: These conflicts are deeper because bisexuality is "only" a choice of an object, and earlier we were also talking about doubts concerning gender identity – who am I? A woman, a man, a little bit a woman, a little bit a man, or none? These conflicts have descended to a lower level, to the level of gender identity. The youth can even bond, connect over it. They form rainbow communities and have conversations in the context of who has even more doubts.

K.P.-L.: In primitive cultures, there was a ritualized creation of identity. A girl became a woman through an initiatory passage, it's like a bridge beyond conflicts. When you did something specific, you became a man,

a woman. It wasn't written into the conflict to be resolved internally, it was a socially given, concrete ritual.

M.P.: We're moving in the direction that a patient is healthy when they integrate themselves somehow, when they identify with something, when an identity is clarified. Sometimes I have a problem with a 17–18-year-old who identifies as non-binary. The internal problem is to ask if he's healthy personality-wise, and what I should do about it. Of course, I can observe it and reflect with him on the nuts and bolts of his situation, but at such moments, I myself begin to lose that kind of knowledge, certainty, or conviction as to whether an explicit identification is really necessary.

K.P.-L.: We're in the middle of a discussion about whether you can be transgender or gay and be mentally healthy. That's something that hurts us the most and that we're afraid to say openly.

M.D.: Samuels writes directly that this is the greatest weakness, and at the same time, the advantage of psychoanalysis, that it doesn't and cannot answer this question unambiguously. We have cases, not a formula. And true, this is a painful discussion. I have all these thoughts in my head right now about the labeling of minorities, women, queer, trans. They're often talked about as if they're test subjects. And we're talking about each other – I want to emphasize that.

M.P.: I agree. Research shows that in the population of homosexual and bisexual people the rates of mental health problems are higher than in the general population [Iniewicz]. However, one has to look at it very broadly, for example, through the perspective of minority stress or the fact that the psychosexual development of a gay person encounters various difficulties when it takes place in a very heteronormative society. As a therapist, the context of non-choice and non-identification simply gives me more pause.

M.A.-R.: Could it be that in a given period, you don't have to choose it? That's what I mean by the idea of new terms for old things. As Kasia says, developmentally, there is a period when you don't know.

K.P.-L.: Marta is right in that it's the social constructivism of diagnosis. The social processes in which we're all stuck as diagnosticians influence the creation of norms, the discussion of norms, and the way we discuss observed phenomena. Many of the dilemmas related to identity, orientation, and gender roles used to be repressed; colloquially, our psychological defenses swept them under the rug. Sometimes this could be supportive and sometimes hurtful. Children went through homosexual phases of development without thinking about it, and went on with their development; in that sense, this ignorance was supportive. I didn't know I could be anything, so I didn't think about it, and those snippets of developmental urges and desires were quickly repressed. For people whose identity

formation was different, whose orientations or gender role perspectives were different, social repression was hurtful, failing to recognize that things could be different. For me, it would be important that we're able to see that it's different, and at the level of science and social discussion, we can explore what it's like and why. We won't go back to social repression of areas of human sexuality, but I fear going the way of: "If you have questions or doubts, that means you're pathologizing sexual otherness". And I still don't understand a lot of the phenomena of our sexuality, I have a lot of questions. I've had neurotic homosexual patients, but at the same time, each of them has had some kind of trauma that may have affected their psychosexual development. I read about medications that can affect identity and orientation. And I hope to create a space for dialogue here.

M.D.: I have such concerns myself. In this context, it's interesting how I get patients who can quickly find out my research area, the fact that I've written this or that book on gender. And I can talk about their identifications with them. I can challenge them, explore them. It's interesting on the level of my exposure, which offsets their fears. And it also fits into these social divisions. We go to our kind with our needs, because otherwise, anxiety won't let us work. I can then say: "I don't understand your nonbinary." In response, I usually hear a dictionary definition and inquire further about what it is in an individual experience, what it means to you.

But they don't lead me to answers other than those dictionary ones. This definition is sort of external. There are no individual metaphors, experiences.

M.P.: I see it too. Often. Words that are said but sound empty. Sometimes even unconsidered, unexplored, unfelt. Sometimes it's hard to analyze it with a patient, because they don't know either. And I also associate this with the process of identity construction, that something is trying to be filled, invented, created. Paradoxically, I learn many concepts, how they're described in various equality dictionaries and what they mean in terms of definition, but when someone needs to say what it means in their experience, they often sound hollow.

K.P.-L.: Again we come back to the possibility of dialogue, to be inspired to want and be able to see what's going on inside, beyond the external definition of the concept; to explore this internal reality without fear that we are pathologizing it by exploring it.

M.A.-R.: Different things can have different causes, but this would immediately mean that there are worse or better ones.

M.D.: Yes, that it immediately has to be followed by a label. Pondering is labeling. I see this in conversations with humanists when I use a psychodynamic term. I immediately fall into the category of medicalization and gaslighting.

K.P.-L.: Maybe it's because we all have fears, anxieties, desires from different areas and from different depths of our sexuality; we're afraid of exploration – even if it's only verbal – of uncertainty, and an analysis of phenomena. We prefer to give it a label and insulate ourselves with this "knowledge". Marta talked about denial and the pandemic – the more we fear, the faster and more intensely we need to deny and feel that we know.

M.A.-R.: What you're saying makes me wonder: in what direction the society might be heading culturally? Driving here today, we talked about prisons, about family conflicts.

K.C.: About anti-social individuals and patients.

M.A.-R.: That if someone is related, people turn away from each other, stop talking to each other, siblings are out of touch for years or longer. What's happened that different processes can translate into the functioning of a group, that we all came with such vibes?

K.P.-L.: Just a dozen years ago, gossiping among therapists, we saw ourselves in the social process at the narcissistic stage. Now, when I think about it, I see a lower level of the narcissistic process, the anti-social one.

M.D.: That was quick. When I looked at the characteristics of the society, only eight years ago it was narcissism that came to the fore.

K.P.-L.: I have the impression that, as a society, we no longer adhere to reality. We can't know who is who and how they identify. We can't name what we see because identification is different than reality. How do we test reality?

M.D.: We're going one way, and in the topic of sexuality and gender that we're discussing there's a great deal of reality; for example, economics and inequality, the fact that we have feminized or non-feminized fields, professions, and positions, also in psychotherapy; the fact that someone is telling our patients and us that we are an ideology and not human beings. And we have to deal with that in real terms. That's the other side of the coin.

M.P.: Yes, words with a caring intention can be experienced aggressively, because real-life experiences are also this way. The pandemic has made it even more difficult to differentiate where a symptom comes from: is it the reality, culture, pandemic, temperament, family interactions? In kids, this is superimposed on the developmental process. They're coming out of latency, they're entering early adolescence, and at the same time, there's a pandemic, and these kids are becoming listless, withdrawn, insecure, they're experiencing a lot of things with their bodies. At this point, it's hard to say unequivocally whether the symptom comes from someone being at the stage of discovering their femininity or whether it comes from home isolation. I see this

both in some of the environments I go to and at home. There's another factor that might produce a problem.

M.A.-R.: And which we can't get out of because it affects us.

K.C.: And which is in the air all the time.

K.P.-L.: Certain phenomena have been around, only we interpret them now. We don't know how people would have reacted to a pandemic 100 years ago. Is our isolation as a result of the pandemic, as Maciek said, just an acceleration of the processes we've been involved in? We've already had our faces in these phones, tablets. And we processed the pandemic in that very way, going in the familiar direction of isolation. Or would populations at a different stage have done it differently?

M.A.-R.: I was thinking about this functioning of kids online. My generation, we were all sitting online and chatted on Gadu-Gadu [a messenger – trans. note]. It didn't take a pandemic to keep us at home, so as time went on, certain processes and trends would have happened anyway. Of course, today we have a significant difference, because now the school reality has disappeared completely; in the past, you would log off Gadu-Gadu and hang around the school hallways. I also wondered if it's not narcissistic in a way, because behind the screen of a computer or smartphone you're focused on your own process. You don't see the live reaction of another person,

you don't have the flow of everything that happens spontaneously in person. You're actually alone with yourself.

K.C.: What bothered me most about the pandemic was the isolation of children in homes where things were bad, where there's violence and five people live in a single room. What's happening to them, to these kids who were disappearing from the system, who didn't take online classes. I'm also concerned about the kids who already had social problems, recognized phobias of social anxiety before the pandemic. For them, this pandemic was a good thing because suddenly they didn't have to go to school, they reaped a lot of secondary benefits from it. And what's going to happen when they return? How will they have to adapt again?

M.A.-R.: I think for the first time it turned out that introverts are better off and they're on top.

K.C.: You're saying that we're moving in an anti-social direction. What I see is a split into better "us" and worse "them". We even started talking about it in the form of specialists: better specialists, worse specialists. Apropos of politics: sometimes I think to myself whether I'm not in this split, whether I'm not a part of it, because I also say that the party I'm not fond of is paranoid. It's difficult not to succumb to this split.

M.D.: As voters, we are, according to what Stawiszyński writes, in collusion with the other side [Stawiszynski]. And we're not able to go beyond it.

K.C.: We tend to think of ourselves as better, purer, wiser, safer, non-threatening, while they are primitive, boorish. That risk is high.

M.D.: Do we know what it gives us and what it takes away?

K.C.: This poses a risk of building various discriminatory, homophobic attitudes.

M.D.: I'd like to mention one more important thing. I'd like to ask you to explain, clarify the context of depressiveness and narcissism. How can we come out of the pandemic in the context of working through losses and mourning? After all, we also socially pathologize mourning instead of entering into it.

K.P.-L.: Wait, because I was quite struck by what you said about the LGBT, the accusation that it's an ideology, not people. It's a narcissistic process that we hate PiS or KO or LGBT, or that LGBT is an ideology because there is no human being behind those acronyms. We're not in contact with a person, we're in narcissistic contact with a fantasy. And it's easier to project onto a fantasy than a real person. Fantasy won't make us real. That goes for LGBT people, but also for politicians of various parties. When I talk to a colleague who voted for another party, I get furious, we argue, but still, I'm not able to devalue him, because behind the views stands a person close to me. I even listen to his arguments about why he votes for this

particular party. I understand that he has his perspective, his understanding, his interests. But I can only do this when I talk to people, when I go beyond contact with ideology, the construct of parties, and political views.

M.P.: But this goes further because politicians can even out a particular transsexual child from a smaller town because they've received information that the school management has agreed to change pronouns and address the child in the form in which he or she feels comfortable. So a concrete child, not an ideology, not a certain theoretical construct, is singled out and publicly analyzed.

K.P.-L.: I don't think that this politician thought about this child and noticed it.

M.A.-R.: I imagine that Jewish analysts found it easier to relate to the Holocaust, and I'm thinking about pregnancies, the abortion ban, the ban on prenatal tests. I don't know if there's fantasy underneath that, that there's going to be a deformed fetus and you're not allowed to see that. I find it outrageous and that hasn't come up in our conversation yet. Again, this lacks human contact. Everything is related to some moral principle and not to life, to people.

K.C.: Conflicts concerning freedom of choice, life, death are always more difficult and deeper because they concern what we fear most. I wonder about the limits of imposing our own morality and our own worldview. But going further: it's connected to something sadistic, forcing women

to suffer, to be heroic. In my office, I hear how it intensifies the fears of women who are afraid to get pregnant.

M.D.: There is no real woman, only the phantasm of the madonna, the mother.

K.C.: When you talked about experiencing depressiveness and the pandemic, I thought that the pandemic took away certain rituals, including our office ones; when we were in front of the screen, we had to suddenly abandon the familiar psychodynamic frame that served as a container and thus provided a sense of security (a patient coming to the session, physical presence, going home after the session). I also think of the rituals of everyday life: weddings, funerals; I've experienced this myself. For various reasons, I couldn't attend the funeral of my grandmother, who died alone in the hospital, sick with COVID-19. My family couldn't say goodbye. The pandemic took it away from us. Once again, I saw the importance of ritual, something that can be experienced. Symbols compensate for deficiencies in reality, and both were missing.

K.P.-L.: And we, as a culture, agreed to it. This is the greatest tragedy. We all let these people pass away alone. Maybe if we were in a different place in this process, we would have said no. I see in my patients that they can't get over the fact that their loved ones were dying alone, they can't work through it. It was horrible: that you couldn't go into the hospital.

K.C.: This is a new experience for me. Until now there had been no situation where you couldn't visit a sick person in the hospital.

M.A.-R.: There were voices saying that they weren't taken care of, that there were staff shortages, no equipment. This intensified fantasies about what was happening there and what they had to go through in their last moments.
K.C.: Do you remember those early photographs, the sad images of families on a crane waving to sick people in nursing homes?

M.A.-R.: Or how people used a plastic sheet to be able to meet. They could hug each other like that. It was terribly moving.

K.P.-L.: Or the story about a grandfather who died and the grandson stayed with his corpse for three days. Culturally, we gave permission for this. When my mother was ill, her neighbor still brought her groceries, despite the threat and insistence that she not do it. My grandmother said: "I'm 90 years old, if I get infected, I'll die, so be it, but you have to come and visit me anyway".

M.A.-R.: There are such voices among the elderly.

K.P.-L.: The pandemic could also be interpreted in different ways. My grandmother would

say: "Remember, if I get sick, I won't go to the hospital, I prefer to die at home". And for some reason, we allowed for something else.

M.D.: That would mean that the pandemic is a litmus test that augments what we have.

M.A.-R.: Even when we talk about older people, I get the sense that they're the generation that could have managed the pandemic differently.

K.P.-L.: My grandmother used to say: "We went through war, disease and epidemics and it was important to stay together".

K.C.: During the pandemic, there have also been these dilemmas: should I watch out for my loved ones or visit for Christmas? If I go, get someone infected, can I face the responsibility? Some people went, they didn't think. And others stayed at home.

M.D.: Or they slept in their cars so as not to infect their children.

K.C.: I see that there are now lines for child therapists in the private system as well. This shows that children are functioning worse. When the pandemic hit, those who had been taken care of continued to get care. Others who were in crisis and hadn't received help up to that point had quite a hard time getting it.

M.P.: The pandemic has hindered getting help. People were procrastinating, saying that this wasn't the time yet, the pandemic wasn't over. I see this, for example, in the area of Municipal Family Support Centers, where seeking psychological help was delayed for a year and a half. At some point, the pandemic became an excuse. And it's also hard for the therapist to step in, confront, and name it, because they would have to take responsibility for exposing the child to the potential disease. After all, infectiousness continues.

K.C.: There were also moments of unity, solidarity, when help for various circles was established, people were sewing masks, collecting medical supplies.

M.D.: To what extent was it important for us as organizers, and to what extent did the recipients need it? I remember that no one called my hotline.

M.A.-R.: That's true, no one called mine either.

M.D.: I don't know if it was a matter of misinformation about the initiative or something else.

K.P.-L.: There are two ways to deal with anxiety. We control it by isolation or proximity. We have long been afraid of death and disease. We're afraid of saying goodbye to our loved ones. They're no longer at home; we don't mourn them at home. This process began a long time ago.

M.A.-R.: But we don't welcome them either. We medicalize birth and death.

K.P.-L.: Childbirth is also marked by a great fear for life. We've distanced ourselves from death and by not seeing it, we fear it even more. We don't take care of the elderly, so how can we not be afraid of old age?

K.C.: We used to have a whole process of saying goodbye, rituals.

M.D.: It sounds like resentment, longing for the lost or a conservative thought. One could ask provocatively: what's the point of this suffering? Why confront it? These are obviously questions of escape.

K.P.-L.: We don't want to have contact with old age, with death, and at the same time, we don't have the understanding that this is the only way for us to deal with it. And that can be difficult in working through this pandemic. We couldn't see it, our loved ones in hospitals, staff in protective suits, be around it.

K.C.: When the pandemic started and we locked ourselves in our homes, we also had the phenomenon of trying things out: time to bake bread, exercise, take care of ourselves. As if we wanted to deny what was happening. That it wasn't loss, but gain.

M.D.: Have any of you managed to do anything like that?

K.C.: I exercised a little [*laughs*].

M.A.-R.: At one point, I thought that this lockdown was very valuable. My husband could work remotely and see the development of our daughter, who had been born just before the pandemic, which would have been impossible in the earlier system. This kind of sentencing to closeness could potentially encourage growth.

K.C.: In some homes, the confinement situation compounded conflicts. In many families, the financial situation deteriorated.

M.A.-R.: Sure. Just like a crisis: it can always end well or badly.

K.C.: In the spring, I said to my husband: "Finally I can see what spring looks like. Not be back in the evening, but actually be there."

K.P.-L.: The isolation forced us to focus on smaller things. A training in mindfulness.

M.A.-R.: At the beginning of the remote work, we agreed that we would behave like in the office, so it would be the same. I was getting ready, putting on shoes, using perfume.

K.P.-L.: Did you really put on shoes?
I walked around in slippers! [*laughs*]

M.A.-R.: I even brushed my teeth, but towards the end, I just put on mascara and wore sweat pants [*laughs*]. But it was difficult to maintain all that.

K.C.: I had it the other way round.

M.P.: Me too.

K.C.: I was very distracted by being at home; the moment I knew my husband was coming home and was behind the wall, I wanted to get out and start living my private life. This wasn't helpful for me. A dog barking behind the wall or a baby crying. But I remembered something when Marta read about this psychoanalyst and toilet paper. I saw a comparison that when Freud came to America, he said: "We have brought them the plague" – speaking of psychoanalysis. That suddenly took on a new context for me: how do we deal with this plague?

M.D.: Nice. That's going to be the title of our conversation. [*laughs*]

K.P.-L.: When you approached us with the question of how much we should maintain neutrality, I had contemplated it for a long time before our conversation. I was always conflicted, and then I thought, actually, it's pretty clear to me, only I don't think anyone has asked me as directly as you have. I thought we should all share our knowledge, not just therapists. This restoration of dialogue is key, because after all, a strike is

a symptom of a broken dialogue. That's when people take to the streets. And it's this breaking of dialogue that is the plague of our times. If therapy is to show us something, psychotherapy is to give something to society, it's the knowledge of mental and group processes that we have, but above all, some know-how. I take know-how to mean our focus on relating, analyzing, maintaining doubt and dialogue rather than diagnosing one leader or another who is stuck in these psychological-social-cosmic processes as much as we are. A few moments later, I turn off the recorder. The evening continues. It ends with a discussion of *The Tender Narrator* and a reading of a poem by Louise Glück.

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