In the last ACP newsletter, then President Ruth Karush provided us with a broad picture of the state of child and adolescent psychoanalysis today. She noted a trend to less frequency in number of sessions as well as the providing of analysis by a preponderance of older clinicians. The ACP has begun now to address these issues with the recent bylaw amendment enabling Candidate Members to vote and to chair a number of committees. We hope to invigorate our organization with younger members who will take an active role in the ACP’s contribution to the work of child and adolescent psychoanalysis. At the same time the practice of sponsorship of new members will allow us to maintain the standards of child and adolescent psychoanalytic treatment which we as a group support.

The ACP traditionally has been a relatively small organization, one in which analysts have felt comfortable to present and discuss detailed clinical material in depth. A shared theoretical perspective has contributed to this phenomenon. As we broaden our membership guidelines and empower current and future Candidates with a stronger role in the ACP, a natural consequence involves the inclusion of more theoretical models in our thinking. As Regular Members we need to welcome new ideas, to examine them carefully in the light of our own child and adolescent analytic experiences, and to integrate them where we find them valuable. In turn we count on Candidate Members to welcome the opportunity the ACP offers for thinking seriously about the work they have undertaken and to benefit from the accumulated knowledge of older colleagues.

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The Association for Child Psychoanalysis, Inc.

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Grants from the ACP supporting low-fee analysis of children and adolescents for the calendar year 2007 are available. Please request the grant application from Tricia Hall at
childanalysis@comcast.net

Mail completed application to
Tricia Hall
7820 Enchanted Hills Boulevard, #A-233
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Deadline for Submission of Application:
October 20, 2006
Cynthia Carlson
Chairman, Grants Committee
Another issue claiming our attention is the ongoing development of practice parameter guidelines initiated by the American Association for Child and Adolescent Psychiatry’s Quality Issues Committee. (The current issue being studied is “childhood depression”.) The DSM-V is also underway with a target publishing date of 2010. The focus for this work is on “evidence-based medicine”. As child psychoanalysts we can influence the construction of these guidelines if we participate. AACAP has funded Rachel Ritvo and Tom Anders to coordinate this project. Members should be expecting emails to alert them to the need for involvement. Looking forward, we shall all need to remember to use DSM-friendly language in our published works so that they can be accessed on the Internet. The AACAP Quality Issues Committee will welcome psychoanalytically-based articles as they work to provide malpractice guidelines for the field. Our treasurer Helene Keable has joined that work. Nat Donson and Barbara Deutsch are also actively involved. We rely on them to keep us apprised of contributions the ACP can make toward that very important effort. It is through such member activity that the ACP can influence the more troubling policies of the DSM.

All in all, the ACP is working hard to balance its role in deepening our understanding of the inner world of the child while recognizing the value of interfacing with the broader professional world.

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Message from the President

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Striking a Balance: The Selection and Cost of Annual Meetings

Tricia Hall

The ACP initiates the Annual Meeting site selection process by first choosing a host city. At each Annual Meeting, the ACP asks members to suggest locales for future meetings, and after these suggestions are compiled, the Executive Committee chooses a city that might be a unique fit for the next Annual Meeting. After a city is selected, we request proposals from properties in the city. We always seek proposals from hotels that are conveniently located near local attractions, dining, and shopping.

Because the ACP Annual Meeting presents an excellent booking opportunity for hotels, the proposals that we receive often include a variety of incentives. The ACP’s room block is large enough to merit a discount off of current rack rates (full rates), which can be several hundred dollars per night, depending on the city and property. These proposals also offer a discount on the meeting space that the ACP uses for its lectures, presentations, and discussions, as well as a reduction on standard food and beverage menus.

Once the ACP has evaluated the competing proposals and properties, it selects a hotel that can address all of its needs. Although it is very important that we receive a discounted room rate for our members, this is only one of many factors that we must weigh before a decision is made. It is important to understand that our meeting room requirements are very space-intensive. The general session meeting room must be able to accommodate all attendees in a classroom-style setup, and this space must be available for use throughout the Annual Meeting weekend. In addition, we must also use a number of smaller breakout rooms for lectures, presentations, and discussions. This is often a tall order for many properties because although our Annual Meeting room block is considerable, it is not huge. Therefore, the ACP must work

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Leon Hoffman, M.D., moderator of the Plenary Session, began the presentation with introductory comments. After thanking Anita Schmukler, D.O., and the Program Committee, he expressed his gratitude to Sydney Anderson, Ph.D. and Kelly Hill, M.D. for providing the clinical material for the discussion. Dr. Hoffman explicated the structure of the session: after each case presentation, there would be time for brief clarifying questions from the audience. After the second presentation, Dr. Hoffman would highlight a situation in the analytic work in each case where the material seemed to evolve and a situation where the material did not seem to evolve and would ask the presenters to comment. The discussion would then be opened to the audience.

Dr. Hoffman identified the nature of therapeutic action for child analysis and the actual mutative interventions as key questions for child analysts. He focused the attention of the group on painful affects and the defenses against them as a theme of this plenary, and that affect attunement leads to interventions that work. Dr. Hoffman remarked that both interpretive and non-interpretive techniques are necessary, but that younger children and more “disturbed” children required to use of more non-interpretive techniques or “developmental help.”

Before introducing the first presenter, Dr. Hoffman recognized the death of Donald Cohen, M.D. Not only was he a long-time member and former chair of the Child Analysis Committee at the New York Psychoanalytic Institute, he had supervised both Drs. Anderson and Hill.

Dr. Hoffman then introduced Sydney Anderson PhD. Her presentation was entitled, *Psychoanalysis with the Master of Mischief: Providing Containment and Rediscovering Affect.* Alex had begun his analysis at age 5 because of relationship struggles, speech issues and externalizing symptoms. He had some traumas at age 3 and separations were difficult for Alex. His responses to his difficulties included attacking and stealing. He was on the verge of expulsion from school and he was unresponsive to the gravity of this situation. While there was some question of an autistic spectrum disorder, through the course of the clinical work, Dr. Anderson came to believe that Alex suffered from an extreme isolation of affect and disconnection from others stemming from internal conflict.

One characteristic of Dr. Anderson’s work with Alex included regular communication with Alex’s parents and teachers. Although Alex felt disrespected and angry by her regular communication with parents and teachers, he was also grateful. He remarked to Dr. Anderson about his school problems, “I need you to help me figure out my feelings so that I can stop.”

Dr. Anderson then proceeded to highlight two periods of particular difficulty for Alex in school. The first example involved a break due to the therapist’s vacation. Dr. Anderson allowed Alex access to certain food items in the kitchen of her office and also to other belongings of hers including coins, a particular interest for Alex. Following this break, Alex found a Peso in her coins and realized that she had traveled to Mexico during the break. He gleefully stole the Peso even after Dr. Anderson remarked upon his hiding the Peso and tricking her into believing that he had returned it. Dr. Anderson helped the audience to enter her world with this child by sharing her anger and subsequent guilt about the situation. Further, Alex reacted by becoming more aggressive and destructive at school. Dr. Anderson helped the audience see how her reflection upon the action in the treatment room and in school in conjunction with her supervision helped her to respond in a more attuned way with Alex. Alex then began to work through his anger and brought it into the room with Dr. Anderson. Dr. Anderson remarked, “I began to feel that we were really (Continued on page 5)
having an exchange that involved an interchange of both our thoughts and feelings - not just words.”

Dr. Anderson’s second example involved Alex’s stealing school work from another student, a girl. Alex believed that the assignment was a difficult one for him, and he also believed that this girl preferred another boy to him. Alex was threatened with expulsion and endured a one-day suspension. Dr. Anderson talked about her countertransference in this situation, and how her insight into this allowed her to work with the teacher and parents to address Alex’s escalating anxiety and destructiveness. With the resolution of some of his anxiety, Alex’s behavior settled, and this ushered in another phase of the analysis – material focused upon sexual issues. Although Alex continued to sing, “The world is a very scary place” in regard to opening himself up to the idea that he could not control his significant others, he was able to address his immense pain and loneliness.

After a break and some brief questions, Dr. Hoffman introduced the case to be presented by Kelly Hill, MD. Sarah was a late latency-aged child at the beginning of the analysis. Like Alex, Sarah had had early trauma, but her trauma was related to a medical intervention. Sarah’s difficulties tended to be manifested through somatic complaints. She became obsessed with death. Further, Dr. Hill had to contend with the parents’ denial of her patient’s depression. Sarah saw herself as “defective.”

Dr. Hill took the audience through her thought processes in determining whether analysis was the proper treatment for her patient. The stress involved in doing intensive work could influence the medical condition. However, her patient, distressed as she was, remarked after a session, “I would like to come every day.” Through play with puppets, Sarah began to explore her anger, greed, aggression, fear, starvation, and deprivation. Her character had a sister who was ill and a mother who just had a baby boy. Competitive strivings entered the picture and were accompanied by attraction to death scenes.

As the play involved more characters, Dr. Hill began to feel trapped in a sadomasochistic cycle. There was evidence in the play of Sarah having a very punitive superego; this issue was dealt with analytically. At the same time, the patient’s attachment to her analyst became increasingly difficult for Sarah’s mother. If Sarah improved too quickly, she would lose her analyst. Issues of body image and appearance came into the treatment.

After questions on Dr. Hill’s presentation, Dr. Hoffman asked the presenters and audience to consider four broad issues prominent in every child analytic case: interpretative techniques; management techniques; the role of play; and the centrality of work with parents. Dr. Hoffman asked Dr. Anderson to comment on two parts of her treatment of Alex, one that illustrated interpretative work and one that illustrated management of the situation. Dr. Hoffman asked Dr. Hill to comment on two parts of her treatment of Sarah, one that illustrated the role of play and another that illustrated primarily the work with parents. Each commented upon these points in their respective treatments and which they felt were more and less effective.

A lively discussion ensued. Questions from the audience addressed the loss of a supervisor during the treatment; the issue of diagnoses; the question of whether through contact, a diagnosis could change; the decision of whether to prescribe medication for an analytic patient; contact with teachers; boundary violations; and countertransference issues to name a few. All commentators expressed their thanks to the presenters for their wonderful work and their willingness to share it and themselves with the group.
The Marianne Kris Memorial Lecture, *The Development of a Psychoanalyst*, was presented by Dr. Judith F. Chused. It was a delightful, informative and moving paper that reached across the developmental lines of psychoanalytic training and work. As a candidate, it was especially meaningful for me to follow her journey and identify with and learn from her personal, theoretical and technical questions and struggles.

Dr. Chused began by saying she had always wanted to be a psychoanalyst and that she followed a path her father began as a co-founder of the St. Louis Psychoanalytic Institute in the era when psychoanalysts were either immigrants, fleeing the war in Europe, or veterans of WW II. She said analysts of that time believed that psychoanalysis was not only a solution for the neuroses of individuals but also the solution for social problems such as war. Dr. Chused said that the analysts she met as a child rarely questioned aspects of their work.

She went on to discuss her medical and psychoanalytic training which began at a time when she was one of the few women in her medical school class. With humor, curiosity and insight she described disregarding warnings to avoid the “do nothing” field of psychiatry. Instead she completed residencies in psychiatry and child psychiatry and then proceeded with analytic training, the only woman in her analytic class of 12. When she began her training she said candidates “religiously” followed teachers’ and TA’s teaching and that questioning was considered a sign of problems with authority. Dr. Chused and her peers who came of age protesting the Viet Nam war were more comfortable challenging rules.

Dr. Chused interwove her personal story with the evolution of her theoretical and professional development. At this early stage of her career she said she decided she was a clinician, not a theoretician because it was difficult for her to relate her work in her office with the subtleties of metapsychology. Dr. Chused said she thought that with enough experience theory would become unimportant once she developed the capacity to follow the patient’s and her own associations to make known what was not known. She approached technique with a focus on engaging the patient.

This paper is rich in its scope and thoughtfulness. Selections from the material reflect some of the topics that were particularly compelling and informative.

Her early experience and insight led to her interest in writing about enactments. Dr. Chused said working with children taught her that children do not have the ego defenses to tolerate strong affect and they become overwhelmed when words convey too much too soon. Working in a therapeutic nursery for profoundly disturbed children who were resistant to treatment, Dr. Chused described her realization that child therapists, frustrated in their attempts to help their patients, sometimes expressed this in action by over-talking. This intensified the withdrawal of the children. According to Dr. Chused, belief in the power of words and loyalty to their technique interfered with the therapists’ neutrality and made them vulnerable to enactment. In this setting Dr. Chused reported she learned about nonverbal communication and the communicative power of action. While she recognized engagement was crucial she said she also came to recognize that transference and working with it through the action of play rather than only words was also crucial. She recognized that behavior itself can function as a clarification. Dr. Chused said she discovered that an interaction that has emotional impact on a child (or adult) and informs an individual about himself allows for later words and interpretation that can facilitate change. She made the point that the analyst needs to develop the ability to tolerate the patient’s and her own psychic demands without defensiveness.

As her career progressed, Dr. Chused’s focus on the interaction between patient and psychoanalyst in her work and writing led to many insights. She modified her technique in her efforts to engage her patients in treatment. Dr. Chused’s empathy for the patient as well as the analyst in this difficult work, so apparent in her presentation, led her to further ex-
plore the concept of mastery. She explained that the patient and the analyst both need to feel competent, to believe they have the capacity for mastery. She made the point that to change we need to be able to observe ourselves in action and be the observer rather than just the observed. For example, Dr. Chused shared material from her analysis of a 6 year old boy. In talking with the boy she saw how the change of one word, as in “You became mad because I told you it was the end of the hour” to “You became mad when I told you it was the end of the hour” changed the description of a causal relationship to that of a temporal one. Changing one word of the interpretation gave the child a tool to learn about himself rather than convey in an authoritative manner that she knew more about the patient than he knew himself. From this experience Dr. Chused described learning how and when to talk, how to be willing to not be an authority, how to sound uncertain and how to be the object of scrutiny. She said changing her technique increased her patients’ participation in the work.

Dr. Chused’s ideas about theory evolved and changed. She stated that our investment in our ideas helps us gain mastery over internal problems and is an outgrowth of that mastery. Dr. Chused noted that theories are not only products of education and experience but are also reflections of our personalities. Learning to become comfortable with our own impulses and fantasies is essential in doing the demanding and rewarding work of psychoanalysis.

In her personal and professional development, writing became a treasured part of Dr. Chused’s identity as she strove to organize her ideas and express herself. She shared that as she liberated herself from the intellectual control of her teachers, she became less absolute in her thinking. Dr. Chused said she is less insistent on the correctness of her ideas and more interested in the process of communication. She explained that awareness and acceptance of her own immutable personality traits allowed her to be less defensive and helped her work. She continues to look for new ways of interacting with child and adult patients. Dr. Chused’s ability to share her work in such a personal and professional way allowed the audience to share her journey with great pleasure.

Welcome New Members!

The following child analysts became new ACP members. We welcome them and look forward to their contributions in the field and in our organization.

Regular Members

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<td>Anna Balas</td>
<td>Ruth Karush, Susan Sherkow</td>
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<td>Dagnija Tenne</td>
<td>Elizabeth Tuters, Robin Holloway</td>
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<td>Era Loewenstein</td>
<td>Stanley Leiken, Jack Novick</td>
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<td>John Rosengart</td>
<td>Katharine Rees, Dale Ryan</td>
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<td>Andrea Weiss</td>
<td>Stanley Leiken, Kerry Novick</td>
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Candidate Members

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<td>Daniel Prezant</td>
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<td>Violet Little</td>
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<td>Ira Brenner</td>
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<td>Joanna Goodman</td>
<td>Charles Mangham, Werner Schimmelbusch</td>
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<td>Christopher Kido</td>
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<td>Mary Claudia Wall</td>
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Anna was a seriously disturbed 6 ½-year-old girl: she had not attended school for several months, had stopped talking, showed no affect and neither ate nor moved spontaneously. When Dr. Henderson received a referral from the parents' HMO to see Anna, the parents had refused to see four other mental health professionals who would not permit them to attend the evaluation of their daughter. At the end of her meeting with the parents, Anna’s mother told her that she didn’t think Anna would come to Dr. Henderson’s office. Dr. Henderson asked permission to come to their home and saw Anna there seven days a week for the next three months.

When Anna and her mother came to the office, Dr. H focused on making running comments on Anna’s play, talking about the possible meanings of the actions and commenting on Anna’s feelings. After six weeks, Anna’s mother announced that she would wait for Anna in the waiting room. Dr. Henderson made sure to let Anna know that their sessions were private. She spoke through the stuffed animal Anna held to let her know that she might not have felt safe at school and that she may have been angry. The next day Dr. Henderson brought in her own puppet as well as other characters from Anna’s favorite story. During the sessions, when she didn’t understand what was happening in Anna’s play, she wondered about what the puppets were doing and how they might be feeling.

After staying silent every day for six months, Anna finally sang along with a favorite tape that her mother had brought. Her physical activity increased and other sounds emerged. At home Anna became calmer and more involved in daily activities. After their first break in treatment, Anna said her first word and soon began talking more in the sessions. She started talking in complete sentences to her mother. She eventually expressed interest in returning to school. About a year after treatment began, Anna returned to school.

Although Dr. Henderson focused on the beginning of Anna’s analysis, she also included delightful process notes from other years. In an hour from the third year, they explored Anna’s mixed feelings about going to school and her perfectionism through the metaphor of her imaginative play. Moreover, Dr. Henderson described her own dilemma about interpreting Anna’s metaphors too directly, so that Anna would shut down versus being too easy with Anna in her interventions. During an hour of the last year of this six-year, five month analysis, Anna was more articulate about the ways her analyst resembled her parents and in which way she differed from them and she had also become more articulate about her feelings of emptiness and anger. When she terminated, Anna understood the reasons for her anger and could write well about her feelings.

Our small group had a wide-ranging discussion of this unusual treatment. Dr. Shaw touched on the following issues: how unusual it is to start a therapy with a home visit; how one might reach a selectively mute child; what factors might have been involved that helped Anna change; the work with the parents and Anna’s intrapsychic experience of the school and her mother’s attempts to control her. What brought tears to the eyes of some of the participants was Dr. Shaw’s playing of Harry Chapin’s song about a child who conformed to the teacher’s views on the first day of school.

Dr. Henderson mentioned that she felt Anna was analyzable when Anna’s gaze locked onto hers during the first session they had in her office: “there was something there, and if I mobilized the aggression, I could get her on track.”
Inge Pretorius, Ph.D. of The Anna Freud Centre presented a fascinating paper entitled: Recalling Preverbal Memories through Play; the Analysis of a 6 Year-old Boy Who Suffered Trauma as an Infant. Dr. Pretorius described the excellent work she is doing in an ongoing 4 year analysis. She gratefully acknowledged the Association for Child Psychoanalysis for the financial support she received for the first two years of the analysis.

This is the analysis of a boy who at the age of 18 months suffered the major childhood calamitous loss of the object(s), when he witnessed the violent death of his mother and soon thereafter lost his father. After spending a year with a foster family in which he became close with his foster siblings, he again suffered the calamitous loss of the object(s) at 2 ½ years when he lost his foster family and was adopted by new parents.

Dr. Pretorius described how in addition to the salient violent trauma of seeing his mother die, he also suffered from chronic trauma due to the prior marital violence and the multiple changes in his living situation. She was able to integrate the rich clinical material with trauma literature to show that the cumulative and salient traumas had different effects on him and were represented in his memory differently. Dr. Pretorius showed that despite his never being told the details of the traumas, he had clear verbal memories of what he had witnessed in a preverbal stage of his development.

Dr. Pretorius identified three phases to the child’s analysis, which began at the age of 6. In the first phase, he was disorganized, violent and had trouble regulating his affect. In this stage, he seemed to be repeating in his sadomasochistic behavior what he didn’t remember or couldn’t yet say. Rather than interpreting his behavior, attempts were made to provide a container for it and to provide him with a new or reparative object. During this phase, breaks in the analysis led to his breaking his arms in accidental falls. The patient behaved in ways which prompted Dr. Pretorius to hold him, but which made her feel guilty as though she were hurting him. These were understood to be re-enactments of the trauma.

Eighteen months into the analysis, which was the age when he witnessed the traumatic loss of his mother, a second phase of the analysis began; in this phase, early traumatic memories came to the surface and were spoken about. Dr. Pretorius tried to be a container for his powerful feelings, as they evoked countertransferential feelings of suffocation in her. The audience found it very moving when she reported his talking about his mother’s death for the first time, during which he accused Dr. Pretorius of knowing this all along and asking why she never talked about it. This led to more reconstructed memories of the trauma, as well as playing out violent death scenes and his rescue fantasies. This was accompanied by his getting agitated and acting out his rage at Dr. Pretorius in the transference. She had strong countertransferential feelings of rage and helplessness which she was able to use to further inform her analytic interventions when she interpreted his wish that the police had been able to prevent his traumatic losses. This interpretation was first met with a denial of reality, but led to the revelation of a guilty fantasy in which he felt it was his fault.

A third phase began two and a quarter years into the analysis when he moved from acting out the past to using the displacement of play to play out his early memories. Central to his progress was Dr. Pretorius’ acceding to his need to control what she said and did in the displacement of the play. In fact the patient’s responses to her stepping out of her role were very instructive to the general principle of not interpreting the play. During this phase, he remembered in his play details of the trauma that he had never been told about and that happened prior to his

(Continued on page 20)
Dr. Clement’s report of the analysis of a 15½ year old girl ‘playing at sexuality and sophistication’ beautifully illustrated the ways in which conflict interferes with school performance. In addition, through her astute delineation of this child’s defensive structure and her creative use of interpretation, she gave us a developmental lens into analytic work with adolescents.

Dr. Clement began with a description of the presenting problem. The parents described C. as a pretty, talented, bright, articulate girl, always in the limelight and achieving from an early age some success and recognition as an actress. They were concerned with C.’s declining academic performance, and more importantly, her recent lying to parents and teachers to conceal her academic difficulties. The parents were at a loss. Neither firm conversation nor restrictions, such as grounding or punishments, had any effect and they felt helpless and even scared in the face of her downward spiral. Upon meeting C., Dr. Clement was struck by C.’s vivacious energy and enthusiasm, and saw little overt evidence of worry, concern or anxiety. Although C. alluded to her ‘infantile needs,’ for the most part she maintained her upbeat façade and spoke of her ‘great family.’ Dr. Clement began a consultation, and within a few months, saw evidence of C.’s problematic behavior. C. had begun to slip out of school midway through the school day. Despite C.’s assurances to her parents that each problematic incident represented a one-time lapse, her behavior did not change.

During the evaluation phase, Dr. Clement increased the frequency of consultation sessions to twice weekly and she suggested projective testing to assess the severity of C.’s pathology. The testing pointed to serious narcissistic character pathology and highlighted the risk of her spinning out of control without intensive dynamic treatment. Gradually, Dr. Clement began to understand the content of C.’s thoughts during the times away from school, when C. would walk or sit by herself for hours. The solitude provided the setting for uninterrupted daydreams. C. explained: “I am always thinking about one of my scenes” and described that in these scenes she was a present and future star, performing in front of adoring crowds. Dr. Clement wondered how she might help C. become curious about herself, develop a capacity for psychological thinking, tolerate feeling vulnerable and develop resilience in managing the internal and external ups and downs of life with less reliance on posturing and display. Dr. Clement increasingly believed that only an intensive, psychoanalytic approach would provide the level of contact necessary to reach this girl. She also was convinced that without intensive treatment, C.’s condition was likely to deteriorate. When C.’s parents became increasingly concerned by their daughter’s worsening troubles, they accepted the recommendation for a four times weekly treatment.

Highlights of the treatment will be summarized. Because Dr. Clement quickly sensed that C. experienced her comments as jarring and irritating interruptions, she initially restrained verbalization and simply watched and listened. C. hid her pain and troubled internal world in dramatic, larger-than-life, and often wildly humorous terms. Eventually, Dr. Clement herself created dramatic situations in which she could make interpretations. For example, she would try to pique C.’s curiosity: “You know, I just noticed something really important and I have to tell you about it.” She also evolved another technique in which she pretended to be on stage with C. and would turn to an imaginary audience and say: “Ladies and gentlemen, I hope you are all noticing….” Gradually, C. relied less upon her cheerful affect and shared her occasional disappointment, usually when one of her fantasies or ‘scenes’ had failed to come to fruition. Dr. Clement eventually could say to C. that it was particularly hard for her to bear nar-
In this paper Dr. Kohn describes his 2 years of work with E., a boy whom he first saw when E. was 10. E. struggled against a form of chronic anemia, probably of genetic origin, as well as with a neurosis.

E. was referred for lack of academic progress, behavioral difficulties and emotional responses which made him difficult to teach and troubled other students. When asked to perform a task he found difficult, E. responded with aggression or withdrew into fantasy. The immediate precipitant for the referral were some disturbing cartoons, which illustrated fantasies of hurting himself and other children. There was also some evidence that E. was concerned about his gender identity.

E. had received transfusions every 3 to 4 weeks for his entire life, which not only distressed E., but also made his mother anxious. In addition, since about age 3 ½ E. had required nightly infusions of medication via a catheter in his buttocks, in order to counteract the build-up of iron in his body due to the transfusions. These buttocks infusions were administered by his physician father.

The pregnancy with E. was complicated by his mother’s being confined to bed for the 10 weeks prior to his due date. However, he was born at 34 ½ weeks in a traumatic delivery during which he stopped breathing. As a toddler, he was aggressive and had difficulties going to sleep. His aggressiveness improved once he could speak. A sister was born when E. was 3 ¼, around the same time as the buttocks pump was instituted. The family was devoted and loving, but his E.’s mother was often too anxious to be able effectively to soothe him. His father was loving but worked a lot and was less available to his children, or for appointments with the analyst.

E. initially avoided eye contact with the analyst, but was very engageable when the analyst asked him to tell about what happens at school. He clearly described his “explosions” when frustrated, which occurred despite his attempts to contain himself. It was “like holding back a dam that’s about to blow up.”

E. went on to talk about his dreams and to draw cartoons in which he was able to express his concerns symbolically as well as elaborate on the fantasies in more direct discussions with his analyst. One very important character had a “brilliant mind and a wimpy body.” This character had a henchman “to do his dirty work.” When E. told the analyst that other kids did not like his cartoons, his analyst became more aware of E.’s yearnings to feel understood.

The analyst felt pressure from the school to medicate E., but was able to engage the family to try analysis first, without medication. The evaluation process lasted from around Thanksgiving to the following February, when the analysis proper began.

E. quickly revealed the depth and intensity of his anxiety about the intactness of his body as well as the power and dangerousness of his feelings. When the analyst got too close to describing his fears, eg. that I.V.’s could be like scary snakes, E. retreated and withdrew. He became more comfortable again when the analyst focused on his defense against the fears, that is, his efforts to protect himself.

In the summer, E. brought a Far Side cartoon his father sent with him. It depicted a patient threatening to assault his psychiatrist. The analyst talked with the parents about how E.’s doctors could seem threatening to him, addressing via displacement the parents’ anxiety and anger with doctors and recognition of father’s apprehension about the analytic work.

During the same summer, the family attended a camp for families of children with E.’s illness. They returned thinking more seriously than previously about the possibility of a bone marrow transplant, for which his sister could be a donor. They felt time pressure, as they had learned that children with this disorder generally become less cooperative with treatment during adolescence. Also that summer, E.’s family found a new school for him, where he was with other children suffering from disabilities. He was much more comfortable there, and developed buddies. He was no longer an outcast or the least socially capable.

As the year went on, E.’s trust in his analyst and hopefulness grew. In one cartoon of a series he depicted two buddies camping at the base of a cliff. Aliens inhabited the ledges above, but they were simply “weird” rather than threatening to take over the world or sucking out people’s brains.

After Christmas a new child came to class, who threatened to attract E.’s best friend away from him. E. imagined angrily sending his rival to isolation, a condition he would have to endure as part of his (Continued on page 22)
Dr. Alessandra Cavalli is a Jungian analyst from London. Her talk focused on a link between the capacity to learn and the capacity to be with “an-other”. “It is in relation to another that a child apprehends itself and the world in which he lives. With an-other a child learns to regulate affects, to understand and manage them… When a child has an-other, his experiences can find meaning. Meaning promotes understanding and learning.” Underlying development in this model is a process of “deintegration” (not disintegration) and “reintegration”. In deintegrating, a baby opens up to new experiences. The baby’s mother makes sense of the baby’s deintegrative experiences, providing understanding and meaning. The mother helps the baby to reintegrate, assimilating these experiences into its self. Without someone, “an-other”, to communicate with about states of self, the child creates a “do-it-yourself” psychology that defends against deintegrations, prevents meaningful reintegrations, and interferes with learning.

Exemplifying these principles, Dr. Cavalli presented clinical material. The first material came from the Infant Observational Study and was of a girl who had been observed weekly from birth to age three. From 16 to 19 months of age her father was physically unavailable and her mother was depressed. Neither of her parents was able to help her create a meaningful link between her affect and their unavailability. Instead she developed a manic defense in which she learned to mimic perfectly the behavior of some older children on a videotape.

Then Dr. Cavalli presented clinical material from the analysis of a boy from nine to twelve years of age. Very deprived, the boy was unable to read and was defending against knowing reality, internal and external. As he moved from attacking his analyst physically to the pleasurable experience of togetherness with her, he dropped his defenses and revealed delusions involving a lack of differentiation between genders. In the process of revealing these aspects of his internal world to his analyst, he was “deintegrating.” This provided an opportunity for his analyst to help him reintegrate in a way that provided meaning and he became academically successful. The clinical material presented had the purpose of highlighting the presence of infantile sexuality within the scope of the child’s experience. At the same time, it emphasized the significance of thinking and the importance of concept building for the solution of psychic conflict. Even if the child’s interest was directed at sexual matters, the goal was actually the development of his thinking capacity.

Dr. Gilmore, in her discussion, questioned a theoretical distinction made in the paper between self and ego. She felt that what Dr. Cavalli was describing was ego endowment and that the self, an aspect of consciousness, achieved consolidation later in infancy. She also referenced literature describing the crucial role of a mother in helping her infant to learn about individual minds being different and about the pretend mode of thinking. She next raised questions about the influence of nonhuman modalities in teaching children. Finally she expressed her belief that this early adolescent boy was having a struggle with the transformations of puberty that was not addressed in Dr. Cavalli’s interpretations. This led to questions about the place of libido and sexual development in Jungian theory.

The audience discussion was characterized by efforts to understand, compare, and contrast Dr. Cavalli’s theoretical perspective and clinical work with those of the audience. Dr. Cavalli’s theoretical perspective and clinical work with those of the audience. Dr. Cavalli presented a conception of the self (precedent to the ego) as a psychosomatic integrate, devoid of phenomena, with a matrix of potentialities of the organism. These potentialities (as the ego) await the deintegration/reintegration process to become actualized. They unfold out of the self. Questions were raised about the degree to

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Eleven-Year-Old Karen: Masturbation and Obsessive-Compulsive Disorder

Presenter: Nathaniel Donson, MD
Discussant: Carla Neely, PhD
Reporter: Cheryl Yound Goodrich, PhD

What would have happened if Melvin Udall, the character Jack Nicholson played in the 1997 film "As Good As it Gets", had had an analysis as a child? Well, if it had gone like the analysis presented at the Friday Workshop by Dr. Nathaniel Donson, there'd be no movie.

This case presentation, discussed by Dr. Carla Elliot-Neely, was riveting and evocative. The two and a half-year, four times weekly analytic treatment of a ten year old girl with severe OCD completely resolved her symptoms. At referral, Karen was nearly delusional. At bedtimes, she had endless rituals, repeating homework, drawings, getting into bed "properly," insisting that her mother follow in her footsteps and read to her in a strictly dictated way. She worried that she had started fires with her feet and had developed touching and checking "habits" to reassure herself she had not done so. She checked her underpants for leaking, washed her hands compulsively. She feared kidnappers, of being mistaken for dead and locked in a coffin, catching germs and becoming ill. She worried her dolls would become alive in the night and asked to have their faces turned away from her. She frequently cried when her mother left her.

Her parents realized she needed help when she was seven after her intense envy of her younger sister had provoked rageful outbursts. She was taken to an allergist who treated her headaches for the next three years, then to a behavioral therapist who tried for eight months to reduce her compulsions. By the time of referral to Dr. Donson, she had developed a pattern of abdominal pains before tests, frequent visits to the nurse's office, and school refusals.

Karen's parents recalled that after the birth of her first sister Karen had become more clingy, regressed and unfriendly with peers. She had also two older brothers. Striking in her history was the death of a second sister soon after birth, when Karen was three years old. Her mother, a hospice nurse, was from a chaotic family plagued by alcoholism and physical violence. Her father, the more empathic parent, was the main support of his daughter's treatment. He however had a long history of ritualistic inclinations, compulsivity, eye tics, and overt magical thinking.

In the initial meeting with Dr. Donson, Karen jumped, startled, as he appeared at the waiting room door. She said little, often, "I don't know," and was entirely silent in the following two appointments. Dr. Donson related how he quickly learned not to ask too much, not act too interested. After long silences, she told him a little at a time about her parents' angry attempts to distract her from her rituals. She did seem genuinely interested when it was explained that only by carefully understanding all about what she was feeling and thinking when her habits occurred would she eventually be able to control these upsetting behaviors. As treatment proceeded, she ventured to speak more, but these moments too were followed by long silences, often through the next half dozen appointments. Dr. Donson made an art of waiting, listening and observing. He often noted discontinuities in what Karen said. Eventually, Dr. Donson developed a working hypothesis that Karen's early affect hunger, anger, envy and sexual impulses had never been well differentiated. Dr. Neely pointed out that Karen's parents' challenges and limitations, and likely Karen's biologic propensities as well, had led to her failure to master early libidinal phase development. Rigid, harsh and primitive defenses failed to contain her impulses. Since she had come to rely on such fragile defenses, Dr. Donson accommodated to her reticence by remaining silent much of the time.

As the relationship developed, Karen began to find Dr. Donson's ideas helpful. She observed the intensification of her rituals when her mother left, and began to make more sense of herself. Even though she remained largely silent for the first year and a half, her manner became softer; she began to relax and also became more sexualized in her behaviors. She evoked her analyst's interest in her body, for example winding hairs around her tongue, tapping her hips, and finally put words to her tapping ritual:

(Continued on page 21)
In his introductory comments Dr. Cohen welcomed the presenters to this meeting. Now in its 38th year, the workshop meets at the winter and spring meetings of the American Psychoanalytic Association and annually at the ACP annual meeting.

Dr. Rosenblitt’s presentation reviewed the state of diminishing resources allocated to the well-being of children. He noted that the well-being and mental health of children have been relegated to short-sighted benefits of short-term interventions which are often driven by the interest of pharmaceutical entities. This promotes dehumanization of children and reduces them to collections of pathological symptoms in a book full of diseases. While we declare that our children are our most precious resources and are our future, in actuality we fall far short when it comes to political, social and financial choices and long-term commitment to the well-being of children.

Dr. Rosenblitt cited historical and cultural routes of violence, abuse and murder involving children beginning with pre-historical rituals and beliefs such as sacrificing children in order to gain gods’ favor. He elaborated on the theme of the father sacrificing a son, as for example portrayed by Bob Dylan’s song, *Highway 61 Revisited*, in which Abraham asks where God wanted the killing of his son done. He also noted this paradox manifested in his own activities as a fund raiser for Services for Children. He mused on our inability to sufficiently explain something as profoundly irrational as our behavior to our children. This paradox is universal in that it transcends individuals, culture and time. It limits the full and free expression of our love to our children. Children are our future and joy but also reminders of our pain, despair and failure. They compete with us and exhaust our limited supplies. They are insatiable and will always need more. They are to be hated, suppressed, extinguished, controlled and caged. This is further complicated by attitudes regarding gender and the sin of becoming a woman.

From Grimm’s fairy tales, Verdi’s *Rigoletto*, Shakespeare’s *King Lear*, Garcia Lorca’s *House of Bernardo Alba*, the myth of Laius with the father’s aggression to the son and many other artistic productions and works of contemporary literature, Dr. Rosenblitt extracted observations that centered on hatred of children. Children can be hated as rivals and replacements. Toni Morrison’s *The Beloved* is the story of a mother who has to kill her children in order to spare them from what she herself had endured as a child. Love would guide the choice to murder a child, the ultimate in objectification and possession of another’s life. Children mistreated by adults internalize and then repeat these patterns in the next generation. Hatred is easily engendered as adult equilibrium is threatened by children’s easy access to instinctual life, the vibrancy and urgency in the expressions derived from aggression and sexuality. We are all good witches driven by envy, rivalry and self-indulgence depending on the circumstances. At the right price we all sacrifice our children, sometimes for their own redemption or to show love. We are also evil stepmothers, Rigolettos and Laiuses.

Acceptance of our ambivalence about our children allows realistic optimism, and the pursuit of the attainable in a moral universe of competing priorities and unfortunate choices.

In her discussion Dr. Davis noted that most adults learn to love a few children they know and tolerate others. Children we don’t know can easily be dismissed. Too often families and their environment accommodate adults and ignore children. Children are seen as possessions or extensions of ourselves and we expect their wishes and intents to match our own. We expect them to fulfill our fantasies. In Dr. Rosenblitt’s presentation we see how children are exploited: for direct gratification, as when Laius sodomized Chrysippus; to preserve scarce resources, as with Hansel and Gretel; and to rectify past mistakes, as with Bernarda Alba who restricts her daughters’ sexuality.

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Too often treatments we provide view children as collections of symptoms and ignore the complexity of the developing personality. We scold, control, medicate and manage behavior in order to isolate intense affective reactions of rage, grief and terror. Without affect there is no meaning and no coherent narrative. To help our children, we must allow them to be free as unique individuals, not extensions of ourselves.

In his discussion, Dr. Etezady thanked Dr. Rosenblitt for his devotion to the cause of children and for bringing to us such an erudite and creative narrative that weaves culture, history, mythology, fairy tales, art and eternal music in Dr. Rosenblitt’s own touches of work, love and play. A narrative is an abstract representation of an experience and not the experience itself. Moral, personal or cultural values and ideals in abstract narratives do not always agree with what we in fact do. One answer to the paradox posed by Dr. Rosenblitt is that what we uphold, believe and aspire to is an abstract narrative formed to accommodate what in suitable conditions we could do. This narrative is not the same as what we can do or in fact do. Even in our most idealistic aspirations we live within the realm of realities imposed upon us, good and bad, from within and without. Peace and utopian bliss are no more than wishful beacons that center us on hope and keep us searching. It is a miracle that we can find peace and maintain homeostatic equilibrium at all since such an infinite number of ominous factors are constantly conspiring to disrupt this continuity. A second element to consider in aggression targeted at others, our children included, might be the role of empathy. When people “objectify” and hurt each other, empathy has failed. Empathy can fail in many ways including in stress, trauma, pathology and conflict. Empathy may fail to develop when an individual has not had the experience of having been held in the mind of an other. Dr. Rosenblitt appeals to our personal and social conscience to remain vigilant and ask how and when does our unconscious hatred target our children.

(Continued from page 14)
Those attendees at the Denver ACP Sunday meetings were treated to a most astounding presentation by the Seattle-based psychoanalyst Robert Campbell, M.D. Dr. Campbell took the audience through a gutsy presentation of his work with an anorectic girl. In fact, the case dramatically begins out of her refusal to come see him. Unlike so many others, Dr. Campbell does not leave this prospective patient after her adolescent rebuke of treatment. He deftly works with the parents applying the techniques of defense analysis, his vast experience with anorectic adolescents and a gift with the metaphor of separation-individuation in these patients. Thus, the drama begins where many of us never even get started, that is, in the patient’s refusal to enter treatment. Campbell takes this as a message of self-protection and independence as well as the well-known defiance of an adolescent struggling desperately to preserve a sense of self-cohesion.

Dr. Campbell’s presentation is devoted to technique, reality and his own desire to help this patient. Thus he has no trouble taking us through the trials and tribulations of the parents’ attempts to convey his own message of hope and separation to this very troubled, but mostly scared girl, who is unable to separate herself enough to even dis-identify with her mother. And yet, it is the mother who through Dr. Campbell’s empathy ultimately conveys the problem and key to beginning treatment. This is seen in descriptions of early conversations with the mother, which follow:

Jennifer missed her school car pool ride, going to her room in tears. Mrs. M. was feeling very guilty and wavering in her resolve to have her daughter go to a therapist. She called me. We talked and I pointed out if she was wavering so was her daughter as there are two sides to wavering. In other words, Jennifer’s argumentative stance indicates she must also feel like going to the shrink, and mother must also wish for her daughter to not go, possibly to avoid a fear of losing her daughter to “me.” Essentially an interpretation of mother’s conflict.

Later Dr. Campbell gets a call from Jennifer’s mother, who brings Jennifer to treatment. All this followed Dr. Campbell’s instructions to the parents to tell Jennifer that she had “some concerns about her relationship to her family.” Later Jennifer told her parents that psychiatrists force things down your throat. Dr. Campbell tells the parents to instruct Jennifer that she might fear that he would force things on her like words, concepts and beliefs. Dr. Campbell indicates that these interventions, but especially the above mentioned attempt to work with the mother lead Jennifer to sense a change in her mother. This seems to give the critical room necessary to get this girl to the consultation room.

During the outset of the first session, Dr. Campbell thinks about separation, but respects the merger of mother and daughter as when the two come to the door. They look at him somewhat confused, asking if one or both should come in. Dr. Campbell does not force separation, as the previous therapist did. Rather he looks to Jennifer who displayed her ambivalence by going back and forth if her mother should come in. Ultimately they both sat on the couch. Dr. Campbell indicated to the pair that “either way is okay” thus taking himself out of the equation as much as he could. Later in this session mother makes the decision to leave, and Jennifer presupposed that Dr. Campbell thought that something was wrong with her (she states that she surmises this from her mother). Dr. Campbell shrugs and the pair begins to find the right space and metaphor between them. The male track coach emerges as a disguised transference figure and bearer of the metaphor. In response to her complaints about the coach, Dr. Campbell states that “no one can sense another’s needs by a standard that’s set for everyone”. He goes on to talk about the uniqueness of the individual, “only that person can sense that they have other needs that are not apparent.” He thus shows us and tells us that he recognizes her separation-individuation issues. She responds loudly and with sarcasm that no one seems to understand that. She went on to say that people

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In her inspirational presentation entitled “Everyone Denies”, Dr. Helene Keable began by discussing the paradoxical problem whereby child analysts do not seem to get enough cases, while primary care physicians, educators and parents do not seem to know where to turn to when faced with the challenging and complicated problems seen in children with learning problems, psychiatric symptoms and physical problems. In fact, her thoughts lead one to recall that Anna Freud’s “Developmental Lines” may still be a useful tool to approximate the status of mental health in children and adolescents. In addition to the well known obstacles to intensive mental health treatment (overscheduled lifes of children and adolescents, adolescents’ proneness to action, the developmental task of separating from primary objects, models of care and economic forces), Dr. Keable emphasized that parents, educators, primary care physicians and even at times analysts gauge the mental health life of children and their families. It is as if clinging to “normalcy” would magically alleviate the problems at hand.

Dr. Keable illustrated this type of resistance with a selected aspect of the initial assessment of a young adolescent. The patient presented to a primary care physician with a myriad of physical and psychological problems. Despite the complexity of the presenting problems, the adolescent psychiatrist was specifically consulted to assist in finding an appropriate school placement. The parents initially condensed the teenager’s problem under the rubric of “special needs in reading and writing”.

The patient had become a “veteran patient” who had been evaluated by several professionals over several years. Every professional had concentrated the therapeutic effort on a specific part of the body (among others language and motor coordination) or normative activities (i.e. school attendance). The addition of medications had added little value to the treatment goals. The attributed diagnoses had varied and had been of a dire nature.

Dr. Keable reported fragments of her first meeting with the parents and of her first meeting with the adolescent. The history and the direct observation revealed that the adolescent had an enormous capacity for relatedness, observation of people and the environment, capacities for transference, as well as for linking the past with the present. For reasons of confidentiality, specific details are not offered in the context of this report, but the result of those preliminary interviews led Dr. Keable to recommend an intensive analytic treatment for this young adolescent to give him a chance to concentrate on the part of his body that had been, so far, “the most neglected”. Dr. Keable reported fragments of later sessions where the patient’s capacity for work and play as well as his ability to relate to people emerged clearly. A transferential capacity started to get elaborated on and powerful affects emerged.

As conveyed by Dr. Keable, we came to see that a sensitive and adequately intensive treatment of this boy’s mind bridged a gap that was missing in the work of several concerned professionals who had one view of him.

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Call for Papers !!!!

One aspect of our work is the profound manner in which defenses are altered during the course of analysis, both in response to treatment and as a result of normal development and maturation.

For the 2007 annual ACP meeting in Washington we are looking for papers that demonstrate such alterations of defenses. We look forward to a lively meeting with excellent attendance.

Please send papers to Program Chairs:

Anita Schmukler: agpsa1@verizon.net
Denia Barrett: dbarrett@hannaperkins.org
Before our Executive Committee meeting on the morning of 20 January, 2006, Carla Neeley, Barbara Deutsch, Jill Miller, Stevie Smith and I met with Tim Dugan, Chair of the American Academy of Child- & Adolescent Psychiatry’s (AACAP) Psychotherapy Committee. Barbara Rosenfeld, APsaA Liaison Committee Chair, and Rachel Ritvo of the AACAP’s Executive Council were also in attendance. This has become a yearly meeting of representatives from the ACP, AACAP, and APsaA working together to foster collaboration between the three organizations, “in order to assure the survival of psychodynamic and developmental psychotherapeutic concepts within the field of child and adolescent psychiatry and academic medicine.”

The AACAP Psychotherapy Committee, under Tim Dugan’s leadership, has not only co-sponsored our ACP-AACAP case conference at the AACAP annual meeting each October, but they have also invited me to join their committee meetings over these past few years, and have worked to stay on top of the AACAP’s publication of “Practice Parameters.” Practice Parameters have an important role in the preservation (or disruption) of psychodynamic psychotherapy training and practice in the mental health treatment of children and adolescents.

Tim’s committee members (recently aided by a sea change in the wider child psychiatric community) have been concerned about a number of difficulties: the paucity of psychoanalysts working as child psychiatric training directors; the focus on symptom relief as the prime treatment goal; the nearly exclusive emphasis on CBT and psychopharmacology in child psychiatry therapeutic training; and difficulties integrating child and adolescent psychoanalytic supervision within clinical services as well as within the academic and research divisions of child and adolescent psychiatry. Tim and his committee members worry that most child analysts’ ambivalence about using DSM-IV diagnoses and integrating more biologically-based diagnoses, like ADHD and NVLD, into their diagnoses and treatment have served to isolate and marginalize child analysis from the mainstream practice of child and adolescent therapy.

Tim had suggested a year ago that there be speedy preparation of a “Psychodynamic, Psychoanalytic Bibliography Search Initiative” for the purposes of finding supporting psychoanalytic literature for the practice parameters being developed within the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Psychological Association, and other mental health disciplines. A current complicating problem is that the AACAP’s Quality Issues Committee which prepares the “Practice Parameters” prefers recent references, preferably no older than five years (a particular absurdity for child psychoanalytic publications).

AACAP “Practice Parameters” are now posted for member review on the AACAP website, and after approval by the AACAP Executive Council are published in the AACAP Journal. These practice parameters represent the primary source for child psychiatrists (and others) to search the literature on any one of more than twenty subjects (including Psychotropic Medication; Psychodynamic Psychotherapy; ADHD; Family Assessment; Anxiety Disorders; Mood Disorders [in process]; etc). These “Parameters” now SET COMMUNITY (AND THEREFORE LEGAL) STANDARDS for the treatment of children who have been diagnosed under one or more of the usual DSM-IV categories.

DSM-IV diagnoses have therefore become the gateway to the treatment literature for many of...
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the child mental health professions, as well as establishing evolving standards for malpractice liability (untreated symptoms of ADHD, depression, suicidal ideation, learning disabilities, etc.) in long term psychotherapy, in addition to establishing prescribed courses of treatment for children and their families.

We were fortunate last year that Tim, Rachel, Barbara Milrod and others in an eleventh-hour 2005 effort, made some last minute additions to the “Anxiety Disorders” Parameter, such that an entire page describing psychodynamic therapeutic work was added to the (CBT and medication recommending) text in its final form before publication. The next “Mood Disorders” Parameter is now well under way. Tim had suggested last year that COCAA, COCAP, and ACP create a “Joint Advisory and Review Committee on Child and Adolescent Practice Parameters” to help oversee their preparation before any such frantic eleventh-hour efforts become necessary. Since then, within AACAP, Tim’s Psychotherapy Committee has been able to recruit the ACP’s Helene Keable, for a joint appointment on both the Psychotherapy Committee and the Practice Parameters Group (the Quality Issues Committee), so at least we won’t be dealing with these issues toward the end of the parameter development process.

Since psychoanalytic papers are rarely listed with DSM-IV or other usual child psychiatric reference words in their titles, there are in fact very few web-accessible data search engines with adequate references to child analytic literature. DSM-IV “tags” are therefore recommended for future use in titles and web listings of all future child analytic articles. (Phyllis Tyson came last year to our meeting and discussed re-titling an article of hers for just that purpose.)

Barbara Rosenfeld recommended that this matter be taken up under the leadership of the incoming President of the APsaA. Nat suggested that there be a meeting for this purpose between all of the psychoanalytic journal editors (JAPA, IJP, Psychoanalytic Quarterly, Psychoanalytic Study of the Child, Child Analysis, and perhaps others), in order to discuss the re-indexing of extant literature to permit adequate computer searches. Concern was expressed that the current Psychoanalytic Diagnostic Project spearheaded by Stanley Greenspan via the National Center for Clinical Intervention in Infancy (0-3) not be prepared in opposition to, but with the cooperation of, the next DSM-V preparatory committee.

Helene Keable’s appointment as a full member of both the AACAP’s Psychotherapy Committee and their Quality Issues Committee, gives our child analytic community a fortuitous head start to oversee the preparation of AACAP’s “Practice Parameters.” Helene spoke briefly at the later Executive Committee meeting about her interest in these issues. We hope to solicit the assistance of additional ACP members to participate in literature searches as they are needed for future AACAP “Practice Parameters.”
Charles E. Parks, Ph.D. served as the discussant to the case. Dr. Parks spoke very highly of Dr. Pretorius’ work. However, he felt that she was underestimating the power of the excellent transference interpretations she made about his fears that she would leave him if he was mean to her. Related to this, Dr. Parks wondered about the role that guilt might play in his fantasies about why his most important objects abandoned him and the potential guilt in his oedipal fantasies. Dr. Parks highlighted how Dr. Pretorius’ sensitive attunement to the patient and impressive technique allowed the patient to experience enough affective reliving of the trauma to make the treatment meaningful, while at the same time not too much affective reliving to make the treatment a new trauma. Dr. Parks cited evidence that analysis is often the treatment of choice for cases involving early trauma.

A rich and lively discussion about the case followed among the many ACP members in attendance. Issues addressed included the empathic trauma of the analyst while treating a traumatized patient; the struggle over who the patient can identify with; the role of the adopted parents’ attributions in who their son will become; how the chronic trauma is often encapsulated in a fantasy about the salient trauma; the role of verbalization in developing boundaries and turning off the danger signal, which is otherwise turned up high by the trauma; the importance of treating the parent; and that chronic trauma is represented in acting out whereas salient trauma can be verbalized.

which a patient can be allowed to “come apart” in an outpatient setting, with the Jungian perspective being that the self can be trusted to contain a major deintegration to chaotic experience.

Additional history and follow-up were requested about the specific patients that Dr. Cavalli discussed. She was also asked to share her countertransference in an effort to understand more about the adolescent boy. Comments were made about the importance of attending to an early adolescent’s developing sexuality and about the benefits of theory in helping an analyst to “be in the room” with a patient. Questions were raised about what kind of learning takes place with a mother, with a caretaker who is not the mother, and with non-human media, e.g. videotapes. In general, many areas of agreement were identified and the ambience was one of welcoming the opportunity for a dialogue between different psychoanalytic cultures.

innovative work being done at the Allen Creek Preschool will have an enormous impact on preschool education training programs, preschool design and on the image of child psychoanalysis in the community at large. It is a pleasure to present this award to the Allen Creek Preschool. The school’s ability to impact so many families in a very positive way through the application of child psychoanalytic principles is exemplary.

Kerry Kelly Novick, the leading force behind the development of Allen Creek, and Judie Sherick, its current Board President who was a Founding Board Member as well as a Parent-Infant teacher at the school, are here to accept the award.
Eleven-Year-Old Karen: Masturbation and Obsessive-Compulsive Disorder

"Putting out the fire ... I think I started." When Dr. Donson commented that this usually occurred when their time was over, perhaps like when her mother left her behind, she agreed. "They [the fires] start when I'm leaving the house ... a hot feeling in the seat." Suspecting that these were in part genital sensations, Dr. Donson named it a 'fire feeling.' Afterward, her rituals intensified. When she later spoke of fire feelings in her foot, Dr. Donson linked this to her having kicked her mother and sister in anger.

Over time, they identified and clarified a number of intense affects, all components of "fire feelings" -- anger, loss, longing, sexual arousals. These feelings thereby became knowable and safe as they came into awareness, first as observed by Dr. Donson, then for Karen too, as her analyst brought them to her attention. She tested out her worries, her fears that having fire feelings might in fact cause a wished-for event, and her reality testing improved. Her ability to think, work, and to have relationships improved greatly as she learned to differentiate between her internal world of impulses and affects, and real events in the external world. One day she triumphantly announced, "I walked under a ladder and nothing happened!"

Karen's parents abruptly and unilaterally set a termination date just after she turned 13. Although she was free of the severe symptoms, it never became clear what led them to do this. There was however a termination phase. In retrospect, Dr. Donson was curious that what seemed obvious - Karen's believing that she had magically fulfilled her wish to do away with her younger sister - had never been explicitly analyzed, even during termination. Perhaps the content was too painful for Karen to face, but perhaps certain psychological functions originally impaired by this apparent confirmation of her omnipotent wishes were successfully treated and she was freed to function again; and that in fact was what mattered.

When his patient was 27, 15 years after treatment, Dr. Donson phoned her parents. Her mother, pleased to hear from him, reported that her daughter had married her high school sweetheart the year before, and that she was teaching handicapped third grade children in a lower income part of town; she loved working with children. After college she worked for a few years before earning a graduate degree. She and her husband plan to have a family; she hoped to stay home to raise her children.

Of note, this treatment had proceeded without medication; none was known at the time to be effective. This case might appropriately be considered in a discussion of the relative effects of medication in contrast to the efficacy of intensive analytic treatment.

ACP Award For Excellence
Call for Nominations

The Awards Committee invites nominations for the ACP Award For Excellence. This award is given to a center or program exemplifying the highest level of service, training, outreach or research associated with the profession of Child Psychoanalysis and the ACP. Previous winners have been the Lucy Daniels Center, the Hanna Perkins Center and the Allen Creek Preschool in Ann Arbor. This award is given to a program, not to a person, and nominees should meet the following criteria:

The program/center
a) was created and is currently run by child psychoanalysts;
b) has been functioning for a number of years and seems to be stable and a permanent fixture in the community;
c) has achieved a level of excellence in one or more of the areas of training, service, research, outreach, public education or public policy.

Inquiries or nominations can be sent to either of the co-chairs:

Jack Novick PhD: Jacknovick@aol.com
Laurie Levinson PhD: LaurieJLevinson@cs.com

(AFP)
The Inner World of a Child
Confronting Illness and Death

(Continued from page 11)

preparation for the transplant. His analyst worked to help E. see that he could also be angry with his analyst/doctor, like the man in the cartoon the previous summer, for causing him psychological danger parallel to the physical danger he faced.

After one year of analysis, E. turned 12. Sexual concerns and castration anxiety came more clearly into the analytic material. He became obsessively worried about vomiting, which on analytic investigation, seemed to refer to concerns about feelings or his illness overwhelming him from inside. His analyst tried to help him understand he wouldn’t “explode” but E. rejected this reassurance: “the craziest idea ever – like dumb and dumber.”

E. experienced uncertainty about whether danger came from inside or outside and was struggling with fear of his doctors and the bone marrow transplant. This was expressed in a story of aliens who arrive on earth with a book entitled “To Serve Man.” It turned out to be a cook book. He also began expressing fears of death. As his hospitalization in the fall approached, E. got more confused and frightened. But he was able to be very clear in his description of his surroundings and worries there, and worked with his analyst who came to see him during his recovery phase of the transplant.

Around Labor Day E. began to develop symptoms of liver failure resulting from one of his chemotherapy agents. He battled this condition but succumbed to it before Thanksgiving, almost exactly two years after first seeing the analyst. The analyst supported the parents as they made the decision to withdraw life support when it became clear E. could not recover. The analyst continues to work with E.’s father, who sees him as the one person outside the family who understood E.’s special qualities.

Dr. Keable gave a discussion of Dr. Kohn’s paper. She had worked as a hematologist herself for several years, noting how this experience facilitated her transition to becoming an analyst. She explained the medical schedule involved in a bone marrow transplant, and noted that E. may be the only child who has ever been analyzed while suffering from E.’s particular anemia. She took note of the paradox that one of E.’s defenses was withdrawal into fantasy, while at the same time he revealed himself quite explicitly in his cartoons and his work with his analyst, which involved fantasy. She highlighted the fact that the painful nightly ritual of buttocks injections occurred contemporaneously with the birth of his sister, possibly contributing to his conflicts about gender.

She also noted how during the evaluation, E. spelled out that his behavior and symptoms defended him from storms of affect. He revealed how his castration fears had become linked with the medical procedures of injections and later he showed through dreams and cartoons how he tried to protect himself with an island fortress from being an evil misfit who wanted to take over the world. He demonstrated a highly structured neurotic mind in a body harboring a rare illness. Dr. Keable described an initial increase of anxiety during the first two months of the analysis, as E. identified himself with an evil guy enthralled in calamities of death and castration, although he also showed his use of the defense of humor –“it is only a cartoon.” Later he elaborated more clearly his sense of his vulnerabilities, in his fear of snakes. The cartoon of the patient threatening the psychiatrist showed the convergence of fears emanating from the father, the patient, and the analyst. This occurred approximately simultaneously with the family’s more serious contemplation of bone marrow transplantation.

In the second year of the analysis, work with feelings towards the sister emerged in the displaced form of concerns about his new rival at school. E. managed in this year of analysis to gain greater ownership of his mind and to be able to face painful realities without the same necessity to withdraw into fantasy with which he presented initially.

In the discussion following Dr. Keable’s formal discussion, many interesting points were made. It was noted how the analyst’s helping E. sort out the neurotic aspects of his situation aided him in facing better the reality of his death. The analyst aligning himself with the patient’s struggle against illness helped the patient feel less passively victimized in the face of the illness. The analyst noted that he didn’t distinguish so much between the patient’s physical experiences and their symbolic meaning in the work, attempting to stay with whichever metaphor the patient was using. Dr. Keable noted E. probably worried he would be turned into a female by virtue of receiving cells from his sister, as had been explicitly expressed to her by another patient. Dr. Keable noted how the shift toward the decision to pursue the marrow transplant occurred around the time that Dr. Kohn had discussed the Far Side cartoon with E.’s parents. Perhaps this discussion had mobilized some feelings which influenced the decision.

Dr. Kohn noted that he saw in E.’s hostility to his rival also an effort to distance himself from an identification with the rival as a social misfit – feelings
E. had had about himself. There was discussion about the role of the analyst in informing the patient about the risks of the procedure. Dr. Kohn reported that the parents spoke with E. about the potential side effects of the procedure, while he (the analyst) dealt with E.’s fantasies about it, which continued right alongside the information given by the parents. Dr. Keable felt the analyst shouldn’t participate in the informing, in order to keep himself more available to hear the patient’s experience. The analyst should allow the child to mention it first, unless he never does.

The question was raised about how much did the physical illness organize E.’s psychic life. And what is the contribution of the mother’s anxiety? Some of his cartoons portrayed building anxiety that was not calmed. In one, a character runs to a building for help only to find that his potential helper has already left, searching for help elsewhere.

A participant noted E.’s basic good feeling about himself, probably reflecting his perceptions of his parents’ great love for him. The good quality of the therapeutic alliance also reflects the sense of being loved. E. and his father bonded over cartoons. What was the source of the father’s hostility to the analyst? Dr. Kohn felt it reflected the father’s pain when other people responded to his son as weird, and he expected analysis to repeat this. The relationship they now have helps the father keep E. alive. Dr. Kohn also mentioned that the parents were so devoted to being with E. during his final months that he had concerns the sister would feel neglected.

All participants appeared to find this workshop moving, stimulating, and rewarding.

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**Change of Locale for 2007 ACP Annual Meeting**

Ruth Karush, MD

The Executive Committee, at its meeting on April 7, decided that the 2007 Annual Meeting would be held in Boston on May 4-6. The Arrangements Committee, with Tricia Hall’s invaluable help, then began to search for a suitable hotel for the meeting. It was not possible for us to find a hotel for those dates, which would have the appropriate meeting space along with a reasonable room rate. In fact, there were few hotels willing to make a proposal for our meeting.

It was decided that we would look into other cities on the east coast. We searched Philadelphia and Washington D.C. Tricia Hall has come up with some wonderful possibilities for us in Washington. With the agreement of the Executive, we are changing the location of the 2007 Meeting to Washington, D.C. We are confident that we will find a terrific hotel and that you will be pleased with the Washington location.
In her presentation Tyson noted the increasing interest of our field and of society in boundaries and their violation. Social and cultural standards and definition of boundaries and their violation vary from place to place and time to time. It helps to consider, how from a state of mother-infant oneness, the child develops the capacity to maintain an objective and clear sense of boundaries between the mental representation of the self as separate from the object.

We can combine many concepts to deal with this question. Freud's views of primary narcissism or Benedek's idea of mother-infant symbiotic unity, the work of Bowlby, Mahler, Winnicott and many others, show that on the road to formation and regulation of boundaries three elements first evolve: 1) experiencing within the relationship, 2) experiencing the emerging self and 3) experiencing the potential space between the two. The first steps are taken in early childhood; adolescence offers a second opportunity. Maintenance and regulation of self-other boundary is a life-long psychological task. The degree of maturity of relationships is an indicator of healthy development. Guntrip defines meaningful relationships as those that enable the infant to find himself as a person of significance to others who are significant for him, which endows him with values that make life purposeful and worth living.

Tyson elucidated her concept of the self as an agent, aware of possession of power and ability to act, aware of being the instrument of action which can create change. Intentionality and self-responsibility need to be added here. As an intentional mental being the child comes to understand the connections between actions and feelings and becomes accountable for his own thoughts, desires or actions. Forming and maintaining boundaries relies on self responsibility.

The transitional object is a symbol of separation and the emergence of the capacity to generate meaning in a dialectical process (Ogden), entailing the symbol, the symbolized and the interpreting agent. Intense affects often color perception and blur the self-other boundary. As development continues, increasingly complex wishes and infantile conflicts of the genital phase add additional challenges to self and boundary regulation.

In her discussion of Tyson’s presentation, Garfield described an interactional perspective in infant research with a gradual development of the emerging self, the core self and the inter-subjective self and the need for secure but permeable boundaries. Rather than symbiotic loss of the self, early interaction supports growth and differentiation. She used Pine’s notion of “moments of merger” and later manifestations of dissolution of boundaries, delusional merger with anxiety or bliss, anxiety about separateness and longing for merger without loss of boundaries. There are experiences of spiritual or creative merger that are pleasurable and not threatening to the self. The goal of treatment is knowledge of oneself, alone in the presence of an other. This requires mastery of boundaries and of the temptation to violate them. Floating in the reflections of an other informs the erotics of the inter-subjective space. This sets up the trap for both participants in the therapeutic relationship. The experience of being known generates a profound sense of love of self and the other simultaneously. Parents need to have mastered self responsibility to help their children regulate boundaries.

In his presentation, Gabbard described boundaries in the analytic setting with two connotations: the elements that comprise the envelope in which the treatment takes place, and technique. Radical departures from the analytic frame may be rationalized in treating highly disturbed subjects who require containing and “boundedness” to avoid retraumatization. A

(Continued on page 25)
We are very sad to have to announce that the following members have passed away since April 2005:

<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
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<tbody>
<tr>
<td>Francis Bobitt, MD</td>
<td>Seattle, WA</td>
</tr>
<tr>
<td>Herbert Cibul, MD</td>
<td>Chicago, IL</td>
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<tr>
<td>Donald Cohen, MD</td>
<td>New York, NY</td>
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<tr>
<td>Rudolf Ekstein, MD</td>
<td>Los Angeles, CA</td>
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<tr>
<td>Seymour Friedman, MD</td>
<td>Los Angeles, CA</td>
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<tr>
<td>Kenneth Gordon, MD</td>
<td>Radnor, PA</td>
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<tr>
<td>Bertram Gosliner, MD</td>
<td>New York, NY</td>
</tr>
<tr>
<td>Joseph Reidy, MD</td>
<td>Towson, MD</td>
</tr>
<tr>
<td>Lawrence Sabot, MD</td>
<td>Roslyn, NY</td>
</tr>
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Flexible frame is necessary for patients who have greater deficits. They require intervention rather than interpretation. Boundaries are established physically so they can be crossed psychologically. To establish an empathic connection, boundaries must vary at times. It is neither gratification nor frustration but the process of negotiation that matters in order to confirm the patient's subjective experience in a way that is enriching. These boundaries create an analytic object from the interpenetrating subjectivities of the two participants. Countertransference enactments are inevitable throughout the treatment.

We differentiate boundary crossings from boundary violations. Violations are generally egregious, repetitive and harmful. They destroy the viability of the analytic treatment. By contrast, boundary crossings are benign and even helpful if the analyst catches himself and is able to reflect on it. The analyst must simultaneously participate in the “dance” presented by the patient while also reflecting on what is transpiring. He described types of vulnerability to boundary violation and those who are likely to violate.

Brenner acknowledged the debt our field owes to Dr. Gabbard for his pioneering work in this area. He found the example of masochistic surrender of the therapist and rescue fantasies as particularly relevant to work with disturbed patients. Patients with early trauma are enactment-prone and susceptible to exploitative relationships. Addressing such vulnerabilities requires both an interactive and an intra-psychic view of dissociation.

Ilany Kogan presented the treatment of a patient whose parents were Holocaust survivors. This made them unable to preserve incest boundaries between the mother and the child. The patient lived his entire life under the shadow of his craving for a blissful union with his mother and sought to eliminate any obstacles in his way. In the transference he violated all rules and tried to erase all those who might threaten his symbiotic wishes. He experienced the suicide of his son as the actualization of his destructive wishes. The fact that the analyst survived his aggression enabled him to better distinguish fantasy from reality which led to a long and painful work of mourning that resulted in the establishment of psychic boundaries.

In his discussion, Akhtar confirmed Kogan's views and enumerated 5 ways in which traumatized parents may fail to help their children with adequate boundary development: 1) an over-idealized child fails to distinguish between wishes and reality; 2) equating parental assertion with cruelty renders parents unable to set limits on greed and omnipotence; 3) not establishing generational boundaries makes children oedipally triumphant and cocky; 4) envy of the child, e.g. for his better circumstances, may result in direct hostility or reaction formation in the form of spoiling which precludes formation of healthy boundaries; 5) re-enacting their own trauma, violating boundaries with their offspring, traumatized parents relive the experience repeatedly, this time in identification with their aggressor.
I. Call to Order
The Executive Committee meeting was called to order at 12:00 Noon.

Officers Present: President: Ruth Karush, MD, President-Elect: Carla Elliott-Neely, PhD, Secretary: Laurie Levinson, PhD, Secretary-Elect: Jill Miller, PhD, Treasurer: Thomas Barrett, PhD, Treasurer-Elect: Helene Keable, MD.

Councilors Present: Denia Barrett; Alicia Guttman, MD; Kenneth King, MD; Stanley Leiken, MD; Jack Novick, PhD; Noah Shaw, MD; Susan Sherkow, MD; Stephanie Smith, MSW; Candidate Councilors Present: Judith Deutsch, MSW.

Committee Members Present: Peter Blos, MD; Paul Brinich, PhD; Nathaniel Donson, MD; Christian Maetzener, MD; Karen Marschke-Tobier, PhD; Charles Mangham, MD; Kerry Kelly Novick; Anita Schmukler, DO; Susan Sherkow, MD; Moisy Shopper, MD.

ACP Administrator: Tricia Hall, CAE, CMP.

Not Present: Cynthia Carlson, Kirsten Dahl, PhD; Lilo Plaschkes, MSW; Rachel Seidel, MD; Judy Yanof, MD; Barbara Deutsch, MD.

II. Adoption of Agenda
The agenda was adopted unanimously.

III. Review and Approval of Minutes of January 20, 2006
A Motion was made to approve the minutes. The motion passed unanimously.

IV. Reports of Officers

A. Secretary’s Report
Laurie Levinson, PhD
Dr. Levinson reported on the current ACP membership statistics. 501 USA members, 87 international members, and 5 collegial, for a total of 593. Nine members were reported as deceased: Francis Bobbitt (Seattle); Herbert Cibul (Chicago); Donald Cohen (New York); Rudolf (Rudy) Ekstein (Los Angeles); Seymour Friedman (Los Angeles); Kenneth Gordon (Radnor, PA); Bertram Gosliner (New York); Joseph Reidy (Towson, MD); and Larry Sabot (Roslyn, NY).

B. Treasurer’s Report
Thomas Barrett, PhD
Dr. Barrett updated the board on the financial activities of the ACP. There was a minor discrepancy of $248 from the previous administrator’s account and a check to the PIEE for the Child and Adolescent fall seminar was either not received or cashed by the PIEE. Dr. Barrett will work with Tricia and Dr. Blos to rectify these two issues.

Grant Funds: The Grant funds not used in 2006 will roll forward for next year’s grant allocations.

Vanguard Account: Dr. Barrett expressed his appreciation to Mr. Joel Mangham for the excellent rate of return on the ACP investment account which is valued at approximately $305,949.20. Mr. Mangham has recommended a redistribution of funds in the Vanguard account.

Dues Collection: Tricia Hall reported that as of April there are 197 members that have not paid 2006 dues. There are number of members who have not paid 2005 dues. The board agreed to only look at 2005 and 2006 members in arrears and not go past 2005 for collection.

MOTION: A motion was made for President-Elect Carla Elliott-Neely to appoint an ad hoc committee for the non-payment of dues. This committee will work with Tricia to attempt to contact members who owe dues for 2006 and 2005. The motion was 2nded and passed unanimously.

Annual Meeting Registration Fees: Presently Candidate members do not pay annual meeting registration fees. The direct costs associated with each individual’s attendance means that ACP is losing money on each candidate member attending the annual meeting. The board discussed various options to establish a charge for the annual meeting. The board agreed that if a candidate expressed a hardship, the candidate could request a waiver for the registration fee for that particular year.

MOTION: A motion was made to change the registration fee structure and charge Candidate

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members $100 for a full registration fee for the annual meeting. The motion was 2nded and passed unanimously.

**ACTION:** The annual meeting registration fees will be reworded and sent to Dr. Neely and Dr. Miller for approval.

**Membership Roster:** Dr. Barrett clarified that there is $3000 in the budget to spend on a printed membership roster. Because of the inaccuracies in the database, the ACP will not publish a printed roster until the database is reconciled and until after the dues notices go out in the Fall.

Dr. Barrett is working closely with Dr. Helene Keable on the transition of the treasurer’s duties. The board expressed thanks and gratitude to Dr. Barrett for his work on the ACP finances.

**VI. Report on Administrative Transition**

**Tricia Hall, CAE, CMP**

**ACP Credit Card:** Tricia Hall will secure a credit card for the ACP. She is researching the best options.

**Annual Meeting Hotel Issue:** There are several ACP members who use other hotel booking methods when making hotel reservations for the ACP annual meeting. While individually there could be a gain, the overall effect is a penalty to the ACP because booking outside the ACP block undermines the association and its contractual obligations.

**ACTION:** The ACP will publish an article in the newsletter on how the site is selected for the annual meeting, how the meetings are planned, and how group rates are established. This article should be published in the newsletter and should be mailed with the ACP annual meeting notice.

**ACTION:** Tricia will secure the most current AON association insurance policy and will work with Dr. Keable before paying the premium.

**2005 ACP Tax Return:** Tricia worked with the current ACP accountant to file an extension for the 2005 tax return. She will complete this project and copy Dr. Keable and Dr. Neely when completed.

The board thanked Dr. Karush and Tricia Hall for their work in transitioning the ACP.

**VI. Outcome of Bylaws Vote**

**Carla Elliott-Neely, PhD**

Dr. Neely reported the official results of the ballot tally for the bylaws proposal is as follows:

- Yes (to accept Bylaws changes) = 94
- No (not to accept Bylaws changes) = 9

The Board thanked Dr. Carla Elliott-Neely, Dr. Jill Miller and Dr. Rachel Seidel for their work on this committee.

**VII. Committee Reports**

**A. Arrangements:**

Dr. Brinich reviewed the results of the survey taken after the ACP meeting in Tampa in April 2005. Dr. Brinich provided the board members with a synopsis of the survey results. Based on the data, the board discussed various times and locations for the ACP annual meeting and agreed to move the ACP meeting date to the first week in May.

**MOTION:** A motion was made to schedule the 2007 ACP Annual Meeting for May 4-6, 2007 in Boston, Massachusetts. The motion was 2nd and passed unanimously.

**ACTION:** Stephanie Smith will be the local contact for the Boston meeting. Tricia Hall will work with her and schedule a site visit. The board agreed that a 2nd lower-priced hotel should be available to members if possible.

**ACTION:** An email will be sent to ACP members to decide on the 2008 venue. Cities under consideration are Chicago, St. Louis, Santa Fe, Austin, Toronto and Cincinnati. There should be some consideration for a local child analytic program when deciding upon the venue. The results of the email survey will be sent to Dr. Neely, Dr. Miller and Dr. Karush.

**B. Communications**

**Paul Brinich, PhD**

Dr. Brinich discussed the ACP database and the interaction with the website. Tricia and Dr. Brinich will continue to work together on database/website issues.

**ACTION:** Each member will receive a record of their current contact information which will be sent with the dues notice so that the member can confirm or correct the data that the ACP

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currently has on file. Once confirmed, this information will be used for the official ACP roster. The Roster will include an alphabetical listing of all members, a geographic listing of all members, bylaws, current officers and committees.

C. Nominating Committee
Moisy Shopper, MD
Dr. Karush commended Dr. Shopper for his excellent job for coordinating the nominations process and the slate of officers. The official slate approved by the membership is: President: Carla Elliott-Neely, PhD; President-Elect: Kerry Kelly Novick; Secretary: Tom Barrett, PhD; Treasurer: Helene Keable, MD; Treasurer-Elect: Arthur Farley, MD; Councilors for 2006-2009: Lee Ascherman, MD; Sarah Knox, MD; and Charles Parks, PhD. Dr. Karush contacted each candidate and thanked them for running. The ACP agreed that candidates who run for office be notified of the results before the annual meeting. Dr. Moisy Shopper commented that the ACP needs to secure interest in running for Board positions earlier due to time commitments and other organizational involvement. He suggested beginning now to develop the slate for 2007-2008.

D. Membership Committee
Kerry Kelly Novick
Kerry Kelly Novick reported on the membership transition and challenges with the record-keeping. The board discussed the membership process and the continued uncertainty and confusion by applicants. Kerry and Tricia will work together to reconfirm the membership process and to ensure that membership invitation letters are being sent out once a potential member has been approved through the committee and the ACP membership. Kerry also asked everyone to assist in broadening the number of sponsors who are recruiting new members. The Membership Committee will review the criteria for graduated child analysts becoming members without having to be re-sponsored.

ACTION: The board agreed to include a copy of the membership guidelines in the annual dues statements.

E. Program Committee
Anita G. Schmukler, DO
Dr. Schmukler thanked everyone who participated in organizing the annual meeting. She reviewed the program agenda and is hosting a meeting on Friday afternoon for all speakers, discussants and reporters to ensure that this week’s meeting will run smoothly. Dr. Schmukler asked for suggestions for the 2007 meeting. Dr. Karush expressed thanks and gratitude to Dr. Schmukler and her committee for their hard work in organizing the Denver program.

Dr. Karen Marschke-Tobier reported on the Extension Division Program and thanked everyone who helped with program. She expressed her thanks to Tricia for her support and administrative assistance.

F. Liaison Committee
Barbara Deutsch, MD & Nat Donson, MD
A written report was provided in the board packets. Dr. Donson thanked the ACP for extending reciprocity for the other disciplines in our program. Dr. Peter Blos and Lilo Plaschkes asked that the Committee for Child Analysis in Eastern Europe be changed to “ACP Liaison to Eastern European Child Analysis” in order to allow the committee to work directly with the board rather than through the Liaison Committee.

Dr. Donson reported on the AACAP Practice Parameters. He asked for members who would be willing to look over various parameters as they are progressing as it will directly affect what is accepted in practice. Dr. Kenneth King suggested an email notice to members to alert them when issues arise.

Dr. Donson asked for volunteers for members to the Liaison Committee for the social work community. He reported that Carol Austed and Sergio Delgado will be joining the committee. Dr. Donson will provide Tricia with an updated committee list.

G. Donations & Grants
Jill Miller, PhD (for Cynthia Carlson)
Dr. Jill Miller reported for Cynthia Carlson who was unable to attend. Nine grants were awarded for the 2005 grant year. Due to the transition, grants were awarded late, but checks have been sent out to all nine institutes. As a testament to
the success of the program, Dr. Miller reported that four of the grant recipients are on this year’s program. Tricia reported that each donor received a thank you letter under Dr. Karush’ signature.

There was a lengthy discussion about the grant process and some confusion on the grant application requirements. The board discussed the following grant application changes: Grants are capped at $2000 per case. An institution may receive more than one grant. Grant applications will be due by October 20th and decisions will be made by December 1st. The grant committee will meet by conference call in early November to award the grants. Donations to the grant funds will be published only with the permission of the donor. Include the name of the Institution’s contact person (full contact info). Exclude case initials or case name. Change ‘Proposed Frequency’ to ‘Date Analysis Began and Frequency’. All grant applications should be faxed or mailed to the ACP office.

MOTION: A motion was made to accept the grant policies and procedures with the changes recommended. The motion was 2nded and passed unanimously.

ACTION: Dr. Miller and Dr. Carlson will review and revise the form and send it to Tricia who will have it approved by the board and implemented for the 2006 grant year.

ACTION: Dr. Carlson will send a final copy the Ouida Foundation as a courtesy.

Dr. Karush thanked the Dr. Carlson, Dr. Miller and the Grant Committee members for their hard work.

H. Awards Committee

Jack Novick, PhD & Laurie Levinson, PhD

Dr. Novick and Dr. Levinson reported that the Allen Creek School was the 2006 Recipient of the ACP Award of Excellence. The award will be presented at the dinner on Friday evening in Denver. Dr. Novick suggested that the previous award winners should be listed in the conference program. He also suggested that we could publish membership requirements and award of excellence criteria on the back of the program.

I. Newsletter Committee

Christian Maetzener, MD

Dr. Maetzener reported that the newsletter publication dates are September and February. There is some overcrowding of newsletters at the beginning of the year due to the APsaA’s publication which is published in January. The cost of the three issues was $7269.00. He asked the board members to please provide him with any suggestions and new ideas.

J. Study Groups and Continuing Education

Stanley Leiken, MD

Dr. Leiken reported on the continuing education credit available for the Denver meeting. He expressed thanks and appreciation to Tricia for her coordination this year.

K. Committee on Child Analysis in Eastern Europe - Peter Blos, Jr., MD

Dr. Peter Blos reported on the committee activities. Dr. Lilo Plaschkes was unable to attend. Dr. Blos announced that Europe has its first child candidate. The candidate is supervised by Barry Goldsmith and the work is being done in Russian. He announced that the Child & Adolescent Seminar will be held October 2nd in Croatia. Dr. Blos requested ACP members to forward bibliographies to him so that candidates in Eastern Europe have more access.

VIII. Discussion of Archives

Charles Mangham, MD & Robert Tyson, MD

Dr. Karush updated the board on the preservation project for ACP materials. She thanked Dr. Barrett and the Hanna Perkins Center for offering to be the repository of the archives. Dr. Barrett will see if there is a student who would be willing to inventory the materials. Dr. Barrett will report to Dr. Neely and Tricia with the name of the student and the estimated cost of the project.

IX. Old Business

Dr. Susan Sherkow asked if the ACP received any response on the waiving of dues and annual meeting registration fees for Hurricane Katrina victims. Tricia reported that the letters went out and the ACP did receive requests for waiver and a letter of appreciation.

X. New Business

No new business was reported. The Executive Committee meeting adjourned at 3:20 p.m.
are critical and interfere all the time. Dr. Campbell sits tight and recognizes the transference feelings safely disguised from Jennifer.

In fact, the coach serves as a figure with whom the boundaries of connection and ambivalence about such connections can be examined. Dr. Campbell helps the patient explore her frustrations about feeling controlled by her coach, his feelings about food, and her need to maintain a sense of inner organization through the restriction of food. Thus, the controlling and demanding coach is developed in sessions, while Dr. Campbell listens for derivatives of this as metaphor for transference. He later adds that he thinks that she is also apt to have guilty feelings for not meeting the track coaches’ expectations. This comment covers her ambivalence and the flip side of the concerns that her fragile ego must traverse. All the while, a pattern of developmental fixation is seen, because like the track coach, the mother has served as a difficult figure for Jennifer to identify with. She seems to have had one view of how babies and children should be, and at least insofar as Jennifer experiences this, no alternative can be had. Thus, the pressures of adolescence with the desire to individuate and yet regress, attack her ego functions and leave her with no other path. Jennifer develops a symptom around restricting food; she thereby deflects that anxiety associated with adolescent desires. These desires include sexual feelings and autonomy, things that are too scary and not at all tolerable to Jennifer’s inner experience. In fact, after readily taking to four times per week psychoanalysis with a sense of comfort and narcissistic communion, Jennifer began to show her own opinions by beginning many interactions with Dr. Campbell by saying no, or correcting him in some way. Dr. Campbell described a negativity, one delivered in a calm, considerate way.

We are told that up until this point that Dr. Campbell remains entirely in her metaphor. He subsequently makes a defense/transference interpretation which is followed by periods of silence. Jennifer recalled her mother made her feel slightly guilty and anxious for not eating. She blissfully enjoyed the merger transference states but was threatened by them as a potential danger to her early adulthood. As he informs us, Jennifer was conflicted: developmental progression was experienced as overt rebellion, but this created too much guilt and was inhibited. On the other hand, Jennifer’s food refusal prevented the disorganization associated with continued attachment to her mother. While Jennifer feels good and later describes herself as being self-centered, Dr. Campbell discusses the doing and undoing, as a means of avoiding the separation-individuation. She responds to her sexual feelings with conflict and later states that she will never have sex, in other words avoiding her view of her parents’ criticism. She later notes that her mother calms her down with her words, what Dr. Campbell thinks is a conspiracy against conflict. He tells us that this is the same problem seen in the adult avoidant personality disorder. Jennifer later comes to believe that she feels way too guilty. Jennifer is uncharacteristically late to the following session and when Dr. Campbell brings it up, she says he was putting words in her mouth (he states that this suggests a fear of both rebelliousness and sexual activity). He notes that she became afraid of all the guilt, afraid that he would upset the balance she had set up between herself and her mother. Here we have a most striking moment in which the patient’s sexual desires in the transference passionately drive the analysis but also pressure the defenses. Jennifer fears that Dr. Campbell puts words in her mouth (I would also underscore the feeding metaphor) but he helps her draw attention to her ambivalence and the conflict, rather than being a mindless slave to the conflict. Treatment progressed and Jennifer began to experience more adolescent-like fears. As Dr. Campbell puts it:

Letting go of parental ideals creates an immense fear in the adolescent because among other things it makes them feel they will lose their inner regulations, achievements, abilities and control of themselves. My interpretive work with the pathological relationship in the transference implied growth with the loss of these inner regulations.
Dr. Campbell tells us that the patient developed a growing awareness of concerns about how disturbed her relationship with her mother was. He notes that she became increasingly irritable and argumentative. She was angry with him as well, but the analysis lasted for six and a half years and was satisfactorily completed. Thus, Dr. Campbell takes us through the beginnings of a most difficult case, one marked by the struggles of patient and analyst to find a way to relate that does not threaten autonomy, or lead her to be overwhelmed by the fears of it. In effect, development does move forward.

Liaison Group Report

Barbara Deutsch, MD & Nathaniel Donson, MD

In September 2005, the Executive Committee decided that submissions from non-ACP members of our collaborative organizations (see list below) would be accepted and reviewed in the usual manner by the Program Committee. If such papers are accepted, they will be in a Friday Workshop. Those presenting will be welcomed to attend and participate in the full Friday, Saturday, and Sunday ACP scientific (and social) program. We will inform members of our respective disciplines of this invitation.

The members of our Liaison Group wish to thank the Executive and Program Committees for their willingness to accept Workshop papers from non-ACP members from other mental health disciplines. We hope that this will facilitate continued feelings of reciprocity with members of the child psychiatry, infant mental health, psychology and social work communities.

Liaison Group members will continue to encourage members of their respective disciplines to attend ACP Scientific Meetings. Our members have been active in the following mental health disciplines:

**IACAPAP World Congress:**
Stephanie Smith, MSW

Stephanie Smith is hopeful that a number of us will go to Australia for the 2006 IACAPAP Congress. The conference theme is “the continued endeavors of clinicians to help improve the lives of children and families, relieve symptoms and impairment, and remove barriers to individuals achieving their potential in life. The interactive scientific program will feature International and Australasian leaders in infant, child and youth mental health, who will present new knowledge from a wide range of research approaches, from the social sciences to biology, emphasizing both quantitative and qualitative approaches, from epidemiology to contemporary treatment outcome designs.” Francis Salo, an Adult/Child analyst trained at the British Society and at Hampstead, where she became a Course Tutor before moving to Australia, organized an ACP-sponsored Symposium. He will present the analysis of a withdrawn 3½-year-old boy who responded to interpretations to gain not only symptom relief but also to develop a mind of his own and the capacity for self-reflective thinking. Ruth Safier builds on this with an account of infant-parent clinical work in which she worked psychoanalytically with a mother and her 2-year-old autistic girl, intervening with both of them in an equidistant way so that they were able to begin thinking again. The presenters’ discussion will draw out elements of working psychoanalytically, whether it is of an intensive or less intensive frequency.

**Committee for the Development of Child Analysis in Eastern Europe**
Peter Blos, MD & Lilo Plaschkes, MSW

Peter and Lilo have done fine work in Eastern Europe. Since local organizations there have been largely responsible for the “development” of child analysis, they asked that the name of their committee be changed to “ACP Liaison to Eastern European Child Analysis.”

The Han Groen-Prakken Psychoanalytic Institute for Eastern Europe of the IPA (www.hgp-piee.org) has made great strides. In this year alone (2005) it has graduated 9 candidates who became Direct members of the IPA. The number of Direct IPA members in Central and Eastern Europe is steadily increasing. Belgrade and Poland are now provisional IPA Societies. There are 2 IPA Study Groups in Moscow. Croatia is now an IPA Study Group with 8

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members. The 7th Summer School for Child and Adolescent Psychoanalysis was held in Ra-
bac, Croatia from October 8 – 14, 2005. The
theme was “Secrets”. Out of 44 participants
the majority were members of the above-mentioned
IPA Groups. Others came from Bulgaria, Esto-
nia, Latvia, Lithuania, Slovenia and Ukraine as
well as the Russian cities of Dniepropetrovsk,
Rostov and St. Petersburg. Many of the partici-
pants are PIEE candidates in adult psychoana-
lytic training.

For those interested in Child and Adolescent
psychoanalytic training, the major development
has been the approval of specific C/A training
guidelines by the PIEE Board. These guidelines
will facilitate the training of those now qualified
as Adult Analysts to add training in C/A analy-
sis and will provide the first such opportunity in
Eastern and Central Europe. Applicants for C/A
analytic training will be referred by the PIEE
training section to the PIEE Committee for the
Development of Child and Adolescent Psychoana-
lysis in Eastern Europe. [CODECAPE] This
Committee will be responsible for facilitating
the implementation of these new guidelines in
coordination with the PIEE Training Commit-
tee. The members of this new Committee are
Leena Klockars, Finland; Renate Kelleter, Ger-
many; Marta Badoni, Italy; Terttu Eskelinen de
Folch, Barcelona; with Lilo Plaschkes, Israel,
Chair; and Peter Blos Jr., USA, Consultant.
All of these individuals are also on the COCA-
IPA Committee.

Since the guidelines were sent out in October
2005, we have had one applicant who will be
interviewed at the Candidate PIEE week-long
seminar held in Riga, Latvia in February. There
is much interest in this opportunity for training
in C/A psychoanalysis. It should be added that
in addition to the current request that all candi-
dates in adult training attend at least one session
at the Child/ Adolescent Summer School, any
candidate in Child/Adolescent training would be
required to attend this school as part of the
training. The Annual $3000 contribution from
the ACP has been gratefully valued and has played a vital role in facilitating the main-
tenance and development of the C/A Psychoana-
lytic Summer School and the just-beginning

International Psychoanalytic Association
Elizabeth Tuters

Elizabeth Tuters has accepted appointment
(following Christel Aires) as ACP liaison to the
IPA and was responsible for the excellent child
and adolescent IPA panels in RIO. For Berlin in
2007 she would appreciate ACP members as
presenters with good clinical material.

American Psychoanalytic Association
Ruth Karush, MD

Ruth wrote that she was Chair of COCAA at
APsaA until June, 2005. She has completed her
term as Chair of COCAA. Phyllis Tyson is tak-
ing over. Kerry Novick will be Chair of the CO-
CAP - the Council Child Committee, and was
suggested as liaison between the ACP and the
American Psychoanalytic Association. We are
looking for other ACP/APsaA members who
will continue this work with the American. Ruth
has done wonderful work at the American with
COCAA and leaves a legacy of a yearly series
of child analytic panels and workshop(s).

The Program Committee of the American has
agreed to continue one panel with a
child/adolescent analytic focus and one two day
clinical workshop on child/adolescent analysis.
All programs thus far have been well attended
and well received. Suggestions are requested for
interesting and worthwhile topics for future pro-
grams. The ACP has had a rich history of excel-
lent papers presented at former ACP meetings
which could be available for papers for APsaA
panels. Also, the content of ACP/AACAP pan-
els could serve as a format (or papers) for an
APsaA panel and for ACP-Workshops. (Nat’s
paper has been accepted for a Denver meeting
workshop.)

American Academy of
Child & Adolescent Psychiatry
Barbara Deutsch, MD & Nat Donson, MD

On behalf of furthering ACP liaison at the
AACAP, Nat and Barbara have been invited by
Tim Dugan, Chair of AACAP’s Psychotherapy
Committee, to attend that Committee’s meetings
at AACAP annual meetings. (Nat attended the
day-long meeting last October.) With Tim’s
help, a 2nd collaborative AACAP/AP/(APsaA
meeting was held in January 2006.

Last year we discussed the necessity and wisdom for child analysts to review AACAP Practice Parameters while they are in preparation and before they set like concrete and impose their version of community practice principles on all mental health professions including their own (see also page 18 of this Newsletter). The AACAP Work Group on Quality Issues is currently soliciting comments concerning four (4!) Practice Parameters (“Psychotropic Medication”, “Psychodynamic Psychotherapy”, “AD/HD” and “Family Assessment”) which are in the pipeline for (urgent!) publication; these are available for review at the members-only section of the web site www.aacap.org (non-members contact: kkroeger@aacap.org). Also, the next DSM (V) will soon be in preparation and raises similar problems.

We are pleased that once again the American Academy of Child and Adolescent Psychiatry Psychotherapy Committee has asked for a proposal for a "Clinical Case Presentation" under the Title “Contributions from Child Psychoanalysis.” The next proposed subtitle will be “Termination.” Eight of our ACP members have responded with clinical material and willingness to attend their annual meeting in October 2006. If accepted by the AACAP Program Committee, the panel will take place in San Diego.

Despite two very successful panels presented at prior AACAP meetings with over 100 in attendance, our October 2005 presentation of two analyzed children with OCD (by Sergio Delgado & Nat Donson; discussed by Bob King and Brian McConville) in Toronto was attended by only a few. Unfortunately we were scheduled in competition with several other excellent meetings, including a symposium (with Ted Shapiro, Peter Fonagy, Efraim Bleiberg, and other notables) called “Neuroscience Meets Psychoanalysis: Freud’s Grand Theory and Practice in 2005.” The latter left us hopeful that the analysis of children remains alive and well in the 2006 Child Psychiatric world.

Carol Austed and Sergio Delgado have expressed an interest in joining the ACP/AACAP Liaison Group.

We have requested that the ACP Psychotherapy Committee propose an ACP workshop for our scientific meetings. It would be very important for our membership to exchange ideas with child psychiatrists, perhaps in a format consisting of a case presentations with discussions both from child psychiatric and psychoanalytic viewpoints. An interdisciplinary workshop proposal should of course remain within the planned overall meeting topic.

Social Work
Kristen Bergmann

Kristen has completed her ACP liaison work. We are currently looking for ACP members who are interested in liaison work with the Social Work community. There is a current solicitation for papers for the March 2007 meeting of the National Membership Committee on Psychoanalysis in Social Work in Chicago. This committee is currently planning its next national conference which will be held in Chicago in March 2007. Dr. David Phillips is involved in planning a special "pre-conference" presentation which will be on the topic of supervision. The topic of the meeting will be special problems in supervision, for instance, working with a supervisee who might be significantly impaired by drugs, alcohol, or emotional difficulties. There is special interest in considering experiences of supervisors who work with therapists that treat clients with significant trauma. The committee wants to look at how this type of situation affects the supervisor, the supervisory process, etc. Dr. Phillips would like to hear from members of the ACP who have acted as supervisors in this type of situation and may have experience, suggestions, or materials they would be willing to share. He can be reached by phone at 212-831-0181, or by e-mail at: dgphilips@nyc.rr.com.

American Psychological Association
Denise Fort, PhD & Brenda Lepisto, PsyD

Chris Bonovitz of Division 39, Section II has asked about the call for papers for ACP meetings. Section II is comprised of psychoanalytically informed psychotherapists, but few child psychoanalysts. The orientation is mainly relational and interpersonal. There was some com-
Ex-Officio committee chair Moisy Shopper noted, “I chair the liaison meeting with the pediatricians and I think that is always worth doing since they are a source of referrals for us. Wherever we go we should have a person with access to the pediatricians.”

World Association for Infant Mental Health
Elizabeth Tuters, MSW

WAIMH’s call for papers was out in January 2005 for the Congress in Paris in July 2006. ACP members can attend and submit papers. The focus is clinical as well as research and the program committee is interested in infant and young child presentations, independent of the point of view. Three WAIMH proposals were submitted for the Friday workshop to the ACP Program Committee - as long and short abstracts.

Elizabeth Tuters’ proposal of an ACP/WAIMH panel exchange at future meetings of each organization needs careful discussion within our Liaison Group, with members of the ACP Executive Committee, and eventually with the ACP Program Committee. Such mutual commitments are complex and need to be carefully worked out to the advantage of both organizations; her proposal might serve as a model for the perceived respect and mutuality necessary to all liaison work. A child psychoanalytic presence is apparently desirable at WAIMH meetings but, as in all other disciplines, there are contrasting therapeutic viewpoints which require careful consideration. We had discussed the wisdom of a letter from the ACP President to the WAIMH president.

Elizabeth wrote that another group we might be interested in is “Zero to Three”. The editor, Emily Fenichel, has asked me to edit a book on psychoanalytic approach to infant-parent work. They already have a book on the Fraiberg approach which has been popular and they would like to publish as many as possible as the frontline workers are finding that approach to be helpful - something to think about.”

Pediatrics
Helene Keable, MD

One pediatric practice for late adolescents has requested a monthly meeting with their clinicians to discuss difficult cases, once more a window of opportunity for pediatricians to appreciate the role of the mind.

Also, Dr. Keable has started to serve on the AACAP Psychotherapy and Qualities Issues Committees. These committees represent real potential for greater collaboration with child psychoanalysts and offer an opportunity to explore this potential.
Child Psychotherapy: The Analysis of Playing
at Sophistication and Sexuality in an Infantile Adolescent Girl

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cissistically hurtful disappointments because she had often convinced herself that she was so happy, even when she wasn’t. C. continued to talk in glowing terms of the ‘lenient, cool and clueless adults in her life’, and Dr. Clement suggested ‘sometimes kids minded or even felt neglected when adults don’t notice what’s going on’. Soon C. confessed she had not been aware of her academic troubles. After Dr. Clement said “I think you managed to conceal the degree of your academic troubles from yourself, because you are so skilled at occupying your mind with only cheerful thoughts,” C. eventually began voicing real anger toward her mother, saying “she is crazy”.

When a series of events led to the discovery of drug paraphernalia and evidence of cocaine use in C.’s room at home, Dr. Clement referred the family to a substance abuse specialist for an evaluation. Following this, the C. and her parents entered an intensive outpatient drug treatment program. The analytic work continued in tandem with the new program. The drug program required that C. be grounded at home, with her parents. When Dr. Clement noticed that C. didn’t seem to mind the restrictions, C. enthusiastically told her: “It’s great to be home together. It’s cozy and we haven’t ever had time like this.” Subsequently, by the end of the semester, her grades improved.

C. was to spend the summer in a distant community and, in her characteristic way, only looked forward to the ‘new adventure.’ Dr. Clement pointed out that looking to the new could be a way to avoid feeling sad about being apart for the whole summer. C. acknowledged this interpretation, even as she sailed out of the office without ever looking back at Dr. Clement.

Dr. Novick commented that this presentation beautifully highlighted many salient considerations in child analysis: In particular, (1) How does neurosis interfere with a child’s education and learning? (2) How does the child’s develop-
mental level influence our analytic thinking, diagnostic formulations and technique? This case illustrated how Dr. Clement found ways to talk to this girl – through play acting and talking in displacement – a ‘latency technique’ that paved the way for the analysis of defense. Dr. Novick felt the shift in the analytic work came when C. said: “my mother is crazy”, the acknowledgement of a previously denied and warded-off frightening reality. He then posed other questions for consideration: How can the analyst work to avoid premature termination? Did the substance abuse treatment interfere with the analytic process?

Dr. Mangham suggested that because reality had so disappointed C., playacting and magical thinking had become her reality. It was with this child’s increasing involvement in the analysis over time that Dr. Clement became her consistent and reliable reality.

Other discussion group participants noted the absence of age appropriate sexual material and the intensity of C.’s more infantile longing for a mother to take care of her. This child welcomed restrictions that gave her closer proximity to her mother. It was agreed upon that despite slow progress, this child had the imprint of change and that very excellent work had been accomplished.
Save the date:

2007 Annual ACP Meeting

May 4 - 6, 2007
Washington, DC