



Association for Child Psychoanalysis NEWSLETTER

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President's Message
Martin Silverman, M.D.

JUNE 2000

Dear Fellow Members, Colleagues and Friends,

As I indicated in the comments I made when I assumed office in April, we are now in the year 2000, at the interface between two millennia, and it is time for us to set our sights forward rather than backward. Our organization was born in dissension, conflict, and exclusion. Much has happened since then, however. The Association for Child Psychoanalysis has grown strong. The American Psychoanalytic Association has begun to give child analysis its proper recognition, and it has opened itself to non-medical psychoanalysts and erstwhile psychoanalysts, whom it formerly excluded. The International Psycho-Analytical Association has more warmly embraced child analysis than it did in the past, and it appears to have more or less fully accepted the principle of regularly including child and adolescent analytic representation in its scientific programmes.

It is time to relegate the past to the past rather than continuing to nurse old wounds and perpetuate pain that no longer needs to be felt. It is time to forgo bitterness and opt for sweet things in its place. It is my fervent hope that during the next two years we can

move ever closer to internal strength, unity, and harmony and away from internal stress and strife. As child and adolescent psychoanalysts, who still face problems and perils created for us from the external world around us, we need to bond together and band together internally, in mutual and collective courtesy, respect, cordiality, and collegiality. If we do not pull together, we will be vulnerable to being pulled apart by forces external to us. Abraham Lincoln's words about a house divided against itself still hold.

We need to extend and expand our strength, our activities, and our impact. I expect to work closely with my fellow officers, with our councillors, with our excellent and hardworking committees, and with our membership at large not only so that we can fulfill the aims and goals of our organization in an efficient and effective manner, but also so that working together we can grow, internally and externally. We shall do everything we can to enlarge our membership. We shall reach out to child analysts who are not yet members of the ACP to join our ranks, including from parts of the world where we have little or no representation in our membership. We shall make

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President's Message . . .

efforts to widen the circle of those who participate in our scientific and administrative activities. People are being invited to join the Program Committee and other committees from Europe, Canada, Mexico and perhaps elsewhere. We are looking into possibilities of organizing meetings overseas with co-sponsorship by professional organizations with which it is natural for us to collaborate. We shall be exploring the reasons why we do not have members in our organization from areas in the world from which we might expect to attract members and ways in which we might remedy that situation. We shall do what we can to strengthen

our liaison with other mental health organizations.

Finally, I expect to work closely with my fellow officers, councillors, committee chairs, and all of the members at large to widen participation in our decision-making actions and to facilitate free and open communication within our organization, without which no democratic institution can thrive. I belong to many professional organizations, in two of which I have served as President in the past. This long has been my favorite one of all. We are a warm, friendly, for the most part, easy-going and amicable group. I was somewhat troubled in the past that, as I perceived it, the ACP was being run largely by a small subgroup, or perhaps in-group, of influential people

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 Study Groups & Continuing Medical Education
 Stanley Leiken, M.D.

Administrator

Mrs. Nancy Hall
 P.O. Box 253
 Ramsey, New Jersey 07446 USA
 ☎/FAX (201) 825-3138
 E-mail childanalysis@compuserve.com

Newsletter Editors

Denia Barrett, M.S.W. and Barbara Streeter, L.P.C.C.
 2084 Cornell Road
 Cleveland, Ohio 44106 USA
 ☎ (216) 421-7880
 FAX (216) 421-8880
 E-mail bus@po.cwru.edu

Note to contributors: Send contributions to Denia Barrett or Barbara Streeter at the address above. Deadlines are April 15 and October 15, six weeks before our publication dates of June 1 and December 1. E-mail is the mode preferred. When articles are sent via the postal service, file copies on 3.5" disks along with hard copies are very much appreciated. MS-DOS format files (e.g., WordPerfect, Microsoft Word) are preferred (including those created under Windows) but Macintosh format files are also acceptable.

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who seemed to hold the reins in perpetuity. I should like to see that too relegated to the past. During the past fall and winter I distributed a questionnaire to the members of our Executive Committee and to our Committee Chairs containing items I had had placed on the agenda of the mid-year Executive Committee in October 1999, but for which no time had been found for discussion at that meeting. It addressed the issues of promoting free and open discussion in the administration of our organization, the manner in which we nominate candidates for office, broadening participation in the workings of the ACP, and reaching out to new potential members. The response to the questionnaire was overwhelmingly in favor of pursuing these matters further. I reported this to the Executive Committee when it met on April 14, 2000. Time was not available for discussion of these items at that meeting, but they will be discussed further within the membership at large.

We have a wonderful organization. I have made many dear friends from among its members, and I hope to make more in the years to come. I look forward to collaborating closely with my fellow officers and with the rest of the Executive Committee and with the Chairs and Members of the various Administrative Committees. I also invite you, the members, to actively participate in running our organization during the next two years. Your comments, suggestions, opinions, and criticisms will always be welcome and will be given full and careful consideration. It is a pleasure and a privilege to serve such a fine organization and its wonderful members.

Editors' Note:

The minutes of the ACP Executive Committee meeting held April 14, 2000 and the Annual Business meeting held April 16, 2000 are not included in this edition of the newsletter, pending discussion of the Executive Committee regarding the timing of publishing minutes. Joseph Bierman, M.D., Secretary at the April 2000 meeting, completed his preparation of the minutes and bears no responsibility for the publication delay.



LETTERS

TO THE EDITORS

The following is an extract, slightly amended, of a letter that was submitted to the now Past President of the ACP for discussion at the last meeting of our Executive Committee. A full agenda precluded its consideration at that time and so it will have to be carried over as unfinished business to the next meeting of the Executive Committee. December is a long way away and so I would like to share it with our membership to call attention to the situation in the hope some will have ideas how to constructively approach the problem. Incidentally, a copy of the original letter was also sent to the Chair of the Board on Professional Standards of the American, now retired from that role, as he is also an ACP member, currently ACP Secretary-elect.

“Recent weeks have seen attention directed to the use of psychopharmacological agents with toddlers and preschoolers. The response of the National Institute of Health has been to propose an extensive trial of these drugs on an experimental basis using large numbers of very young children as subjects for the project. As an organization with particular expertise in issues of child development, I do believe we should speak out in opposition to such experimentation, seeking instead, the prohibition of the use of such drugs in preschoolers. How many perfectly normal toddlers could be seen as fulfilling the criteria for pathological hyperactivity?

All now know and recognize the tremendous growth of the brain that occurs in the years from birth to six. Not so well known to others than ourselves is the growth of feelings of aggression and excitement during this period as well as the growth and integration of a conscience. Interference with perception of affects, of feelings during this period would interfere with mastery of aggression and excitement, and the proper integration of a fully functioning conscience.

I do believe we should make known our concern about experimentation that could interfere both with brain growth and personality maturation. I am not talking about immediate ‘side effects’ but rather thinking of deleterious long term effects that would not be manifest except many years down the road.

I do believe we should speak up in opposition to the power of the pharmaceutical industry, the less than neutral attitude of the National Institute of Health regarding child psychopharmacology. Could we not urge our members to write their Congressmen, to use their influence to seek activity from the many psychiatric organizations to which they belong? I do not understand the politics involved in such issues, but I am sure others of our members do.

Thank you for your consideration of this issue.”

Respectfully submitted,
Robert A. Furman, M.D.

April 14-16, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

REPORTS OF SCIENTIFIC MEETINGS

PLENARY SESSION

TECHNIQUES OF RECONSTRUCTION OF PRE-VERBAL TRAUMA

Introduction: Jill M. Miller, Ph.D.

Recorder: Cheryl Straus-Witty, Ph.D.

This year's Plenary Address titled, "Techniques of Reconstruction of Pre-Verbal Trauma" offered skillful and moving case presentations by Robert A. Furman, M.D., and Lorraine Weisman, L.P.C.C. The two case presentations illustrated the far-reaching effects of pre-verbal trauma in the analyses of a young boy and girl. Jill M. Miller, Ph.D., the moderator, introduced the participants and provided an edifying introduction to the topic which is presented in its entirety below.

Techniques of Reconstruction of Pre-verbal Trauma

Introduction: Jill Miller, Ph.D.

Our topic today is a rather complicated one. A number of intertwining issues are involved, many of which raise questions of interest to us. I will try to briefly outline a few of them. First is the concept of trauma. In the general community, its meaning has been stretched far beyond the original intent as most any experience which causes some discomfort can be viewed as "traumatic." However, for our purposes, I think it is safe to assume that we are referring to the more classical definition of trauma, the overwhelming of the ego by excessive stimulation, rendering it helpless. We can also probably agree on the symptomatology of trauma: persistent high anxiety, distortions or defects in ego functioning, regressions or developmental delays, avoidance of certain situations or feelings, sleep disturbances, mood shifts, and so on. However, we also know that this picture cannot in and of itself be differentiated from other psychic stresses and strains. We can also view an event as an outside observer and assume that it must have been traumatic, but the fact is that psychic trauma cannot be defined objectively. It is only the child who can tell us what experience or aspect of a particular situation was traumatic for him. But, for a child to tell us, does he need to be able to remember the experience? And if the experience occurred prior to the development of language, how exactly does he tell us?

This leads us to the next question; what is the nature of memory? Procedural or implicit knowledge involves memory systems which operate automatically, are unconscious, some would even say nonconscious, and are often associated with early memories. Joseph and Anne-Marie Sandler (1997) locate procedural memories in what they have called the past unconscious, or "the black box," as opposed to the present unconscious, and believe that memories and representations in the past unconscious are

irretrievable. However, they suggest that work with children has shown that procedural memories from an early age can persist in the forms of patterns of behavior repeated in later life, and that these can be observed, albeit in disguised form, in the transference. In contrast, declarative or explicit memory refers to knowledge that is available to consciousness, can be recalled as coming from the past, and can be communicated to others directly. Thus, it would seem that one distinction between these memory systems could be the way in which past experience might be communicated, declarative memories through language and procedural memories through behaviors. Then there is autobiographical memory. Considered to be a form of declarative memory, it is the ability to represent oneself as having participated in an activity at a given time and place in the past. Developmental researchers have generally found that children are unable to provide descriptions of personally experienced events that occur prior to the onset of language. However, the emphasis in these studies has been on verbal communications. Ted Gaensbauer (1995), who has done extensive work with children who have suffered single episodes of pre-verbal trauma, has demonstrated that children can convey through play reenactments the strong impression that they were communicating what they felt had happened to them personally. In other words, children do demonstrate the capacity to describe personal events from the pre-verbal past, but they use action as a vehicle to communicate as opposed to language. Gaensbauer goes on to say that, "as words became available, each of the children (in his studies) was able to superimpose verbal description on the nonverbal representations in ways which facilitated understanding and communication of the experience" (pg. 143).

However, we must ask what is the nature of these remembrances? Memory is neither exact nor infallible, and is vulnerable to suggestion, which brings us into the whole false memory debate. John Morton (1997), the Chairman of the British Psychological Society's Working Party on Recovered Memories, is of the opinion that "some recovered memories are false but some are likely to be genuine. This means accepting both that false memories can be created and that memories of real events can be forgotten and then recovered" (pg. 63). To complicate matters further, we know that the developmental process itself both impacts and transforms internal representations. Not only do early experiences color later ones, but later

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experiences add significance and meaning to earlier ones retrospectively. In addition, representations can be distorted by fantasy and defense. So, what exactly is true and what truth are we talking about? There is historical truth, meaning what actually happened, and narrative truth which results from the process of remembering and constructing a version of past events. In other words, events which may or may not have happened, but are regarded as psychically true for the individual. Therapeutically, does the difference matter?

As child analysts what are we to do when we suspect, or even know from historical reports from family, that past trauma has occurred, especially a pre-verbal trauma? As far as memory is concerned there are clearly a number of distinctions to make – “between what actually happened, the fantasy component in the memory, the memory as modified during the process of development, the memory as reported by the patient in the analysis, and the memory as actually experienced” (Sandler, 1988, pg. 2). Within these complicated issues it seems clear that there is a difference between remembering and what we reconstruct in analysis, and that reconstructions are actually co-constructions of the analytic dyad. Furthermore, these constructions are not necessarily identical to the actual events. However, actual events, especially traumatic ones, shape and influence ways of functioning and relating. Thus, in analysis what are we aiming to do? Are we concerned with uncovering the trauma, in whatever way it is “remembered,” and is it this process which is healing? Or is it something else?

Hansi Kennedy, in her 1971 paper on reconstruction, expressed her views, controversial at the time, that as child analysts we are less concerned with the specific traumatic event. Rather, we “attempt to catch and verbalize the affective significance and atmosphere of a period of life” (pg. 394). In other words, we deal with patterns rather than with events. Kennedy went on to say that “although in the transference past object relationships and experiences may be relived in some form, the interpretation of the transference aims at showing the child why he tends to function in a particular manner at the moment, and not at the reconstruction of the past, but this may be brought in for purposes of adding conviction” (pg. 400). Thus, the importance of constructing a picture of the past is to understand the present and, I would add, for the benefit of the future.

This leads us to our final series of questions which pertain to technique. Not only is there the issue of what we reconstruct and why, but when and how we do this. In this light we can examine how it is that we gather our data and understand the material presented to us. Then is the issue of how we intervene, be it by interpretations leading to insight; through verbalizations which have a role in organizing experiences into more comprehensible and meaningful ones; by techniques directed at the fragility of the ego and maldeveloped internal self and object relationships; or

through the use and understanding of the multiple dimensions of the analytic relationship. Included in how we intervene is the issue of what we say. When are we constructing or reconstructing? When are we leading or even suggesting? In addition, there are the roles of child and analyst as observers of and participants in the analytic process. A given within this overall process is the ability to tolerate not knowing, at least until one of the parties knows enough to be able to communicate in ways which are meaningful and resonate affectively.

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Case Presentation

Presenter: Robert A. Furman, M.D.

Regarding Dr. Furman’s clinical presentation, to protect his patient’s confidentiality, there will be no published material. It is a case report of six years analysis with an atypical boy from age 8 to 14 uncovering, constructing and partially working through an overwhelming at the end of the first year. Dr. Furman will, for scientific purposes, send a copy of the presentation to any ACP member who, in requesting the material, would accept the responsibilities of treating the material with the same constraints of confidentiality operative with any clinical material heard in his/her consulting room, would use the material just for him or herself, and would destroy the report after reading it. (R. Furman, M.D.)

Open Discussion

Dr. Van Dam interpreted the audience’s initial silence following Dr. Furman’s presentation as a sign of how overwhelmed everyone was by the richness of the presentation. The audience revisited the questions of what defines a traumatic event; how were the child’s transference feelings and enactments of the trauma interpreted at various stages of the analysis and in relation to external events of his life; how much weight should be given to the patient’s perception versus the actuality of traumatic events; how was the child’s development and, specifically, his ego mastery

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affected by the trauma; and how is he currently functioning with regard to his object relations and sexuality? The audience was clearly moved by the work of the patient-analyst dyad.

Tina, The Analysis of a Preverbal Trauma

Presenter: Lorraine Weisman, L.P.C.C.

Mrs. Weisman presented the analysis of a three-year-old girl who was suspected of experiencing a pre-verbal trauma in the form of a sexual overwhelming.

The analysis was preceded by treatment via the parent and two years in the Hanna Perkins Toddler Program.

The original diagnostic impression had been of a very early disturbance with developmental interferences of such severity that questions were raised about retardation or organic deficits. By age three, after the above-mentioned therapeutic interventions, this picture was modified resulting in a more structured personality. Analysis was indicated due to interferences in ego functions, need satisfactions and a marked lack of drive fusion. She had many fears and inhibitions as well as uneven development and anxious states around separations and changes.

Tina was a healthy baby who was developing motility and had a happy disposition until eight months when she became lethargic, refused to eat any solid foods and eventually developed a serious anemia from ingesting only milk.

The original traumatic events took place during a period of time when the mother was distracted and depressed and unable to cathect her infant.

There was ample material in the analysis to indicate the child had experienced intrusive overwhelmings. The child's perception of her experiences was reenacted during the early analytic hours. The mother was in the therapy room during Tina's first five months of treatment while Tina showed how she had been intruded upon, enraged by her mother's failure to protect her and confused by the interferences in integration and differentiation the trauma produced. When she could differentiate herself from the mother, she could attend her analytic hours without mother in the room.

Her presenting symptoms included an eating disturbance with many food fads and refusals, but accompanied by enormous greediness and saving up of sweets. She somatized affects manifested in her stomachaches, headaches and vomiting. She had fears of things going into her mouth, which she brought into her analytic hours via a passive into active defense wanting to be the active participant in her recreation of past trauma. Her oral, anal and phallic level fantasies were influenced by her experience and in turn colored her relationships with intrusive, bossy and envious components. She used her treatment to analyze her fantasies, defenses and the severely harsh superego that resulted.

The analysis helped her integrate a more feminine body image after she had defensively wanted a male body to feel less helpless. The intrusion of an illness at age four had interfered in her oedipal development causing both a regression to anal level concerns and a premature repression of oedipal wishes which eventually returned via the treatment.

Introjects of her abuser and other pertinent figures in her early life were analyzed which helped her to develop a more integrated personality.

By age seven, Tina wanted to terminate her analysis. She had entered into latency, was able to identify with healthy adults in her life, had several sublimations in which she excelled and was developing age appropriate relationships. Her harsh superego had calmed and was no longer a constant interference in her self-esteem.

When external issues in her life stimulated internalized conflicts and revived issues from her early abuse, she returned for follow up treatment in the form of once or twice a week psychotherapy at ages 8, 10, 12 and 13.

As the external issues were resolved in each of these follow up periods and her internalized conflicts were reworked she was able to leave treatment successfully. She had to confront issues of feeling robbed of her original good body feelings. She worked hard to overcome her wish for revenge against the abuser. She successfully attempted to modify her super-ego's responses against her fantasies involving revenge and being the active, powerful one in control. Her passive wishes were most difficult for her and she used her follow up work to better understand her feeling of emptiness caused by the original trauma and her wish to fill up with excitement which her super-ego could not tolerate.

At times she repressed her feelings toward her abuser and displaced her rage and feeling of betrayal to teachers and others. She reworked these occurrences in the follow-up work.

As Tina entered into adolescence, she again reworked the integration of a less damaged body ego. She dealt with her defense against passive wishes and excitement again. She was able to use the treatment to avoid a learning interference caused by her fantasies. She was able to tolerate separations and losses. Tina excelled academically and in sports and was able to maintain age adequate relationships with peers and parents.

Residuals of the devastating effects of her original trauma remained in the form of a harsh super-ego, continued use of somatization and breakthroughs of aggression from all levels that occasionally interfered with relationships and sublimations. However, without an early intervention, this talented, witty, intelligent girl would have had far greater challenges to face.

Open Discussion

The discussion was quite animated following the presentation as the audience grappled with the need to understand the depth and far reaching effect of such early

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REPORTS ON THE WORKSHOPS

“LITTLE ORPHAN ANASTASIA, PART TWO: DEVELOPMENTAL GROWTH, LOVE AND THERAPEUTIC CHANGE”

Presenter: T. Wayne Downey, M.D.

Reporter: Elizabeth Reese, LCSW

Dr. Downey presented for us the second year of the analysis of Anastasia, a now seven-year-old formerly encopretic adopted Russian girl. In 1999, Dr. Downey had given us extensive history and the first year of this analysis. We see that Anastasia, despite a very troubled beginning, had been able to benefit enormously from the beginning phase of treatment. Now we get to see the middle phase of this treatment. This report will include both papers.

These papers are of particular interest as there are increasing numbers of international adoptions. Child psychoanalysts will see more of these children who, in addition to the issues of being adopted, will carry many other scars from their varied orphanage experiences and transition to parents of a different culture. Dr. Downey's papers raise many significant theoretical issues as well as giving us a lively account of this child's analysis.

Anastasia's first month and one-half of life were spent in the hospital because of a suspected intra-cranial hemorrhage (that was never confirmed) during birth. Then she spent a month with her mother who was unable to care for her and placed her in an orphanage. There the care was

sterile but adequate; there was no primary caregiver – thus frustrating her need for an exclusive attachment, which facilitates development. While at the orphanage, Anastasia suffered an intestinal infection that caused diarrhea eventually leading to constipation. Treatment for the intestinal infection included frequent shots of antibiotics in her buttock with large gauge needles. The orphanage lacked current benign medical resources for children. At age nine months, Anastasia was adopted by an American family with minimal transition. Her adoptive parents noted a developmental delay of about five months due to a severe lack of stimulation including long hours lying in a crib or tied in a sitting position. Anastasia withdrew from physical closeness and affection, tantrumed often with little or no apparent provocation, had extreme difficulties sleeping, was physically aggressive, and suffered severe encopresis. She would only have a bowel movement every 12-14 days with a cycle of intense agitation and irritability leading up to each bowel movement followed by a brief period of quiet. The adoptive parents, realizing the severity of Anastasia's problems, sought medical assessment, which unfortunately led to more invasive procedures only exacerbating her symptomatology.

At four years old, she received six months of twice-weekly psychoanalytically-informed psychotherapy during which time she showed steady progress. Thus, when her therapist left the area, he recommended child analysis, which the family pursued. The adoptive parents were exceptional in their evenness and commitment to Anastasia. Their warmth, nurturance, and persistence are a strong ally to the analysis.

As Dr. Downey says, “Anastasia presents us clinically with an ‘experiment of nature and nurture,’ the result of the impingement of random acts of fate upon and in relation to her particular [set] of instinctual and nascent ego attributes.” Anastasia possessed many ego strengths fostered by the secure, adoptive family that allowed her to benefit from analytic treatment.

To help us understand how Anastasia benefited from this treatment, Dr. Downey puts forth three interrelated theoretical concepts to reconsider. He presents a developmental definition of actual neurosis as, “a state of overwhelming passivity in which the infant struggles but fails in achieving any sense of mastery.” Anastasia's neurotic sequela to the actual neurosis is the use of frenetic activity to ward off passivity which signals feeling states of early original pain. Through object relatedness and

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trauma on the young child's personality structure, somatic functioning and interpersonal relationships. Mrs. Weisman emphasized the need to allow the patient to lead her analyst to an understanding of the experience independent of the external event. In response to questions regarding the interpretation of the child's experience in the analysis, Mrs. Weisman added, “you have to observe how the behavior affects you (the analyst).” The discussion underscored the goal of the analysis to rework the conflicts and the ramifications of the trauma in an effort to reestablish the balance of the forces in the personality and to set the child's development back on track. The afternoon discussion groups allowed for further in-depth exploration and discussion of these themes in the rich case material and in our clinical work.

Little Orphan Anastasia, Part Two . . .

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interpretation, the child can begin to differentiate the present object relations and her world from the past.

Second, Dr. Downey looks at Hartmann's (1958) concept that ego function although biologically driven, develops into the conflict free sphere through adequate object relations. Anastasia was fortunate that despite "minimal conditions of relatedness," she developed vision, hearing, memory, and diffuse social bonding, relatively free of developmental impairment or neurotic conflict.

Thirdly, Dr. Downey shows us that the positive parental and social environment enhanced Anastasia's conflict free ego functions but that only a "specialized interpretive and 'new object'" (Downey's term derived from Loewald (Loewald 1960)) aspects of analysis would free her from her neurosis allowing her to develop a capacity for sublimation, further structuralization of her psyche and foster mastery of instincts.

Anastasia's encopretic symptom responded quickly in the first year of analysis to interpretation. Her intelligence and imagination allowed her to communicate in words, fantasy, and play metaphors her complex issues. She had considerable recall of her orphanage experience – supplemented by the parent's information – to bring to the analytic work. The first year of analysis yielded an understanding of the importance of her impacted stool that contained the many facets of her early trauma but also functioned as a part object substitute. Thus, the symptom was also adaptive and organizing. Freed of this neurotic symptom, the analysis could now proceed to foster development with a reworking of object relations, modes of drive discharge, and defensive repertoire through further understanding of the symptoms and their effect on the formation of her character.

In Dr. Downey's 2000 paper, he further challenges us theoretically to look at the narrow definition of therapeutic action, especially the exalted position of transference changes effected by the transference object, the analyst, and the devalued aspects of developmental change. He proposes the "new object" (Downey, 2000b) as containing both transference object and developmental object. He elaborates this as the "shift in understanding therapeutic effect as emanating from the treatment object relations and analytic matrix as well as from transference interpretations. Further, he posits that we need to continue to explore therapeutic change in psychoanalysis that our current theory does not explain.

In the clinical material, we see Anastasia utilize the "new object" both transference and developmentally to understand and integrate her trauma. She is no longer fettered to a sadomasochistic part object where hate and rage fueled aimless activity. She can begin to love and be loved gaining mastery and pleasure in her body. There is an interesting interplay in the material of developmental change and transference change. Dr. Downey shows that when we think we are in the developmental, we can

suddenly see the transference and vice versa. It was fascinating to watch Anastasia grow in this analysis from a "poopie," "butt," "wild child" to a differentiated and psychically structuralized latency age girl.

Dr. Downey also shared with the participants photographs of Anastasia, the orphanage, and some of the complex block play of her later work in analysis.

Time was brief for our discussion and also did not permit me to recognize by name the participants who commented on this valuable paper. Several people wondered how this child sustained any capacity for involvement with people. Dr. Downey explained more of the adoptive parents' ability to remain constant for this child. He pointed out that they were unusually able to remain calm with Anastasia in the face of severe provocation possibly aided by her not being a biological child. One participant speculated about the tact needed in giving an interpretation, which so easily could be experienced by Anastasia as intrusive or invasive leading to retraumatization. Dr. Downey acknowledged this difficulty especially early on in treatment when Anastasia's gaze was averted and she also disliked being looked at. Further Dr. Downey remarked on Anastasia's exceptional capacity for speech, which had enabled her to record and remember the early traumatic events making this accessible to analysis.

This report just begins to capture the richness of this analysis and Dr. Downey's theoretical explorations. The two papers are extremely interesting, and I hope this report will encourage you to read them. The first of these has already been accepted for publication in [The Psychoanalytic Study of the Child](#).

**CHILD ANALYSIS
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Editors: Denia Barrett, Elizabeth Daunton and
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Editorial Advisors: Thomas Barrett, Elizabeth Fleming,
Erna Furman, Robert Furman, Ruth Hall and Deborah Paris

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For Subscription information contact:
Deborah Gray, Assistant Administrator
or
Barbara Streeter, Managing Editor

Hanna Perkins Center
2084 Cornell Road, Cleveland, Ohio 44106
☎ 216-421-7880
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April 14, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

THE EFFECT OF TRAUMA ON THE DEVELOPMENT OF A YOUNG GIRL

Presenter: Barry Landau, M.D.

Reporter: Kristen Bergmann, LISW

On Friday, April 14, 2000 Dr. Barry Landau, M.D. presented a case study of a four-and-a-half year long analysis of a sexually traumatized prelatency girl. The parents consulted Dr. Landau due to school difficulties of their daughter, B., and an extended evaluation was conducted. There was a very teasy older sibling in the family along with overstimulation of the children. Through the evaluation the parents clarified their concerns about their child care arrangements and were able to improve this arrangement. After the changes it became clear that B. had been sexually traumatized. Soon after this disclosure a recommendation for an analysis was made. This intensified their feelings of guilt in that the increase in frequency was felt as an even larger failure in their parenting. The intense guilty feelings of the parents were evident throughout the treatment. The evaluation of the girl indicated anxiety, phobic symptoms, enuresis, and over-stimulation, with extensive use of defensive avoidance, which interfered with development. Psychological testing was done. The results indicated that B. was of average intelligence, which Dr. Landau felt was an underestimate based on his observations.

During the beginning stages of the analysis B. tried to provoke a repetition of the sexual abuse through games and was disappointed when the analyst wouldn't play and wanted to talk instead. Around separations there were fears of castration and longing for the analyst. A change in the analyst's appearance brought up castration anxiety and prompted a change in the child's appearance. At times the analyst felt hesitant in interpreting the trauma so as to avoid overwhelming B. with interpretations, yet Dr. Landau was aware of the possibility of being insufficiently active in interpreting. The participants in the workshop discussion felt that this is a fine line that all of us are aware of at one time or another in working with sexually traumatized and overstimulated children.

The work with the parents was described as challenging and frustrating for the analyst. The sessions were repetitive with much complaining about the child and teasing between the parents. The analyst's relationship with the parents helped maintain the analysis. During the course of the analysis, the issue of the fee was raised along with the parents' feelings of ambivalence.

B. brought a dream in which she was tricked which was linked to being tricked during the sexual abuse. She wanted to have all the power and make the analyst powerless. At times she would taunt the analyst to convey how it felt when no one listened to her. She wanted to be in control of her scary fantasies in playing them out during the sessions and look at other people's aggression rather than her own aggression.

Well into the analysis, the child came to the positive oedipal position. During one session she acknowledged her aggression towards her mother and then regressed to a

preoedipal relationship with her mother. Her oedipal feelings in the transference became more prominent. As her fear of competitive, aggressive and sexual impulses was analyzed she was more able to stand up to her teasy older sibling and her relationship with her father improved. She was anxious about growing up, afraid of having babies and of losing things.

Leading up to her decision to terminate she held onto a pseudo self-esteem at being away from her parents and analyst during the summer holiday which defended against her fear of being unprotected. She discussed saying goodbye to people and appeared to be practicing for the termination. She became more active in the interpretations even though this did have a defensive quality to it, i.e., trying to preempt exploration of her anxieties regarding termination. She was concerned that her parents would want her to grow up before she was ready.

There was a re-emergence of the same conflicts during the termination. She was afraid that her analyst would get angry at her wanting to terminate but seemed very determined. She wanted to leave before there was another separation, which was interpreted. Dr. Landau agreed to the decision to terminate since there had been many gains during the analysis: the emergence of latency with a marked improvement in peer relations, her defenses were working better, and there was a marked improvement in her academic performance. Dr. Landau acknowledged that there may be a need for further treatment at adolescence when conflicts would likely re-emerge.

A lively discussion was ongoing throughout the presentation. The issue of reporting sexual abuse and the predicament of the analyst in such cases was discussed. Specifically addressed was the wish to maintain the child's trust and avoid divulging confidential material yet the importance of validating what happened to the child as a serious matter which is acknowledged by the adults. There is a concern that any investigation of the abuse could feel like a repetition of the trauma to the child. In this case, the trauma was reported by the parents and the abuser confessed to the authorities, thus obviating any need for the child to be questioned.

It was suggested that the title of the paper could also include the issue of betrayal throughout the child's life at not being protected by her parents from overstimulating experiences and being disappointed by her analyst at times of separation. The audience felt this was a wonderful example of how overstimulation can interfere with academic performance and a demonstration of how analytic treatment can free the child to function at her full potential. There was a call for collaboration among analysts to report these kinds of improvements through analytic treatment.

April 14, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

ANNA KARENINA – A BOOK ON MOTHERS: EFFECTS OF EARLY MATERNAL BEREAVEMENT ON THE CAPACITY FOR MOTHERING

Presenter and Recorder: Erna Furman

My contribution relates to the theme of our meeting indirectly. It focuses on the parents and parent-child relationships, rather than the children, but, like our theme, addresses the role of the earliest experiences in their lives which underlie and help shape their parenting – the preverbal factors which facilitate or impede their ability to invest their children and to create a good enough milieu for their survival and personality growth. The topic also represents one of my major areas of scientific interest, is chosen for its literary form in part to lighten the painful heavy implications of its content and in part because I have loved Tolstoy's work since my adolescence. The paper itself is a chapter from my book in press On Being and Having a Mother.

Every work of art reveals many aspects of humanity. With Anna Karenina, I chose to focus on its deeply insightful portrayal of mothers and mothering, in part because the artist himself emphasizes it so strongly. We get to know three mothers: Anna Karenina herself, Dolly Oblonsky, Anna's sister-in-law, and Kitty, younger sister to Dolly. Dolly and Kitty, especially, maintain close relationships with their parents. Anna is described as "brought up by an aunt" (Tolstoy, 1876, p. 791) of whom she thinks only once as a potential but quickly dismissed haven, just prior to suiciding; there is no mention of her mother or father.

We meet Anna arriving in Moscow, worrying about and missing her then eight-year-old son during their first separation. While succeeding in her mission of mending Dolly's marriage, her need of her son becomes replaced by her need of a man. She enthralles Vronsky and he follows her to her loveless home in St. Petersburg. Their affair not only meets Anna's adult sexual needs but also makes up for the developmental loss of her son. Reuniting with him made her realize he was no longer her cuddly, bodily intimate three-year-old – an irredeemable narcissistic depletion. She invests her pregnancy with Vronsky's child ambivalently, certain to die during childbirth, and is then unable to mother little Anna, even though she includes the infant in her menage with Vronsky. At that point her son is left and even forgotten. Despite the riches, glamour and superficial romance of the lovers' life, an increasingly deep chasm opens up between them around the question of having children. We learn of this unfolding tragedy through Dolly's eyes during her visit with them.

Dolly, left alone and impoverished by her philandering selfish husband, finds all her happiness in her six children and bemoans the recent death of her seventh baby – her first time without a nursling since her marriage. In contrast to Anna, her investment in her children is well

in tune with their different developmental needs, yet she can gain sufficient self-love and gratification from the small joys they provide. She "feels she has charming children, all six of them, each one in a different way but all of them rarities – and she was happy in them and proud of them." (p.280) Dolly's earlier admiration and envy of Anna fade as she quickly assesses Anna's lack of maternal investment in her daughter and the hollowness of the lovers' relationship. Vronsky shares his yearning for a legitimate heir and begs Dolly to persuade Anna to take steps towards getting a divorce. Anna shares her use of birth control and determination never to have more children, ostensibly for their sake and in order not to lose her attractiveness through child bearing. Actually, Anna's own capacity to love is increasingly overtaken by aggressive forces from within. She has begun to rely on morphine to calm herself. More certain than ever of her own wealth as a mother and anxious to get back to her children, Dolly leaves right away.

Anna resorts to increasingly desperate means of procuring external supplies of love but is unable to trust or use them. Her inner resources of love and self-love dwindle and her relationships regress to sadomasochistic interplays. Her suicidal ideas begin as a provocative threat to engage Vronsky but end in her throwing herself under a moving train. In doing so the ominous forebodings of her longstanding repetitive nightmare turn into reality. For the reader, however, the questions about the nature of mothering and the struggle to invest one's children lovingly live on as related through the parental experiences of Kitty and her husband Levin.

We follow Kitty's adolescent attempts at object removal and inevitable disappointment as she loses her first love, Vronsky, to Anna and matures to marry her longstanding suitor Levin, a dedicated family man although he too, like Anna, suffered early parental bereavement. Already in the first weeks of her pregnancy, Kitty is so deeply in tune with her upcoming mothering that she insists on "mothering" Levin's dying brother. She soothes and contains his disintegrated personality so effectively that she helps him to love and feel loved and to die in peace. Helped by her mother, she copes with a difficult labor and immediately invests her newborn. His early months are not devoid of growing pains but Kitty uses her mother and sister Dolly's advice to overcome some difficulties with nursing without losing her joyful sense of fulfillment and pleasure in her son's development.

Levin has a much harder time. Undone by Kitty's
(Continued on page 11)

April 14, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

THE ANALYTIC TREATMENT OF AN ELECTIVE MUTE BOY

Presenter: Viviane Green

Recorder: Frances Marton

Viviane Green presented the case of Leo, an elective mute boy, who had been referred for an assessment by his school's speech therapist when he was six years old. Although refusing the initial recommendation for treatment, the parents agreed to psychoanalytic treatment for their son when threatened with the possibility of his being held back at school. Throughout treatment, Mr. and Mrs. T. maintained their attitude of skepticism.

Ms. Green briefly covered significant factors regarding family history. Having a three-year-old sister, Leo was the second child of Mr. and Mrs. T. Details of Leo's early history were not recalled in any great detail by mother who had been preoccupied with family of origin conflicts since the time of Leo's birth. Leo had recurring ear infections which resulted in intermittent hearing loss and two operations. Grommets were inserted when Leo was eighteen months old and again when he was three-and-a-half years old. At two-and-a-half, Leo was briefly

hospitalized for asthma, which coincided with beginning to attend nursery school on a full time basis. Mrs. T. reported that Leo had no overt separation difficulties when he attended nursery school. Leo was close to an au pair who helped care for him from the age of nine months until three-and-a-half years. Several au pairs followed.

Leo's speech development was reported to be within the norm, however, there were some noteworthy aspects with regard to language development. Mrs. T. preferred French as her language of choice. In keeping with her family of origin values, French signified the language of education and culture. Mrs. T. spoke French to her children and English to her non-French speaking husband. Mrs. T. secured primarily French speaking au pairs and insisted the children be schooled in French. However, English was reported to be Leo's first language. Leo was selective in his mutism. He talked freely at home, to his paternal grandparents, and to other children. He would not talk to teachers at school or to other unfamiliar adults, including the therapist.

One of the challenges of treating a child who will not speak includes working with the child's nonverbalized transference and the countertransference response. Ms. Green described Leo's hostile, excitable and controlling relationship to her during the first period of treatment, which lasted thirteen months. Although Leo did not verbally speak during this time, he was very much present in the treatment and he spoke volumes through nonverbal communications. He came willingly to his sessions but frequently would shut the therapist out of his play and the playroom. His provocative and sometimes destructive behavior, especially in response to breaks in the treatment, left the therapist feeling frustrated and disempowered. Leo attempted to engage and enrage the therapist through irritating and hostile behavior, thereby attempting to recreate the real and familiar scenario of his battling relationship with his mother. The therapist's desire to understand Leo and the unanticipated nonexplosive response from the therapist in relation to his provocative behavior, eventually led to a growing sense of safety in the therapeutic setting and more reciprocal forms of distanced and shared play. Initially, Leo engaged with the therapist through lively gesturing and babbling vocalizations. These spontaneous interactions resulted in shared pleasure and also shared frustration. His babbling could not always be understood by the therapist and the therapist could not read his mind. This ushered in the next phase of treatment in which Leo began to talk to the therapist, thereby bridging the gap between self and other.

(Continued on page 12)

Anna Karenina . . .

(Continued from page 10)

suffering during childbirth and exhilarated by the miracle of a new life, he cannot integrate the little stranger into the world of his relationships. Unaware of his hatred of his son, he spends months torturing himself with philosophical uncertainties about God and love. He is often so close to suicide that he dare not carry a rope or gun lest he use them to kill himself. Ultimately, and with the help of Kitty's aware, patient empathy and support, he finds his good feelings, wins the inner battle of ambivalence and becomes a loving father. Unlike all the other parental couples in this novel, Levin and Kitty become a threesome, a real family with appropriate mutual investments, space for each along with togetherness, and shared enjoyment. It is a hard won but happy ending.

Tolstoy, parentally bereaved in his earliest years, achieved only a short period of such happiness in his own life. How fortunate for us that that he could draw on his inner resources to help us know and feel how hard it is to be a mother or father and how much we need the experience of being parented to become a parent.

Reference

Tolstoy, L. (1876). *Anna Karenina*. Translated by Joel Carmichael. New York: Bantam Books, 1960.

The Analytic Treatment of . . .

(Continued from page 11)

Leo's progress in treatment could be seen in his increasing use of symbolic forms of exploration and representation. His play shifted from activities where no fantasy content was conveyed to drawings and activities which had symbolic meaning and expressed curiosity and interest in the therapist. Leo first allowed the therapist to hear him speak with the help of his father. Through the use of a tape recorder, Leo tape recorded a sentence about his wish to phone his paternal grandmother. Then he indicated through gestures his desire to have the therapist's phone number. Leo phoned the therapist in the evening leaving a message that he would see her after the weekend break. Gradually, Leo began to speak more spontaneously inside and outside the sessions.

Once Leo began to talk, Mr. and Mrs. T wanted to stop treatment. During the short termination phase, Leo revealed some of his thoughts and fears. His material portrayed a sense of himself and his parents as "weird" and showed his preoccupation with attempts to assert phallic potency and a fear of belittlement. Unfortunately, these issues could not be elaborated and understood more fully through a longer course of treatment. The therapy had to address termination issues and saying goodbye.

In the discussion, participants shared their experiences of working with children with elective mutism which highlighted the different uses and meanings of the symptom. With regard to Leo, one factor that influenced his mutism included his mother's past and present inability to respond to Leo's needs. The parents speaking different languages to Leo was thought to be another factor. Particular attention was given to the role of the father in bringing Leo to treatment and of Leo's use of the father as a bridge to verbally communicating with the therapist. The therapist's tolerance of Leo's aggression and regression was essential to their developing a relationship. The therapist's desire to understand Leo contributed to the surfacing of his desire to be understood and to verbally communicate in the sessions. As a result of the relationship, Leo could tolerate the therapist's eventual expressed frustration and intolerance of not understanding his babbling when he didn't use words and her wish to understand.

Questions were raised concerning technical issues and of Leo's progress in treatment. Does there need to be a specific focus on the mutism? How much was the change related to the interpretive role of the therapist and how much was related to the use of the therapist as a new developmental object?

Journal of Child Psychotherapy

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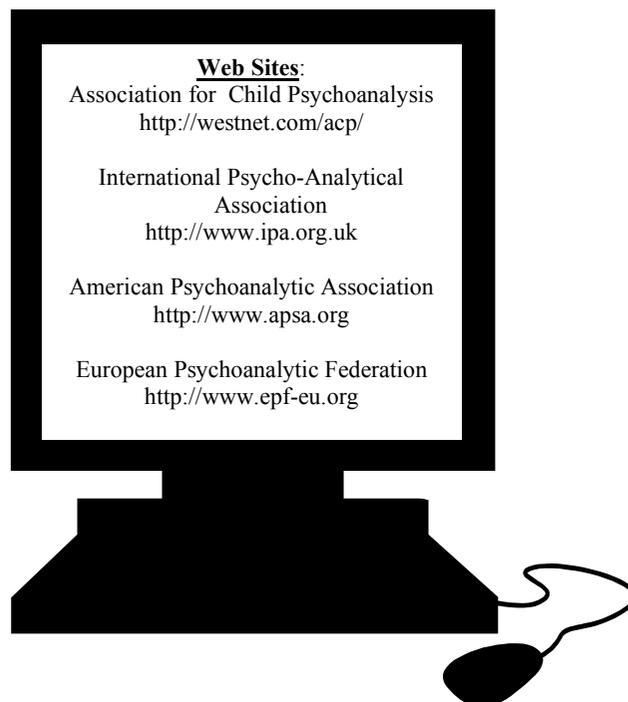
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European Psychoanalytic Federation
<http://www.epf-eu.org>



April 14, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

VULNERABLE CHILD: PSYCHOANALYTIC INTERVENTION IN NURSERY SCHOOL

A Summarized Report by M. Hossein Etezady, M.D.

Chairman: Theodore B. Cohen, M.D.

Co-Chairman: M. Hossein Etezady, M.D.

Presenter: Donald Rosenblitt, M.D.

Discussant: Barbara Shapiro, M.D.

Editors' Note: For reasons of confidentiality, the following is an abbreviated version of the summarized report prepared by Dr. Etezady.

Dr. Rosenblitt presented work being done at the Lucy Daniels Center for Early Childhood as a model for using such a setting to help abused children in multi-problem families. Such children may provoke so someone will contain their aggression. Many traumatized children are trapped in a sequence of aggression, confrontation, projection of the introject onto a teacher or another child, and omnipotent control by attacking the now externalized danger. This stems from lack of differentiation and failure in attachment and separation-individuation. In these children there is little that is identified as good inside and little contact with a comforting internal presence. A way to help is to address the chaotic object world and the way in which objects turn from good to bad and to good again, at the mercy of projective and introjective processes. Teachers can explain that tantrums happen when something scary happens inside. Knowing what makes such children susceptible, teachers can prepare them and help them make plans. When working with traumatized children, it is important to help them master their trauma through preparation, appropriate reliance on others, and self-reliance. Their activity has often been misdirected into efforts to turn passive into active through identification with the aggressor and re-enactment.

Traumatized children do not confine their problems within the treatment setting. Behavior at home and school may deteriorate as they recall and express their trauma through action and distortion in object relations. The parents need support and suggestions about how to remove themselves from angry interactions. Teachers need to persevere in developing a relationship with the parent(s), since in the absence of maintaining a good enough holding environment, the child cannot be assisted.

In her discussion of this paper, Dr. Shapiro noted that such children are commonly medicated first with one and then an increasing number of medications with an assumption of biological immutability, diagnoses such as ADD, PDD, and bipolar disorder. HMO funding does not allow for careful evaluation of intrapsychic and family

dynamics and intergenerational considerations. As analysts, we need to consider systems as well as the intrapsychic factors. Child analysts can do a lot to educate professionals in other agencies which may be involved with the family. One identifies where holding is needed and selects the most receptive targets. When intervention is effective with parents, it often benefits other siblings. Some families cannot be helped, e.g. when parents are severely sadomasochistic and unable to form a loving bond with their children. Staff working with these children are susceptible to secondary trauma, hearing about and dealing with sadomasochistic and murderous reenactments.

Dr. Farley spoke from his own experience with similar children in Texas. He advocated working with the families and developing relationships with other professionals involved.

Dr. Morales observed that this was a psychoanalytic milieu therapy. The question is whether changes persist after the child has left the milieu.

Dr. Cohen commented that at the Hampstead Clinic, when children didn't respond in the therapeutic nursery, they were placed in psychoanalytic treatment, sometimes repeatedly, at various developmental crises.

From his past experience in Chicago, Dr. Wilkerson recalled that working with the same teacher for three or four years helped these children with attachment and ego growth which prepared them for psychotherapy at a later time.

Dr. Etezady addressed problems of separation individuation. Critical deficits in self and object constancy may result in narcissistic pathology and problems of affect and self-regulation. When the balance of libido versus aggression favors the latter, splitting as the primary defense persists and integration is not possible. He said that in helping mothers of these children, he is impressed with the results when he succeeds in teaching the mothers that their interaction with the child can be productive when the emotional atmosphere between them is primarily positive. He finds this simple technique surprisingly effective.

March 26, 1999 v Annual Meeting of the Association for Child Analysis v Seattle, Washington

INTRODUCTION TO THE 1999 MARIANNE KRIS LECTURE

by Erna Furman

Editors' Note: Each year the president of our association selects a colleague or colleagues to deliver a paper on Sunday morning at our annual meeting in memory of Marianne Kris. In this edition of the newsletter we include the complete text of Erna Furman's introductions of Peter Blos, Jr. and Jack and Kerry Novick. We do so to share with our readers the many accomplishments and contributions they have made to child analysis and to our organization which make them such worthy choices to honor the memory of Marianne Kris.

I think you all know Peter Blos Jr., M.D., not least because he has been such a prominent, effective, and dedicated member of the ACP for so many years. This alone would merit more than his being honored today but this could apply equally to his scientific contributions, to his role in training child analysts and in promoting our professional growth, and to his many-sided efforts in working with mental health professionals and applying his analytic knowledge to their tasks. I shall shortly list just a few details of his achievements in each of these areas, but I want above all to underline what it is that means most to Peter:

"I have been in private practice since I finished my residency and Child Fellowship in 1962. First I worked as a psychotherapist and then added psychoanalytic work with children, adolescents and adults as I completed my psychoanalytic studies. It has been this work which has provided the practical experience and stimulated my thinking and reflection over the years. I still find it to be the heart of my work."

This statement marks the true analyst and, in my estimate, the colleague most deserving of our appreciation. "Always learning from my patients" implies respecting them, being humble in working with them, being scrupulously honest with them and with ourselves. Having known Peter as a colleague and friend over many years, I can vouch for his having these sterling qualities. But I also admire Peter for his kindness to everyone, his ability to accept us as we are and to find the best in us, not just to get along, but to engage with us in constructive cooperated endeavors. This, his utterly decent humanity, provides the important context for his many undertakings and accomplishments.

Peter Blos, Jr. earned his medical doctorate at Yale and completed his residency training at the Albert Einstein College of Medicine, first in pediatrics, then in adult and child psychiatry, with board certification in the latter two specialties awarded in 1966 and 1969 respectively. His

psychoanalytic education followed closely. He graduated as an analyst of adults from the New York Psychoanalytic Institute in 1967 and in 1975 as an analyst of children and adolescents from the Michigan Psychoanalytic Institute, his home base to this day. He has served the Michigan Institute as faculty, as training and supervising analyst and, since 1982, has chaired their Child and Adolescent Psychoanalytic Training Program. Dedicated to working with mental health professionals, he was also Director of the University of Michigan Medical Center's Child Development Project and has worked at the Hawthorn Center for Children.

Dr. Blos has also been an active participant in national and international psychoanalytic and related professional organizations, among them the American Psychoanalytic and Psychiatric Associations, the Center for Advanced Psychoanalytic Studies at Princeton, Zero to Three, and, not least, our Association for Child Psychoanalysis. He became a member in 1976, has served as Councillor, Chair of the Program and now Ethical Guidelines Committees, as President-Elect and President and, during the last decade, as lecturer at the summer schools for our Eastern European colleagues in training and as the most successful coordinator of the ACP-IPC child and adolescent analytic programs. These take place every other year in conjunction with the Congress of the International, constitute its only child analytic program and have been appreciated and enjoyed by more numerous audiences than any other Congress session.

Peter has made a significant scientific contribution to our field, with quite a list of publications and many presentations in this country and abroad, in Finland, Sweden, and England. A number of his papers have sensitively and knowledgeably explored the impact of bodily illness and anomaly on children and their families, and have also shown helpful ways of intervention. In quite a different vein, one of my favorites is his 1991 article on "Sado-masochism and the defense against the recall of painful affect," a thoughtful elucidation of early personality functioning. Beyond that, though, all who have had the opportunity to discuss analytic topics or clinical material with him, one-to-one or in big groups, have learned from and with him and enjoyed the intellectual stimulation.

Dr. Blos has been on The Best Doctors in America listing since 1994 and was the honored Melitta Sperling Lecturer of the New York Psychoanalytic Association in 1993. It is a great pleasure today to present him as our Association's 1999 recipient of the Marianne Kris Memorial Lecture Award.

April 16, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

INTRODUCTION TO THE 2000 MARIANNE KRIS LECTURE AWARD

by Erna Furman

Kerry and Jack joined the ACP in 1977 -- a very fortunate event for us all because they have used these many years to contribute uninterruptedly to all the best that our Association stands for and to help it thrive. They have been councillors, secretary, committee chairs and members, program moderators and presenters, discussants, and, in each of these capacities have given of themselves so unstintingly and participated so forthrightly and soundly that none among us can have missed knowing, respecting and admiring them. We are fortunate now in having the opportunity to honor them and to thank them, with the fond wish that they shall continue their dedicated work for us and with us for many years in this new millennium.

It is the first time that the Kris award goes to a couple. This merits a word of comment. Since the beginning of psychoanalysis a century ago, there have been quite a number of analytic couples, husband and wife teams, who have been of special support to one another in their scientific work and creative thinking, not to mention their mutual use as consultants or even consolers in times of stress -- all very important forms of collaboration that do not necessarily show in footnotes of acknowledgment or printed co-authorship. But it has seemed to me that the Novicks differ from these in the quantity as well as quality of their joint undertaking. So much and so brilliant a part of their work stems from the creativity of their partnership that it tends to overshadow the more strictly individual productions of each. Therefore this award celebrates Kerry and Jack but also, and especially, the analytic creativity embodied in their partnership.

From among the many offsprings of this partnership, let me just mention their earliest publications on projection and externalization and their almost equally longstanding exploration of the theme of termination, some of its strands intertwined with yet another area of major interest, namely, the therapeutic alliance. In all these publications we can follow a development of thinking that reaches increasing depth of insight paralleled by finely honed technical applicability, with data and findings rooted in clinical child analysis and never straying from it. Sado-masochism, perhaps their most prominent topic of investigation and special theoretical contribution, also goes back many years, starting with their study of beating fantasies, followed by a new view of masochism and omnipotence in a developmental context, and culminating in their book "Fearful Symmetry." Although their clinical data always encompassed all developmental levels, from infancy through late adolescence, the preschool years were the main focus of interest in their thinking. In 1994, after years of consultation in community preschools, this focus bore concrete fruit with the establishment of the Allen Creek Preschool, a psychoanalytic preschool devoted to supporting

the parent-child relationship from pregnancy through six years of age. Building on the traditions of the Anna Freud Centre and the Hanna Perkins Center in Cleveland, Kerry, Jack and their colleagues evolved a unique approach to starting, running, and funding a psychoanalytic preschool that has brought together over forty cooperating colleagues, all volunteering to work with families in the school, and that has already exercised considerable influence in the wider community. They are justly proud of this achievement and we are proud of them.

Now to a brief account of their backgrounds, professional pursuits, teaching and participation in the psychoanalytic community. Kerry and Jack graduated in psychology and trained in child analysis at the Anna Freud Centre where they subsequently worked. Jack qualified in the analysis of adults at the British Institute of Psychoanalysis. Kerry added adult training more recently at the New York Freudian Society where Jack participates as a training and supervising analyst.

On their return to the USA from London, they settled in Michigan and have been part of that analytic community since, as members of the local societies and on the faculty of the Michigan Psychoanalytic Institute. Both, but Jack especially, have academic appointments at several universities where they teach, supervise, and consult in related child service centers, such as the Pound House Children's Center of the University of Michigan. Consulting in several settings has always been an important part of their work which they use to learn from as well as to teach. The Arbor Clinic, Jewish Family Services, and many others have been fortunate to benefit.

Jack and Kerry give of themselves far beyond the local scene. Individually and together, they have made an enormous number of presentations at professional meetings nationwide and abroad, invited to share their insights with the many who have also learned from their publications. Among my early introductions to Jack was his paper on "Negative therapeutic motivation and negative therapeutic alliance." It was then and still is a gem. Similarly I recall my feeling of "There's a real analyst!" when I first came across Kerry's "Issues in the analysis of a preschool girl" long ago.

Kerry and Jack belong to every psychoanalytic organization, from the IPA and American to the Freudian Society and Association for Child Psychotherapy, and Jack includes the psychological associations as well. With most people this would mean just a string of listings; with the Novicks it is a wide field of active contributions. There is not one of all these organizations that has not benefitted from their scientific papers and presentations as well as from their administrative acumen.

(Continued on page 16)

April 16, 1999 v Annual Meeting of the Association for Child Analysis v Miami, Florida

SUMMARY OF THE 2000 MARIANNE KRIS LECTURE

RECLAIMING THE LAND

Kerry Kelly Novick & Jack Novick, Ph.D.
Presenters and Recorders

The authors responded to the honor of the occasion by reflecting that it is Freud's metapsychology that has remained of value to them through momentous changes in psychoanalytic theory and technique. The use of a metapsychological framework defines psychoanalysis and differentiates it from all other psychologies. Metapsychology is a multidimensional approach that requires time to master and discipline to apply. It does not provide quick solutions to complex problems, but does give the practitioner both scope for expansion and a structure for safety.

Kerry and Jack Novick described the constant efforts of the Dutch to reclaim land from the sea as a metaphor for the task ahead. They suggested that Freud's idea of psychoanalysis resting on observation and a multidimensional or metapsychological description of what is observed has been swept out to sea and replaced by a narrow structural theory and a single-track model of development.

The authors demonstrated the value of reclaiming this piece of psychoanalytic land by outlining some things that they find useful in each metapsychological point of view. For each one, they noted first how they see child analysis especially contributing to understanding the value of a particular point of view. Then they touched on concepts with psychoanalytic origins that have been lost, discarded, unintegrated, or hived off, which they think are worth reclaiming. They also looked at some ideas from outside psychoanalysis that might be integrated from the perspectives of metapsychology. In relation to each point of view, they indicated where in their own work they have attempted to integrate and synthesize old and new concepts.

Lastly, they pointed out how metapsychology helps to organize technical precepts, whether familiar ones or those that are less so.

In this way Kerry and Jack Novick used a metapsychological framework to sketch some ways that lost or prematurely discarded analytic ideas could be reclaimed and ideas from other approaches could be integrated for fruitful use in reinvigorating our field. They pointed out that defining psychoanalysis as a multidimensional theory sets us again on the path of formulating it as a general psychology.

They then suggested that the six metapsychological points of view can usefully be applied also to ourselves, our training and our practices, generating optimism, conviction, creativity, and social effectiveness. They charged us to forge a language that is direct, meaningful and adapted to our current historical/cultural situation. Child analysts are uniquely equipped by history, training and experience to do this and to offer the community knowledge that can have profound social implications.

They highlighted the importance of the representational world of the analyst, in particular, the presence in it of models for identification and inspiration. They named Anna Freud and Erna Furman among their many teachers and colleagues who have provided such inspiration. Jack and Kerry Novick concluded by returning to the image of reclaiming the land. They noted that Goethe was an inspiration to Freud, and, in Goethe's great drama, *Faust* discovered that none of the worldly pleasures, nor even the promise of immortality, compared to the satisfaction he could find in draining the marshes, reclaiming land.

Introduction to the Marianne Kris. . .

(Continued from page 15)

Their indefatigable zest and hard work serves analysis in general and child analysis in particular, everywhere. And they bring to it an admirable courage in speaking up and speaking out for basic principles when they feel these have been or are in danger of being jeopardized. Time and again, both, and in my limited experience Jack especially, have tactfully but forthrightly reminded presenters and audience when analytic thinking went astray, be it in clinical technique or in theoretical formulation. Such courage is not

politically correct and does not bring easy friends. But it speaks to a principled dedication to psychoanalysis -- something we very much need. We find this same principled dedication in their own scientific contributions. I have never heard or read any of them without feeling intellectually challenged, without experiencing the thrill of getting something worthwhile to mull over that will spur and enrich my own understanding. And this too we need very much. We have such a treat coming today with a paper we as yet know nothing about, except its title, "Reclaiming the Land."

April 16, 2000 v Annual Meeting of the Association for Child Analysis v Miami, Florida

COPING WITH LOST RELATIONSHIPS

Workshop for Mental Health Professionals

Co-Sponsored by the Association for Child Psychoanalysis and The Florida Psychoanalytic Society
supported by the Gabriel Casuso Memorial Fund and the Florida Psychoanalytic Foundation.

Sunday, April 16, 2000.

Presented and reported by Erna Furman

This workshop focused on the role of the professional mental health worker with children and their families who have suffered a variety of disruptions in their relationships due to death, divorce, illness or separations caused by other circumstances. These sad and often desperate situations have been the subject of many articles and books, but most of them have not addressed the specific aspect of this workshop, namely the role of the professional vis à vis the parent-child relationship.

We all know and essentially agree on the indispensability of the mother-child relationship to start with, the importance of additional relationships at successive developmental phases – fathers, relatives, siblings, teachers, peers – and that any one of these relationships cannot be substituted for another. Their lack creates a deficit. The loss creates first of all a need to restore them because they cannot be replaced by another relationship without major and difficult internal psychological adjustments. If and when this latter task has to be undertaken by a child, he needs the support and help of his remaining loved ones, especially the parenting person. Therapy is not a substitute and the professional's role is to support and help the parenting person.

Although not only we, the professionals, but also parents, relatives, friends *and* the children know these basic truths, the concerned adults from within and without the stricken family set them aside and fail to act on them. Several clinical vignettes were used to illustrate this – a recently bereaved child taken into analysis to assist her with the bereavement but without helping the mother and child to include the father's death in their relationship; teachers forbidding the father to make mention of mother's death when his three-year-old daughter entered preschool, with disastrous consequences for her and the group; a teenage mother sent home and forbidden to visit her ten-month-old after she brought him to the hospital with a high fever, then suspecting her of neglect when he developed a serious anaclitic depression which was misdiagnosed as a failure-to-thrive syndrome, and luckily rescued in the nick of time by a consulting child analyst. Highly skilled professionals and devoted parents all, with good will, yet so ready to disregard the basic truths! The paper describes some of the parents' motives for "handing over" their children to the "experts" and failing to fulfill their parental function. The paper also explores some of the professionals' motives for usurping parental rights and rationalizing their reason for doing so – sometimes to protect the parents from added burdens,

sometimes to compensate for their assumed inadequacy in helping their children.

Anna Freud admonished us during my training half a century ago, "The child analyst has to consider the child, the mother, and the mother-child relationship." I would say "parent-child relationship," but what does she mean? Saramago, the Portuguese Nobel laureate explained it in his recent novel in terms of a marriage. He wrote that a marriage has three partners, a man, a woman, and a third party which they created from an amalgam of parts of each – an entity as important as each of them. When one of the partners is unfaithful, he or she may be hurt but the one who is hurt most is the third partner, their relationship. When we work with or on behalf of a child, we have to make sure that we do not injure the parent-child relationship which is so easy to do by just coming on the scene. Unless and until the parent and child begin to trust us to protect their relationship and not to make one or the other unfaithful, our work cannot really begin.

With this in mind we shall approach any kind of "lost relationship" by ascertaining: first, the viability of the *available* relationship with the mothering person (Is there such a relationship and does it function adequately?); second, the nature of the lost relationship and whether or to what extent it can be restored (all except death have some potential for contact); and third, whether and how the *available* relationship is used to cope with the *unavailable* relationship and what kind of help it would need to serve in this capacity. Even partial initial data will assist us in deciding where to start. Three case illustrations were included – one a recently maternally bereaved family in which the father wanted his children professionally helped but could, instead, be helped to help them himself; second, a single mother family where mother and prelatency daughter increasingly attacked each other to ward off knowledge and feelings about a long absent father and were helped to feel with one another and to reach out to him; and third was another single mother family, this one due to divorce, where the mother became seriously ill while working with the therapist on the effects on her child's personality of a period much earlier when the little girl had been very ill and the mother, at doctor's advice, had failed to be with and care for her. Although the mother was tempted in the present to deny the effects of separation through illness, she was determined not to repeat and helped her child and her relationship with her child to weather the stress. Last but

(Continued on page 18)

AN ACP BROCHURE ON CHILD ANALYSIS

Erna Furman

At the Open Forum and Outreach meetings last year in Seattle there were several requests that we produce not only a brochure about our association -- which we did -- but also a brochure on child analysis, perhaps for parents or for professionals or both. Since that time a number of members submitted individual requests along the same lines. I gave this considerable thought, discussed it with ACP members and brought my conclusion and suggestion to the Executive Committee in Miami Beach on April 14, 2000.

There is such a wide range of opinions on aspects of child analysis among our members that it would be extremely difficult to produce a brochure that is truly representative and acceptable for all; for example, on the question of working with parents, some members state that they avoid contact with parents to protect the transference, others state that child analysis cannot proceed without work with parents, and even within these two extreme opinions there are many variations that do not allow for compromise. Although the Executive Committee will continue to explore the feasibility of a brochure on child analysis, they agreed to my interim suggestion which I have already shared with corresponding individual members.

Brochures on the nature and practice of child analysis are best produced by groups and local centers where analysts share the same views. Several such brochures have been produced and are available at the addresses listed below so they can be adapted to local needs:

1. The Swedish Psychoanalytical Society, Västerlanggata 60. S-111 29 Stockholm; phone 46-8-214103; fax 46-8-108095.
2. The British Psychotherapy Trust -- Contact through the Anna Freud Centre.
3. The Hanna Perkins Center Newsletter on Child Analysis, 2084 Cornell Road, Cleveland, OH 44106; phone 216 421-7880; fax 216 421-8880. There is also a booklet "Inside Helper" which describes several forms of therapeutic intervention, including child analysis.

Several centers are already preparing their own brochures. I encourage them to notify our Newsletter editors when their brochures become available so that our membership can learn about them.

GUIDELINES FOR ACP CO-SPONSORED LOCAL WORKSHOPS

Approved by the Executive Committee on October 2, 1999

The success of Local Workshops for Mental Health Professionals depends on the close and active cooperation between the ACP (represented by the Chair of the Extension Committee and the Administration) and the local professional group, such as the child analytic group, Society or Institute. Successful cooperation is helped by clearly stated and agreed upon responsibilities undertaken by both parties.

The guidelines listed below may be altered, by mutual agreement, to suit local circumstances but their acceptance, in the original or changed form, will be negotiated between the Extension Committee Chair and the local representative and stated in writing before the work begins.

1. The Extension Committee Chair and local representative will get in touch with one another as early as possible but at least six months prior to the planned date of the Local Workshop.
2. The topic and speaker (s) will be selected in shared consultation between the Extension Chair and the local representative. Both will work together to get the speaker of their choice. Speakers are ACP members who contribute their Workshop presentations without remuneration. A speaker's availability affects the selection of topic.
3. The printing and mailing out of the Local Workshop Brochure/Registration Form may be arranged to be done by the ACP, by the local group, or cooperatively.
4. The registration fee for the Workshop will be set by shared consultation of Extension Chair and local representative.
5. The venue for the Workshop is usually contributed by the ACP if the Workshop takes place at the time of the Annual Meeting, but this item requires specific confirmation.
6. Expenses, proceeds or deficit will be shared equally between the ACP and local group.

Coping with Lost Relationships . . .

(Continued from page 17)

not least, the paper addressed the problems created by the separations parents often disregard altogether or think of in terms of "But I won't be gone long," i.e. the separations which, if unprepared, can be experienced as devastating by the child, especially when the parents, because of their denial and guilt, fail to empathize and lose touch with their child's feelings.

Each separation and each family suffering a separation

or loss are individual and different, as is the mental task of mastering such experiences. There is just one thing they all have in common: These tasks cannot be mastered without a good enough relationship with a mothering person, be this the mother or the father or another who fulfills that role. As professionals, our main task is to respect, support, and strengthen that relationship, for when there is no viable parental relationship, our therapies, however kind and skilled, are of no use.

ACP OUTREACH MEETING

Miami Beach, Florida, April 14, 2000

Reported by Karen Marschke-Tobier, Secretary and Erna Furman, Chair Substitute

Mrs. Furman opened the meeting, acknowledging that she was substituting for the Chair of the Communications Committee, Dr. Hoffman. She began the meeting by reviewing some of the activities participants shared last year and drew our attention to the fact that in the most successful ones in regard to generating referrals, the critical factor was relationships developed with the community.

Elizabeth Tuters from Toronto shared an update of their outreach activities. The films chosen for the film series were about children, highlighting the shaping of identity or the influences of peers. In addition to the films, a series of six lectures on issues such as adoption, bereavement, separation, divorce, ADHD, were offered. Attendees could sign up for the series or for a single topic. About 35 people, mostly mental health professionals, attended these lecture/discussions, two of whom subsequently applied for training.

Another Toronto outreach effort described at the meeting was the newly designed brochures featuring a logo which is included on all the various publications to impress the public with the unity of focus of the various psychoanalytic activities. These materials were also distributed at the film series and have been actively requested. Moreover, a referral committee now took responsibility for outreach phone calls to the community and generated enough analytic cases for their current candidates. A web page is in the making.

Mrs. Furman commented that Canada has an advantage over the USA in that they provide for mental health services within their national health system.

Tom Barrett told us that Cleveland had been inspired by Toronto's experience with a film series and is now planning its own. Four films will be shown in the fall at a local independent film theater. It is hoped that this series will reach a general population. The films will be chosen to include issues which impact on families and individuals over the wide span of development.

With the goal of furthering name recognition, awareness of available services and referrals to the School and Clinic, the Hanna Perkins Center has distributed 5,000 copies of its "Inside Helper" story/brochure which will also become available on their website. In addition, there is a widely circulated video.

Another referral-oriented program is a recently started series of parent discussion groups. These groups of 10-16 parents meet for four to six sessions focusing on a selected topic with a child analyst associated with the Center. The topics include fatherhood, toddlers, new babies, divorce, separation, leaving home for college.

Fall in Cleveland will also bring a fundraising sailboat regatta.

A special study group has worked on aspects of the referral process with the help of the metapsychological profile data which form the basis of Hanna Perkins's long-term research. Review of the last 79 referrals to the school during

1996-1999 showed that 1/3 were referred by their own family or friends whose children attended the school, another 1/3 were referred by child analysts associated with the Center, and the almost 1/3 of the remainder were referred by daycare or preschool directors and pediatricians who were very familiar with the Center. Only four referrals came from sources, such as ads, that had no direct relationship.

Mrs. Furman underscored that the relationships leading to referrals had developed over many years of close cooperation. She added another finding of this study group, i. e., that referrals from family and friends sought help for the youngest children and were motivated and able to work with a therapist. Referrals by associated child analysts and other professionals brought older children, sometimes under pressure, such as exclusion from other schools. These families took longer to work through their narcissistic hurt. In response to Dr. Gluckman's question, Tom Barrett said there are currently spaces for 44 children in the Hanna Perkins School - 12 mother/toddler pairs, 16 in the preschool and 16 in the kindergarten. He went on to say that among the child analysts who handle the outreach consultations of the Center are Ruth Hall and Marion Barnes, both attending this meeting. Ruth Hall, long-time consultant to day care centers, said she has found a deep resistance on the part of parents in daycare to acknowledge any basic difficulty their child may have, attributing troubles to the teacher, the class, etc. rather than as related to separation issues.

Dr. Gluckman told us that in the Chicago area he participates in a suburban mental health association of some 500 members, drawn from the professional and lay community. The organization arose out of the community's wish to become better educated and informed. As Chair of the organization's Professional Advisory Committee, he has been working towards programs for specific audiences and their interests and needs, such as a series of lectures and discussion with special education teachers in the school system. This past year the groups, led by members of the committee, discussed subjects such as psychosis, neurosis, autism, manic depression, ADHD.

Next spring the local library board will show two films dealing with mental illness and committee members will serve as discussion leaders. The committee also responds to legislation related to mental health and actively encourages members and the community to let legislators know their views. Paul Brinich responded that it was great to have a program housed at a public library and asked whether CE credits were offered to the teachers for the lecture series. Dr. Gluckman replied that they were not. Paul Brinich reported that the Lucy Daniels School series of talks aimed at public school teachers was approved by the Department of Public Instruction to provide CE credits. Since teachers need the credits, they are more likely to attend. The fee for each evening was \$8.

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ACP Outreach Meeting . . .

(Continued from page 19)

Joe Bierman shared that last year the Baltimore-Washington group's all day seminars for mental health professionals hosted Steve Marans from Yale. He and two colleagues brought case material about their work with the police department. He felt the program that they offered was valuable for the participating mental health workers and police department, educating them as to how child analysts can support them in their work with families and children. Mrs. Furman reminded us that this area of police consultation was not one in which we would readily find candidates or cases.

Michael Coleman spoke about his work as a consultant to receiving homes in Detroit's foster care system. His work with children who have suffered deeply because of multiple foster home assignments and no contact with their birth parents due to rescinded parental rights, has prompted him to advocate strongly for maintaining contact with parents, with supervised visits.

Marty Silverman commented that recent studies (Bruce La Rue) have shown that children who have lost one or both parents to violence are often riddled with family problems, learning and attentional difficulties. He is working to get his local school district to offer a program on this issue. He added that analysts' interest in the community is invaluable and cited advice received 18 years ago on this issue – you've got to give something to get something. Mrs. Furman agreed that we do have to give to the community regardless of whether it leads to referrals.

Ms. Furman then asked the group whether we should accumulate a list of all our outreach activities. The consensus was that it would be helpful to have such a list.

Catherine Henderson reported that in Seattle she gave an address to the state Preschool Teachers Association on "Understanding Play Therapy." A lively discussion followed with questions to clarify the therapeutic value of play therapy. Many attending teachers have referred children to child analysts for play therapy and are asking child analysts to speak at their monthly parent meetings on such topics as developmental milestones, hostility and aggression, toilet training, encouraging positive emotional growth.

In Seattle, many child analysts consult with private schools, discuss individual children and talk to parent groups. There are also consultations with the neonatology units at two hospitals and the infant and child organ transplant unit at the children's orthopedic hospital.

Attendees:

Christel Airas, Marion Barnes, Denia Barrett, Tom Barrett, Joe Bierman, Paul Brinich, Michael Coleman, Elizabeth Daunton, Erna Furman, Bob Furman, Robert Gluckman, Ruth Hall, Catherine Henderson, Ruth Karush, Brenda Lovegrove Lepisto, Adriana Lis, Lilo Plaschkes, Martin Silverman, Elisabetta Superchi, Karen Marschke-Tobier, Elizabeth Tuters.

GUIDELINES FOR GRANT APPLICATIONS FOR CHILD ANALYSES

Approved by the Executive Committee on October 2, 1999

Depending on available funds, the ACP dispenses yearly varying amounts of money to support the analytic treatment of indigent children.

Applications should be sent to the Chair of the Grant Committee, c/o Mrs. Nancy Hall, P.O. Box 253, Ramsey, NJ 07446.

Grant applications need to include the following information:
The amount of funds requested;

- a. A one or two page description of the patient and his/her analysis, excluding data that could identify the individual child and family, but including the reasons for their inability to pay all or any part of the analysis;
- b. Name of the person who will use the grant;
- c. Name of the sponsoring organization with statement of their (501) (C) (3) tax exempt approval by the IRS;

Availability of matching funds by the sponsoring organization:

The Grant Committee favors the availability of matching funds and encourages applicants to provide them, but applications without matching funds will also be considered.

If the grant is approved, the transfer of funds needs to be accompanied by the applicant signing the following disclaimer:

By providing grants toward the analytic treatment of this case and all therapeutic contacts related to it, the ACP makes no representation and accepts no responsibility concerning the nature or quality of any care, consultation or treatment which may be provided, nor does the ACP provide any care, consultation or treatment as an organization. The undersigned hereby accepts and agrees to the above disclaimer.

If the grant is approved, the analyst of the case also accepts the understanding that he/she may be asked to present the analytic work at an Annual Scientific Meeting of the ACP.

Grants are for one year only but are renewable by reapplying and including a progress report.

Unused funds are returnable to the ACP.



WHY AN ENDOWMENT FUND?

Robert A. Furman, M.D.

As one of the members of the Ad Hoc Committee on Donations and Budgets, I was a guest at the October meeting of the Executive Committee when financial matters were under consideration. The question was asked, "Why do we have an Endowment Fund?" There was general consensus that some members of the Association might have the same question and I was volunteered to write this bit about Endowment Funds for our Newsletter. I assume I was selected because of 25 years of experience championing endowment funding for the Cleveland Center for Research in Child Development and the Hanna Perkins School under the guidance of a superb pro bono three member Financial Committee of the city's best experts.

It is easy to say an Endowment exists for two reasons: to provide financial stability for an organization with monies always available for unexpected crises; to be a never failing source of income for operational expenses. This simple start is a bit deceptive because of the questions that follow in its wake, starting with how large should an Endowment Fund be, how much of its income can be diverted each year for operations?

For some the answer to the first question, how large should an Endowment be, will always be "larger." In general, however, financial managers usually set as a guiding rule that an Endowment, or an organization's total financial reserves, should be twice annual operating costs. I use the expression "total financial reserves" because our Association has for years, before implementation of an annual budget, had rather large sums in an Operational Fund and in our checking account in addition to those monies explicitly designated as the Endowment Fund. This practice was started to deal with potential cash flow problems without ever having to resort to withdrawing funds from the Endowment proper. Incidentally, this is a cardinal rule about Endowment Funds: once dollars have entered the Fund, they can never be withdrawn, the corpus or body of the Endowment always untouchable except in the most dire of emergencies. Any banker on your Board of Trustees will convince you that this rule is actually the Eleventh Commandment.

The second question involves calculation of Endowment income. To some the income is only the total of the dividends and interest earned by the Endowment's investments. To others it also includes appreciation in the value of the investments, the stocks and bonds held by the Fund. For example, a fund of \$100,000.00 might in one year have earnings of \$5,000 while appreciating during the year by \$10,000.00 not including the income from stocks and bonds. To some the Fund's income will be just \$5,000, to others \$15,000, the latter representing total earnings which is perhaps the more conventional way to

calculate earnings.

This leads to the subsidiary question of how much of an Endowment's total earnings each year can be distributed for operational purposes while still retaining sufficient portions of those earnings in the Endowment to protect it from inflation that would reduce the value of its dollars. Experience over 10-20 year cycles indicates that withdrawing 5%-6% of the value of the Endowment each year will over time protect the Fund from inflation at the same time yielding a constant source of income that can be counted on by administrators who can then ignore the annual market fluctuations and earnings fluctuations. This rule is hard to stand by in the years of 20%-25% security or stock yields, but is a great relief when those yields have their 1%-2% years. With our example of the \$100,000.00 Endowment Fund with \$15,000.00 total earnings that increase its year-end value to \$115,000.00, 5%-6% of that \$115,000.00 (\$5,750.00-\$6,900.00) could conservatively be made available for operational purposes. The banker on the Board of Trustees to whom I referred earlier would, however, try hard to convince you the figure should be but 5% as if that 5% rule was in effect the Twelfth Commandment.

Two final thoughts about Endowment beginning with how hard these dollars are to raise from foundations which rarely will support such grants, though fortunately there are exceptions. Endowment dollars only come from those familiar with and dedicated to your aims and with child analysis that means child analysts themselves. An endowment gift earning at our 6% figure would in 16 years have developed in total annual income its initial value and still in that initial value be there to keep on working and contributing. One Cleveland philanthropist said he liked the idea of giving to endowment because "those dollars will go on working long after I am gone."

The second thought about endowments concerns questions about their size, annual yield, and types of investments that some psychoanalysts find very tempting to answer, somehow being able to view themselves as financial experts not in need of expert professional advice and guidance, analysts who would never think of asking an investment counselor how to conduct an analysis. In the instance of the Association we are very fortunate in having the pro bono services of a superb financial expert in Mr. Joel Mangham of Charlottesville. Those of us who know and respect his father, Dr. Charles Mangham of Seattle, can only say Mr. Mangham's availability proves the value of judicious nepotism.

FROM THE EDITORS. . .THE NEWSLETTER THEN AND NOW

With the June ACP Newsletter, we mark the 35th year since Marianne Kris first wrote to the members of the newly established American Association for Child Psychoanalysis. We include portions of her "informal newsletter" here as a glimpse into our past. In their Marianne Kris Lecture delivered at the 2000 Scientific Meeting, Jack and Kerry Novick spoke compellingly, urging child analysts to "reclaim the land" of metapsychology as a way to integrate the richness to be found in both old and new theories. In his first President's Message, our new president, Dr. Silverman, speaks to the importance of looking to the future. We welcome him as we say good-bye and thank you to Mrs. Furman for her devoted service to our organization during her term of office. We hope all our members will continue to feel the spirit of "excitement" and "impression of something of importance" that Marianne Kris described at the First Annual Scientific Meeting in Topeka in 1966. We are pleased to include here summaries of the many excellent presentations which were offered at the 35th Annual Meeting in Miami which we hope you will enjoy reading. Let us hear from you about your own child analytic activities so that we may share them with our readers as we carry on the tradition set by Dr. Kris of "letting you know of the activities of the Association."

Denia Barrett

Barbara Streeter

ACP HISTORY A COPY OF THE FIRST AACP NEWSLETTER

AMERICAN ASSOCIATION FOR CHILD PSYCHOANALYSIS

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Peter Blos, Ph.D., Secretary

Grace McLean Abbate, M.D., Treasurer

Please address all communication to:

Dr. Peter Blos, Secretary
53 East 92nd Street
New York, N.Y. 10028

June 29, 1966

Dear Member:

It might be of interest to you to hear through an informal newsletter from time to time of the various activities of the Association.

The most important event during the last year was our First Annual Scientific Meeting which took place in Topeka on April 9-10 at The Menninger Foundation. On Friday evening, April 8, Drs. Karl and William Menninger and the other members of the Foundation were hosts at a cocktail party and a dinner following at which a few words of welcome by the hosts and thanks on our side were exchanged. There were 87 members of the Association registered at the meeting and 15 special guests. A photograph (10x4) taken of a number of those attending the meeting is available to each member.

The general feeling among the participants during the meeting was one of excitement and the impression that the beginning of something of importance was taking place.

Some excellent presentations were offered, but the high point of the scientific meeting was provided by Dr. Anna Freud's continuous participation as discussant and moderator in our deliberations.

The generous hospitality of Drs. Karl and William Menninger and their staff contributed considerably to the

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A Copy of the First AACP Newsletter . . .

(Continued from page 22)

success of the meeting.

At a luncheon meeting on Saturday, April 9, the regional representatives reported on activities of groups already existing and of other study groups that were in the stages of being inaugurated. Others we hope will follow. As we receive more detailed information, we shall send this on to you.

As of this date, the present membership numbers 178.

We are starting to plan for our next Annual Meeting and would be grateful to have your recommendations for its program. Should you wish to present a paper, please let us know. If workshops or panel meetings would be favored by you, we would be interested in knowing so. It would be a great help to Dr. Anny Katan, Chairman of the Program Committee, to have suggestions as early as possible.

We are about to prepare some By-laws necessary to facilitate the nomination of officers for next year.

Since it is of the utmost importance that all members are acquainted with the requirements for membership and for sponsorship, the Membership Committee would like to refer you to the paragraphs pertaining to criteria for membership which were sent you following the Second Membership Meeting which was held in New York, December 1, 1965. We realize that you may have misplaced the original copy or that if your membership took place in 1966, you may not have received this information.

Potential members can only be sponsored by a member of the AACP. The sponsoring member should inform the Membership Committee of the training, clinical and/or research capability of the potential member, and some additional names of reference should be furnished by the sponsor. If the potential member is neither a member of the American nor of an Institute accredited by the American, the sponsor should also furnish the Membership Committee with a curriculum vitae of the potential member. Individuals who work in research only are eligible. Minimum criteria for those potential members who have not been trained in an Institute or in another recognized training institution for child analysis are:

1. The member should have, preferably, a minimum of three years of analysis by an analyst acceptable to the Committee.
2. Information should be provided as to the theoretical knowledge and background of the potential member, as well as how and where such were acquired. If it exists, a list of his publications should be added.
3. Information regarding current activities should be given.
4. Those who work in clinical child analysis and/or adolescent analysis (the age of the adolescents should be between 12 and 16 years) should have had supervision of two or three cases, a minimum of two years each and one case carried for more than two years. The supervisors should be acceptable to the committee.

Points 1-4 apply to potential members who are engaged in the practice of child analysis.

Points 1-3 apply to potential members who work in research only.

With my very best wishes for a pleasant summer, and in the fall you will hear from me again of the worthwhile happenings of the AACP.

Sincerely yours,

Marianne Kris, M.D.
President

December 16, 1999 v The American Psychoanalytic Association v New York, NY

VULNERABLE CHILD: CHILD ANALYSIS AMONG DEVELOPMENTAL SCIENCES

A Summarized Report by M. Hossein Etezady, M.D.

Chairman: Theodore B. Cohen, M.D.

Presenters: Steven J. Berkowitz, M.D., Jean Adnopoz, M.P.H., Mark Schaefer, Ph.D.

Discussant: Jennifer Bonovitz, Ph.D.

Coordinator & Reporter: M. Hossein Etezady, M.D.

Editors' Note: The Vulnerable Child Discussion Group at the December 1999 meetings of the American Psychoanalytic Association included descriptions of programs provided in conjunction with the Yale Child Study Center. Dr. Hossein Etezady provided a summary of these presentations, which has been edited in accord with space limitations. The presentations will be included in the fourth volume of presentations to the Vulnerable Child Discussion Group.

The New Haven Child Development Community Policing Program

Dr. Berkowitz described the New Haven Child Development Community Policing Program founded in 1991 and replicated since in 12 cities in the U.S. and Italy. The program incorporates five basic elements.

1. Seminars and clinical observations on developmental needs and conflicts of children and adolescents co-led by experienced supervisory police officers and clinicians.
2. Participating officers become fellows of the program and the Child Study Center.
3. Clinicians participate in a course on police practice and procedures and join in rides in the squad cars.
4. Weekly conferences discuss best interventions in current cases.
5. 24 hour/7 days a week consultation service that officers call. Clinicians are always available to work with children immediately after an event in homes, schools or the police station.

The program provides training and technical assistance as well as public education about the sequelae of violence and trauma in children and has been supported by the Department of Justice.

Dr. Berkowitz described his experience on a call and his reliance on psychoanalytic principles through this process. He described his anxiety in anticipation of the encounter at the scene of a tragedy, the way he used this to assist him in empathizing with the victims, and the way that his active role in preparing for the encounter assisted him in dealing with the anxiety. He also described his cooperative work with the police

officer, both in preparation and at the site of the tragedy. He used his understanding of children's adaptive responses to the helplessness they feel in order to effectively interact with them at the site and, in conversation with the parents, to pave the way towards providing further assistance through their program.

He described his ability to connect and provide assistance in such a situation as follows: The child's defenses have not been fully reestablished and many complex thoughts and conflicted feelings are accessible. His job is to help children describe the inner turmoil and to initiate a reorganization. He helps them metabolize the poisonous event and use insight and higher level defenses to accomplish this. He listens and does not force the child to tell exacting detail. It is harder to listen and ask few questions than to be active and structured. The principles of psychoanalytic psychotherapy are continually reiterated and discussed in meetings and supervision even though not every clinician in the program is an analyst.

In her discussion of this presentation, Dr. Bonovitz described this work as an excellent example of how psychoanalysis can be utilized by frontline workers in the trenches. The physiological, neurobiological and the cardiovascular effects of trauma in children have been well documented. The acute impact of trauma affects perception, appraisal and the response. The intensity and duration of the arousal are other determinants of the affective experience and the ensuing states. Empathic attunement and provision of a safe environment facilitates the psychic processing and reorganization necessary for healing of traumatic injuries. Psychoanalytic intervention facilitates the psychic processing and reorganization by providing a safe environment for verbalization and through empathic attunement.

The project's special emphasis on development constitutes a major contribution to the recognition and empathic understanding of the impact of trauma in children. The appraisal of the external events vary according to age. Infants and toddlers rely on social referencing. Preschoolers either dissociate themselves

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Vulnerable Child . . .

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or seek protection from caregivers. School age children are more likely to resort to more active than passive measures. Terror, rage and shame forever change the expectations and the sense of safety in relationship to the world. This project does a great deal to mitigate psychic damage as it draws upon knowledge about factors that mitigate such damage. The immediate availability of intervention is most crucial before permanent distortions and pathological defenses have become well established. Providing safety, protection and containment, as well as securing assistance for and organizing the resources of the parents, therapists, teacher and other providers, are other critical aspects of this mode of intervention.

Clinical Work with Children in Homes, Schools and Hospitals

In her presentation, Jean Adnopoz described decades of work based on psychoanalytic principles at the Yale Child Study Center with vulnerable children in homes, schools and hospitals. As this population is least likely to seek intervention, these services were directly brought to these children in their community. These models are currently being replicated statewide as well as throughout the United States. The data base dates back to 1988 and includes more than 1,900 families and 3,700 children. Abuse, neglect, abandonment, violence, substance abuse and poverty are nearly always present. The goals consist of clinical assessment of the child and his relationship to his parents and the environment. When appropriate, preparations are made for referral to more traditional sources of treatment. In the absence of the capacity of the family to provide for the needs of the child, appropriate alternatives may be considered. Support will be provided for foster parents and additional resources will be developed. The study is based on two outcome indicators – whether placement was avoided and the treatment goals were achieved, and whether or not additional reports were made to protective services. The program providers rely on the development of a therapeutic alliance as the primary means of achieving a level of change sufficient to alter the family's current low level functioning. In order to facilitate differentiation between the mother and the child in the high risk families, often a different staff is assigned to the child and the mother. Those mothers may sabotage the treatment of their children by failing to keep outpatient appointments. Visits to the home allow the mother to remain in control in her own home. The home structure enhances the capacity of the clinician to hold the anxiety and concern aroused in the

work.

In 1966, in response to the emergence of managed care, a program was developed to keep the children out of the hospital through intensive intervention by combining the medical model with the features of the in-home services. All therapeutic options are mediated by specific human relationships at individual, family and social levels of organization. Treatment is focused on measurable objectives. The team is available 24 hours a day, seven days a week. Active cooperation among parents, foster parents and the professional systems is essential in treatment planning. Both the internal and the external worlds of the child are considered, as are strengths, together with deviation and pathology. Objects of primary attachment of the child have to be identified and preserved at all times when clinically appropriate. Countertransference problems need special attention and are the focus of supervision. Often the best that can be hoped is damage control; namely the preservation of the current level of functioning. Therapists work actively to enter the child's family life and convene with all other agencies to motivate them to do their part in securing needed service.

A case presentation covered the steps involved in the course of intervention with a student in a partial hospitalization program who was threatening violence. In trying to establish a therapeutic alliance with the family, it became apparent that only the father was willing to participate and he was the more competent of the two divorced parents. The team was able to arrange for the father to assume primary care of the patient who, after several months of intensive treatment and in-home services, was able to return to school and continued his treatment in outpatient care. Father and son are seen once a week in family therapy. The team has provided five hours of service a week for the family for the past five months. In a month, the services will be reduced to one hour a week, and the patient will be seen once a week for continued individual psychotherapy.

In discussing the presentation, Dr. Bonovitz recalled her own days of social work, and the sense of bewilderment that being in such a home setting creates as a sample of the sense of chaos and helplessness felt by those to whom we bring our resources. The alternatives may be total disintegration, or if we succeed, there may be reconstitution and the possibility of further growth. The secret to success may well be in the psychoanalytic technique of providing a holding environment. Here the involvement of the parents is crucial. Many traditional office-based approaches may be unable to overcome obstacles in this area. Entering the physical environment of the family facilitates entering into their psychological environment. Entering

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Vulnerable Child . . .

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the reality of the lives of the family members allows the team members to base their treatment plan and strategy on the realistic circumstances and the actual needs of the children and their support system. The valuable feature of the program presented is that, in spite of today's managed care environment, it evolves around establishing a relationship. For this reason the capacity for good object relationships in those involved in the work is essential. Another important feature is the accumulation of data on such a large number of children in this vulnerable population thus enabling us to assess the value of psychoanalytically informed, multidisciplinary intervention.

Ensuring Quality in Clinical Decision Making in Work with Families

In his presentation, Dr. Schaefer commented on the difficulties inherent in the application of these principles to high risk families typical in their multitude of unforeseen and difficult challenges.

In the recent effort to replicate this model to a statewide health plan, it has been necessary to rely on unlicensed, master level clinicians due to funding constraints. In addition, well trained professionals in these areas are limited in numbers. How to ensure quality in clinical decision making is the focus of the following discussion.

The program requires weekly supervision by experienced clinicians at each center. All centers must review cases with a child and adolescent psychiatrist every three weeks. Outcome data can be used to encourage development of effective practices. A monitoring program for periodical assessment of social competence, symptoms, functional impairment, and family adjustment has been implemented. Tools to compare provider performance across the network are being developed.

Monitoring clinical process is achieved through chart review. Guidelines must be articulated and indicate fidelity to the model. For example, one might determine whether an evaluation was made of the primary attachment and whether the data supports the team's conclusions. It is also important to identify clinical decisions that are not consistent with the model which result in poor outcomes.

Two case presentations were provided, illustrating the importance of using psychoanalytic understanding in decision making. In one instance, plans to rescue a defiant adolescent from her dysfunctional maternal environment through placement in boarding school

failed because the team had not recognized the extent of the enmeshment between the daughter and mother, nor their collusion with the girl's fantasies. In the other instance, a severely disturbed boy was successfully placed in residential treatment because the team did not attempt to take over the executive functioning of his disturbed mother. Counter transference reactions were handled in supervision and a major part of the process included helping the mother work through her ambivalence in sending her son away.

There are innumerable threats to clinical decision making that might be considered, such as over-identification, helplessness, reciprocal dependency, and failure to maintain boundaries. In considering these dynamics in program evaluation, several steps are necessary:

- Our health plan must provide training and a manual articulating theory, principles and practices.
- Providing reliable criteria for assessing therapeutic and counter-therapeutic measures consistent with the model.
- Chart reviewers must apply these principles.
- Identification of key treatment decisions, clinical rational, and related therapeutic process. For example, the decision to set a termination date could document the parent's capacity for stable functioning, preparation for termination, and the presence of social supports.

Regarding questions about establishing a workable relationship with the managed care companies, the presenters described the process of reaching out and explaining the model and its attributes, asking what from the menu they might wish to consider. This then opens the possibility of partnership in that each side achieves their aims in a mutually beneficial arrangement. The key factor is to approach them as potential partners and not adversaries.

In a concluding comment, Ms. Adnopoz noted that one of many contributions of psychoanalysis would be in developing public policy in providing consistent long-term and high quality care of the kind that is needed but not addressed by our political system. As constituents of the political system, how we make our views heard and our position clear is extremely important.

IN MEMORIAM

SELMA KRAMER

Dr. Selma Kramer was not only a very significant person in many people's lives, but she was also a pioneer in at least three different areas: women's rights, child psychoanalysis, and combining a professional career and raising a family.

Dr. Kramer was born and raised in Philadelphia, attended Temple College and received her medical degree from the then Woman's Medical College of Pennsylvania. Among her numerous firsts as a woman, she was the first female intern at the St. Luke's and Children's Medical Center. She went on to receive her psychiatric training at Norristown State Hospital where she was exposed to psychoanalytic concepts and psychoanalysts, including Robert Bookhammer and Herbert Herskovitz, the latter encouraging her to enter analytic training. Attendance at Dr. Gerald Pearson's Child Analytic Center plus her own natural inclination made it inevitable that she would become a child analyst. In preparation for this, she took her child psychiatric training at the Child Study Center at the Institute of the Pennsylvania Hospital. She became a candidate at the Philadelphia Psychoanalytic Institute and completed both adult and child work in six years, eventually becoming the only woman training analyst for many years.

When Dr. Kramer was a student at the Institute, there was no program in child analysis. Dr. Margaret Mahler was invited to begin a program to organize a child psychoanalytic training program for the Philadelphia Psychoanalytic Institute and Selma was one of the major forces in implementing that program. At that time, child analysis was just developing in many institutions and was not fully accepted by a number of them. It was Selma Kramer who fought her own institute for the recognition of child analysis and established an accredited program working with Margaret Mahler. Selma became nationally known for her work and was eventually appointed as Chair of the Child Analysis Committee of the American Psychoanalytic Association for five years.

Dr. Kramer, working with Dr. Mahler and with the assistance of Dr. Robert Prall, established the annual Margaret Mahler Symposia which have become known both nationally and internationally for their in-depth exploration of various aspects of child development. There have already been meetings in Germany and, this year, in Japan.

Her numerous publications include over 30 articles

and books. She was invited to speak throughout the country and became known as a major proponent of Margaret Mahler's work. She established the Margaret Mahler Foundation which has been raising money to support various projects involved in studying child development. Dr. Kramer's academic achievements were a clear indication of the recognition she received from her colleagues. She organized and became the chairperson of the Section of Child Psychiatry in the department of Psychiatry at the Woman's Medical College where she was the chair of Child Psychiatry. She worked with Dr. Robert Prall who headed a Child Psychiatry residency at Eastern Pennsylvania Psychiatric Institute to develop one of the most highly regarded child psychiatry programs in the East. Selma had the ability to stimulate the child psychiatry residents to reach their potential and served as a role model for the residents, many of whom became child analysts. The child analysis program started by Dr. Mahler flourished under Dr. Kramer's direction and she formed a child analysis committee within the Philadelphia Psychoanalytic Institute that is responsible for all child analytic programs and training.

Dr. Kramer's contributions to the community led to her being awarded the Commonwealth Award of the Medical College of Pennsylvania for the Outstanding Woman in Medicine in the State of Pennsylvania.

Dr. Kramer married Ernest Witkin who was a strong supporter and a real helpmate of her work. Despite her enormous workload, Selma was able to raise two accomplished, successful children: Karen, who has a doctorate in psychology from Bryn Mawr and is a practicing clinical psychologist; and James, who has a law degree from Harvard University and is practicing law in the Washington, D.C. area. The lights of Selma's life were her four grandchildren.

Dr. Kramer's husband once summarized her pivotal contributions in a single phrase: "She was the friend of the little people."

Leo Madow, M.D.
Emeritus Chair and Professor of Psychiatry
Medical College of Pennsylvania

EDITORS' NOTICES



NOTES TO CONTRIBUTORS

Association for Child Psychoanalysis
Newsletter

We welcome reports, notices, program descriptions, summaries of scientific meetings and other articles informing members of the ACP about activities of child analysts around the world.

Length of articles:

We request that any one submission be no more than 1,000 words in length.

Deadlines for submission of articles:

The deadline for submission is six weeks prior to publication. The deadline for the June newsletter is April 15th. The deadline for the December newsletter is October 15th.

Submission of articles:

1. We prefer to receive submissions via e-mail to: bus@po.cwru.edu.
2. Our second choice is to receive articles on 3.5 inch floppy disks. We use Windows 98 with MS Publisher, Microsoft Word and WordPerfect, and can translate most software texts. If you are unsure as to the compatibility of your word processing program, it would be helpful for you to send the document in ASCII.
3. If you prefer, you may submit hard copies of articles which we will type into the newsletter. As well, if you are concerned about accurate punctuation, etc., in the translation of your word processing system, it would be helpful for you to send a hard copy of the item you wished published as well.

Please mail disks and hard copies to:

Barbara Streeter, Editor,
ACP Newsletter, Hanna Perkins Center,
2084 Cornell Rd., Cleveland, OH 44106

Hard copies may also be faxed with attention to:

Barbara Streeter at: 216-421-8880.

If you have questions or need clarification, please call

Barbara Streeter at: 216-421-7880 x226
Denia Barrett may be reached at 216-932-4165.



CONFIDENTIALITY

An important function of the ACP Newsletter is to provide summaries of scientific meetings of our own organization, as well as others which may be of interest to our membership. Shared clinical experiences, based on actual day-to-day analytic material, make vital contributions to our knowledge of technique and theory. When submitting reports or summaries which include clinical material, please omit potentially confidential or identifying details. If there is any question about confidentiality, the presenter whose material is being reported should have the opportunity to review and authorize its inclusion in the Newsletter.

Anyone who is aware of the death of a colleague is encouraged to notify Mrs. Nancy Hall. We will inform members in a subsequent Newsletter and we welcome personal reminiscences.

The Editors



ADVERTISING POLICY

The ACP Newsletter publishes announcements of scientific meetings and professional opportunities, colloquia, and seminars in an effort to inform members of upcoming events. In addition, we include information about training centers, child analytic journals and notices of programs offered by various members' organizations. All such announcements are provided at no cost and are intended to serve professional rather than commercial interests.

The Anna Freud Centre Training in the Psychoanalytic Study and Treatment of Children and Adolescents

Director: Julia Fabricius

Head of Clinical Training: Viviane Green

The Centre offers a 4-year Training Course in child analysis and child psychotherapy to graduates with an honours degree in Psychology or equivalent subjects and some professional experience with children. Personal analysis with an analyst approved by the Training Committee is required. The Course has been substantially reorganized to enable trainees to work part-time to support themselves during the training. (Interest-free loans are sometimes available.) The first (pre-clinical) year of the training can be taken as an MSc in Psychoanalytic Developmental Psychology.

The Course comprises

- A theoretical framework of psychoanalytic and developmental concepts, gained via participation in seminars, workshops, research groups, diagnostic groups and other meetings of the Centre.
- Observation of babies, toddlers, nursery school children, atypical children, disturbed adolescents and adults.
- Supervised clinical work in the psychoanalytic treatment of children of selected age ranges — under-fives, latency and adolescents; also, supervised psychotherapy with children, and supervised work with parents.

The Course is designed for trainees to become qualified in the field of child psychoanalysis and psychotherapy and experienced in diagnostic, consultative and applied work with children and adolescents. It leads to the qualification of Child Psychotherapist and is recognized by the Association of Child Psychotherapists for work in the National Health Service in Britain, and by the Association for Child Psychoanalysis, Inc. Trainees can also register for the Doctorate in Psychotherapy in Child and Adolescent Psychoanalytic Psychotherapy run in conjunction with University College London.

Enquiries and applications should be made to: The Head of Clinical Training, Anna Freud Centre, 21 Maresfield Gardens, London NW3 5FH

**University College London
M.Sc. in Theoretical Psychoanalytic Studies (non-clinical)**

This one-year full-time (two years part-time) course includes 12 units covering historical and current theoretical developments worldwide, which is taught mainly by members of the British Psycho-Analytical Society. Assessment is through written examination in June and dissertation and viva voce examination in September. The course is offered by the Department of Psychology, in the Psychoanalysis Unit which was directed jointly by Professor Joseph Sandler and Professor Peter Fonagy until Professor Sandler's death and continues now under the direction of Peter Fonagy. University College is the oldest and largest part of London University, and academically ranks a close third to Oxford and Cambridge among British universities.

A grounding in psychoanalytic theory would enable those who already have professional qualifications to add a thorough knowledge of psychoanalytic ideas, students interested in clinical trainings to complement the prevailing trend towards briefer and highly symptom-focused treatment approaches, and those from other disciplines to add this perspective to their understanding of philosophy, literature, art, history, anthropology, and many other fields. The course has been running for two years, and has established a very international, interdisciplinary feel. The only academic requirement is an honours degree in any subject from a university recognized by UCL. Students are not required to be in any therapy or to have clinical work experience, though many do.

Fees for overseas students are approximately \$17,000 for one year, or \$8,500 per year part-time. Application forms and further details may be obtained from: Dr. Mary Target, MSc Course Organizer, Subdepartment of Clinical Health Psychology, UCL, Gower St., London WC1E 6BT, UK. ☎ 011-44-171 380 7899 – Fax 011-44-171 916 8502 - E-mail mary.target@ucl.ac.uk.



**Hanna Perkins Center for Child Development
Course in Child Psychoanalysis**

The Course in Child Psychoanalysis is for non-medical professionals with postgraduate degrees who are experienced in the care of children and who wish to be trained in the psychoanalytic treatment of children. Those with medical degrees are also welcome to apply. This program has been in operation since 1958.

The curriculum begins with courses in theory and technique and observation of infants and observation of young children at the Hanna Perkins Therapeutic Nursery School and Kindergarten. It then proceeds to the supervised clinical treatment of three children by the psychoanalytic method and one case of a preschooler treated via the parent at Hanna Perkins.

The course is designed so that full time employment may be maintained while taking up to two children in analysis. Candidates are required to have a personal analysis and to plan to stay long enough to complete their clinical work. Applications are accepted at any time for groups which begin in September each year. Partial scholarships may be available.

For a brochure on the Program and further information, write to: Thomas F. Barrett, Ph.D., Director, or Elizabeth Fleming, Assistant Director, Hanna Perkins Center for Child Development, 2084 Cornell Road, Cleveland, Ohio 44106. ☎ 216-421-7880

**42nd INTERNATIONAL PSYCHOANALYTIC CONGRESS – JULY 22-27, 2001
NICE, FRANCE**

**PROGRAMS FOR THE IPA-ACP CO-SPONSORED HALF DAY PANEL ON
CHILD AND ADOLESCENT PSYCHOANALYSIS**

CHILD PSYCHOANALYSIS

Catlecting and Verbalizing Affects in a New Relationship: Aspects of the Analytic Method in Work with Children

Welcome: Coordinator – Christel Airas
Introduction: ACP President - Elect – Paul Brinich
Case I Vivane Chetrik, Jerusalem
Case II H el ene Keable, New York
TOTAL TIME: 3 1/2 hours

ADOLESCENT PSYCHOANALYSIS

Catlecting Body and Mind in a New Relationship: Aspects of the Analytic Method in Work with Adolescents

Welcome: Coordinator – Christel Airas
Introduction: Moderator – Donald Campbell, London
CASE I: Anita G. Schmukler, Wynnewood, PA
CASE II: Kaarina Brummer, Helsinki
TOTAL TIME: 3 1/2 hours

For more information please contact: Christel Airas, Liasion – ACP-IPA Programme Committee
H ogbergsg. 15 B 20, 00130 Helsinki, Finland
Phone/Fax: 358-9-629105 Email: christel.airas@pp.inet.fi

Non-Member Attendance at ACP Meetings

Non-members wishing to attend the Annual ACP Scientific Meeting may do so under the sponsorship of a member. The application form will include a line for identification of the sponsoring member. If the standard \$200 attendance fee poses hardship for a non-member, requests for a reduction of fee to the level of a candidate’s fee of \$100 may be addressed to the Treasurer of the ACP.

Non-Member Subscriptions to the Newsletter

Non-members attending an ACP Scientific Meeting will receive one complimentary copy of the ACP Newsletter. Those non-members wishing to receive future copies of the newsletter may do so at a subscription rate of \$10/year (\$5/copy). The charge will cover the cost of production and mailing, a cost covered for members through their annual membership dues. See below for subscription order form.

Because of rising costs, the Association for Child Psychoanalysis can no longer provide this Newsletter free of charge to those who are not members of the Association. If you are not a member of the ACP and would like to continue receiving the Newsletter, please remit the annual subscription cost of \$10 to: Association for Child Psychoanalysis, Inc., P.O. Box 253, Ramsey, NJ 07446

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**Calendar of Events
2000 – 2002**

July 26–30, 2000

“Diversity: Challenges and Opportunities in Infancy”

7th Congress World Association for Infant Mental Health
Montreal, Quebec, Canada

For information contact:

WAIMH, Kellogg Center, #27 MSU, East Lansing, Michigan
48824, USA

FAX.....517-432-3694

E-mail..... waimh@pilot.msu.edu

September 15-17, 2000

Challenges in Psychoanalysis in the 21st Century:

Psychoanalysis, Health and Psychosexuality
in the Era of Virtual Reality

Inter-Regional Conference of the International Psychoanalytic
Association

Geneva, Switzerland

October 12-15, 2000

Confidentiality & Society:

Psychotherapy, Ethics and the Law

Plenary Speakers: C. Bollas, C.L’Heureux-Dube, O.

Kernberg, J. Lear, F. Lowy, D. Weisstub

An Initiative of the Canadian Psychoanalytic Society & the

International Psychoanalytical Association

Montreal, Quebec Canada

October 24–29, 2000

American Academy of Child and Adolescent Psychiatry

47th Annual Scientific Meeting

New York City, NY

Panels Co-sponsored by the Association for Child

Psychoanalysis and its Members:

The Psychology of Learning Disabilities:

A Psychoanalytic Perspective

Presenters: Susan Sherkow and Martin A. Silverman

Discussants: Jules Glenn and Paulina Kernberg

Contributions from Child Psychoanalysis –

Gender Identity Disorder

Presenters: Judith Yanof and Stanley Leiken

Discussants: Susan Coates, Susan Bradley and Ken Zucker

For more information contact:

☎202-966-7300

Fax.....202-966-2891

Websitehttp://www.aacap.org

December 13-17, 2000

Fall Meetings of the American Psychoanalytic Association

New York, NY

March 30 – April 1, 2001

**Please Note: The Annual ACP meeting has traditionally been scheduled on the weekend of Palm Sunday. The 2001 meeting has been scheduled for the weekend prior to Palm Sunday weekend because of Passover.*

Annual Meeting of the Association for Child Psychoanalysis
Los Angeles, CA

For information contact:

Nancy Hall

☎/Fax201-825-3138

E-mailchildanalysis@compuserve.com

April 20-22, 2001

**The Second International Neuro-Psychoanalytic
Conference: Neuroscientific and Psychoanalytic
Perspectives on Memory**

Presenters: Daniel L. Schacter, Harvard and Mark Solms
The New York Academy of Medicine

For information contact:

Paula Barkay, Anna Freud Centre,

21 Maresfield Gardens, London NW3 5SH

☎ +44 20 7794 2313

Fax..... +44 20 7794 6506

E-mailannafreudcentre@compuserve.com

May 2-6, 2001

90th Annual Meeting of the American Psychoanalytic Assoc.
New Orleans, LA

July 22 – 27, 2001

42nd Congress of the International Psychoanalytic Association
IPA-ACP Co-Sponsored Program:

Half Day Panel on Child and Adolescent Psychoanalysis

Cathecting and Verbalizing Affects in a New Relationship:

Aspects of the Analytic Method in Work with Children

Cathecting Body and Mind in a New Relationship:

Aspects of the Analytic Method in Work with

Adolescents

Nice, France

For more information contact:

Christel Airas, Liasion – ACP-IPA Programme Committee

Hogbergsg. 15 B 20, 00130 Helsinki, Finland

☎/Fax358-9-629105

E-mailchristel.airas@pp.inet.fi

October 29 – November 2, 2002

International Association for Child and Adolescent Psychiatry
and Allied Professions [IACAPAP] Congress

New Delhi, India

Roster Update Form for ACP Members

Please check your listing as it appears in your most recent ACP Roster. If any changes or additions are necessary, please complete this form (or a copy) and send it to our administrator, Mrs. Nancy Hall, P.O. Box 253, Ramsey, New Jersey 07446
☎/FAX: (201) 825-3138 — E-mail: childanalysis@compuserve.com

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E-mail _____



**Association for Child Psychoanalysis
Newsletter**
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Mrs. Nancy Hall, Administrator
P.O. Box 253
Ramsey, New Jersey 07446 USA
☎/FAX (201) 825-3138
E-mail: childanalysis@compuserve.com

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