Hope is Where We Start From

“The ACP was founded to assert the dignity of child psychoanalysis, demonstrate the seriousness of our contributions, and support the growth of the field. In short, the ACP was created to give us a professional home.”

Kerry Kelly Novick
President’s Message Fall 2008

Kerry Novick ended her term as ACP President on a welcome note of optimism. To prepare for my first message to all of you, I went to a large stack of old ACP newsletters in my own attic to see what my predecessors had to say. A decade ago, during her own ACP presidency, Erna Furman established a “Future Planning Committee,” chaired by Jack Novick. That committee delineated five priorities for our organization: the annual meeting, the newsletter, case finding, maintaining and expanding membership, and evaluation of how effectively the various committee proposals were actually carried out to further our mission. All of these remain valid, though we might want to add a sixth: grant support for low fee child psychoanalysis.

Now it is my privilege to take a turn as president in this home for child psychoanalysts. I am grateful that our Secretary Charlie Parks will be my partner for the next two years as we work to achieve our shared goals of inspiring hope, turning hope into aspirations, and aspirations into creative and productive contributions on behalf of our real constituency, the children and parents we all serve.

The Annual Meeting

The first meeting of the American Association for Child Psychoanalysis (now the ACP) was held April 28, 1965, 45 years ago, and the text of Mari-anne Kris’s Opening Statement can be found in the October, 1989 ACP newsletter. The first sci-
A C P Newsletter
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www.childanalysis.org
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Submissions
Submissions are most welcome. They should not be longer than 1000 words and should be e-mailed to the editor (mcolman@comcast.net) as an attached Microsoft Word file (*.doc) or Rich Text Format file (*.rtf). The deadline for submissions for the Fall edition is June 30th, and for the Spring Edition the deadline is January 31st.
Scientific meeting took place April 9-10, 1966, with Anna Freud participating as discussant and moderator. Marianne Kris’s description of the meeting appears in the June 2000 Newsletter and the notes Charlie Mangham took at the time appear in June 1999. There were 87 members registered in 1966, along with 15 special guests.

For our 2010 Annual Meeting in Baltimore there were 110 registrants from the United States and Canada, as well as two attendees from Paris, Florence Guignard and Anne Catherine Pernot. “Affect Regulation, Impulse Control, and Ego Development in Child Analysis” was the theme around which the Friday workshops and Saturday plenary session were organized. Ruth Karush and the members of the Program Committee brought together a memorable offering of papers, all providing material from children in psychoanalysis—the hallmark of our scientific meetings. Some of the cases brought into the light the use of psychotropic medication for children in analysis, an uneasy topic, but our analytic data provide a unique basis for thought and discussion about it.

At the annual banquet the 2010 ACP Award for Excellence was given to the Engel School in Birmingham, Alabama and accepted by Lee Ascheman, Director and Headmaster.

The meeting ended with the 29th Marianne Kris Memorial Lecture, Stan Leiken’s warm and playful reflections on “People, Psychoanalysis, and Huckleberry Finn.”

Congratulations and appreciation are due to Ruth Karush, wearing her other hat as Chair of the Arrangements Committee, and Tricia Hall for all their advance legwork that brought us to a wonderful venue for our meeting at the InterContinental Harbor Court Hotel in Baltimore’s inner harbor. Easy walks to fine restaurants and the organized visit to the National Aquarium provided the chance to visit with friends and colleagues—the other hallmark of our meeting.

If you have done the math, you will have realized that our next annual meeting in Cincinnati will be our 45th Scientific Meeting. The Program Committee, chaired by Ruth Karush and Laurie Levinson, began work before leaving Baltimore to ensure that the scientific program will again be excellent. The topic is Techniques of Dealing with Aggression in Child Analysis and the committee invites your submissions. The Cincinnati child psychoanalytic community has already been welcoming and busy as they prepare to host our meeting and organize a Sunday extension program for the wider community. Save the dates April 29—May 1, 2011 for our 45th annual meeting.

The Newsletter

Through the years the newsletter has provided a record of our evolution. “From Our Archives,” written by one of our founding members, Robert Furman, for the December 1998 edition, shares contents of a letter dated April 1963 from Marianne Kris to Grete Bibring, then president of APsaA, in which she writes of the founding of a forum for the discussion of child analysis and “to provide a scientific home in which members of the American Psychoanalytic Association and those well-recognized child analysts who are not members of the American” could join together (December 1998).

A copy of the first newsletter of the AACP was reprinted in the June 2000 edition. It was written by Marianne Kris and dated June 29, 1966. Along with her account of the first scientific meeting, she also included the original criteria for membership.

Reading through the editions of the past decade, one can follow the changes in thinking about the criteria for membership as well as summaries of the papers presented at the workshops and plenary sessions of our annual meeting and reports of papers dealing with work on behalf of children presented at other meetings. These reports allowed
The Unhappy Wanderer: The Analysis of a Latency Aged Boy on His Way Toward Ego Mastery Despite Parental Roadblocks

It was a distinct privilege to hear consummate senior child analysts present and discuss child analytic material. Dr. S. Kalman Kolansky, presenter, and Dr. Samuel E. Rubin, discussant, brought to life the complex nuances as described by the analytic process portrayed in Dr. Kolansky’s paper, An Unhappy Wanderer: The Analysis of a Latency Age Boy. The 3½-year analysis of a 10-year-old boy, Sam, provided a valuable example of the conference themes: affect regulation, impulse control and ego development. Treatment was motivated by the father’s concerns about Sam’s depression, episodic mild enuresis, and the child’s deceptions about his performance in school and sports. The analytic process was shaped by this boy’s struggle to cope with multiple, severe losses within the context of the disquieting and periodically volatile dynamics of his two blended families.

Dr. Kolansky’s presentation focused our attention on four areas. First, the in-the-moment interaction of the analytic dyad was highlighted as an essential element of therapeutic action. This was further expanded by the analyst’s recognition of and receptivity to the different ways in which both the child and his father made use of him throughout their work, a reminder of the importance of maintaining flexibility regarding the various familial relationships. Second, the process material provided a window into Dr. Kolansky’s establishment of a safe play space which enabled Sam to participate fully in the analytic process despite several external crises. Sam’s growing capacity to manage his powerful conscious and unconscious affects, impulses and longings was facilitated by helping him make meaning of his play which included fantasy play, drawings and story-telling within the analytic relationship. Third was the value of a discerning use of interpretation. The analysis of Sam’s castration anxiety revolved around his extra-transferential anger towards and fear of his father, foretold in Sam’s development of a negative-oedipal father-transference. This material brought to mind the importance of distinguishing between when insights needed to be articulated as part of the play displacement versus when insights could and perhaps should go unsaid. Moreover, Dr. Kolansky’s verbalizing what was happening in the play gave permission for certain ideas and feelings to exist while putting a space between thought and action. This was particularly evident in a play series over a few months when he returned home from an extended visit to his biological mother. It began with Sam’s concern about messes in his drawings, proceeded to his preoccupation with making noises and drawing attention to smells in the office, and culminated with his “trying to control his hands, one hand holding the other as it would make uncontrollable movements.” These were seen as reflecting Sam’s concerns about anal soiling, reservations about talking to the analyst about his masturbatory wishes, and worries about “body parts he felt he couldn’t control and feared could go out of control.” Dr. Kolansky’s interpretive statements allowed Sam to understand and acknowledge his sexual curiosity and emerging masturbatory activity without having to speak

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directly about them, reminding us that implicit change is possible during play because symbolic ideas can be ‘played with’ metaphorically without being referenced directly. That is, change can occur in conscious and non-conscious systems with and without words. Fourth, but hardly of least importance and often quite challenging, is balancing the work with the child and the work with the parents. Dr. Kolansky’s clinical work skillfully demonstrated a fundamental commitment to maintaining a protected private space for the child while creating a “holding environment” for the parents (specifically the father, in this case) such that they could support the analytic endeavor.

The inescapable reality that children’s conflicts are part of a family system and, moreover, that the dynamics of the family culture influence a child’s way of seeing himself was evinced by the father’s notable identification with Sam along with the biological mother’s early and continued concerns about Sam’s eating and elimination. The clinical material dramatized how this family’s dynamics and each parent’s issues contributed to the color and shape of Sam’s inner conflicts, affect regulation and internalized self-and object-representations. As Dr. Kolansky stated, “often the parental pathology can signal the kinds of things that will come up in the child’s analysis.” This seems particularly pertinent when working with complicated parental dyads and family systems.

Dr. Samuel Rubin achieved his stated goal of facilitating a rich discussion by accentuating several key elements of the case, inviting our curiosity by raising a number of worthwhile questions. The issue of the analyst’s countertransference feelings led to a lively discussion regarding the analyst’s capacity to hold and metabolize intense internal and external reactions from the entire family constellation. Dr. Rubin pointed out that the analyst was able “to maintain a seeming calm, accepting analytic demeanor as well as thinking quickly on his feet” in the face of the parent’s inability to grasp and empathize with Sam’s conflicts and struggles. Once, when the father’s request for a particular appointment time for himself could not be met, he threatened to disrupt Sam’s analysis. It was only through Dr. Kolansky’s understanding and flexible handling of the father’s competitive feelings towards Sam regarding the analyst’s time and attention along with the father’s negative oedipal longings that the analysis was preserved.

Discussion was further enlivened when Dr. Rubin identified one possible countertransference enactment within the father-analyst dyad which occurred some time after Sam’s analysis had been terminated. The father, who had referred other people to Dr. Kolansky in the past, called Dr. Kolansky with another referral saying he told a boy’s father “Dr. Kolansky will see your son four times a week for a number of years and he will improve.” Dr. Kolansky thanked him and said he would be glad to see the father and his son for evaluation to clarify what would be most helpful. Sam’s father angrily said, “I already told you what his son needed.” Dr. Kolansky, aware that he touched a sensitive cord, agreed but never heard from that father or Sam’s father again. This raised some speculation that a ‘crack’ in the mirror transference (in the narrower sense) to the analyst, was more than the father’s narcissistic vulnerability could bear.

Finally, Dr. Rubin noted a striking disparity between Sam’s ability to internalize his conflicts while having an awareness of his distress, and the parents’ limited capacity for insight, sustained attachments and a propensity for impulsivity. It was suggested that good endowment and genetics might have been cultivated by early security and nurturance from Sam’s biological mother and paternal grandmother, later sustained by other important relationships which Sam was able to utilize. The strength of some children’s resilience and capacity to push forward despite extraordinary external deterrents is remarkable and always a source of wonderment for all of us as child analysts.

**Ami Berkowitz, M.Ed.**
Workshop C

Sex, Drugs and Rock ‘n’ Roll: Self Regulation in a Late Adolescent

Dr. Jack Novick presented the case of Nate, a 19-year-old college student whom he treated in analysis. Nate presented in the dire circumstances of skipping classes, spending endless days in his darkened room, stoned from early morning. He complained of having disappointed everyone and feeling depressed. Dr. Novick deftly characterized the early stages of forming the working partnership with Nate in 1) defining the nature of a therapeutic relationship, and 2) establishing therapeutic goals, among them, figuring out what was stopping Nate from holding on to good feelings and having a joyful and happy life. A second goal involved engaging his fears of expressing his critical thoughts about Dr. Novick and others.

Dr. Novick vividly characterized the complexity of influences that had shaped Nate’s life experiences and difficulties, particularly 1) the “family language” of intense anger playing out between all members of the family; 2) the confusion of anger and power; 3) the parents’ divorce; 4) his witnessing the fierce competition between his father and sister; 5) being diagnosed with ADHD, learning and behavioral disorders at an early age. He was placed on Ritalin starting in kindergarten, and by 10 he was diagnosed with a bipolar disorder and put on Prozac. At first the medication made him feel damaged, but then he grew to view it as making him special. By extension at 19 he became a heavy pot user, abused alcohol, and in all likelihood prescription medications. Around campus he was well known for dealing drugs.

Dr. Novick turned to the Novicks’ two-system model of conflict resolution and affect regulation in conceptualizing and treating Nate’s problems (J. and K.K. Novick, 1996, 2002, 2004; K.K. and J. Novick, 2005). The “open system” is attuned to reality and is characterized by joy, competence and creativity. The “closed system” avoids reality and is characterized by sadomasochistic, omnipotent beliefs, and stasis. When an infant or child fails to experience the satisfying, pleasurable and safe regulation of self states in a relational context, he/she may, in reaction to feelings of helplessness and vulnerability, resort to pathological sadomasochistic, omnipotent, rigid patterns of thought and behavior. Although maladaptive, this closed

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system can be highly effective and powerful in the economy of self-regulation. In Dr. Novick’s view the closed system does not reflect deficits in the self-regulation of affect as some have argued (Fonagy, et al, 2002; Palombo, 2011; Shore, 2010) but rather the expression of pathological self-regulation. He argues that every person regulates affects even if the modes of regulation are highly maladaptive and massively interfere with one’s well-being and growth.

In this framework the treatment involved helping Nate shift from his closed sadomasochistic, omnipotent system to an open system taking pleasure in his creativity and competence. This therapeutic process involved two vital elements. First, Dr. Novick expressed to Nate that one of the goals of the analysis was to help him and through him help his parents transform their relationship into a far more satisfying one. Accordingly Dr. Novick met with Nate and his mother and separately with Nate and his father on the few occasions they came to town. This proved to be invaluable and necessary in preserving the parents’ support of Nate’s analysis and in some measure defusing the charged nature of Nate’s relationship with each of his parents. Second, over the two year course of the analysis Dr. Novick was able to address Nate’s omnipotent closed system defensive structure that was so constraining and dysfunctional. Nate was able to set aside his need to be all powerful, to perform perfectly either sexually with his girlfriend, or in writing his thesis. In allowing himself to be “good enough,” he could begin to take satisfaction in his real accomplishments involving hard work and productive effort. In the process of this analysis Nate became a highly engaged, productive and creative person and enjoyed a far more satisfying emotional and sexual relationship with his girlfriend.

Stephen M. Robinson, Ph.D.
Samuel C. Roth, Ph.D.

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Linda and Brian were in conflict over the management of Emmie. It was apparent that Linda was becoming depressed and angry. She had threatened to leave on several occasions, usually in front of Emmie. Dr. Wright surmised that Emmie was worried about the possible disruption of her relationship with Linda. She cried with her Dad and said that she missed her mother and didn’t want Linda to be her mother. Emmie protectively pushed Linda away, while also feeling responsible for the possible loss.

Dr. Wright described this third period of trauma as oedipal trauma. The internal origin of this trauma was the manner in which dangerous and unresolved pre-oedipal fantasies colored the oedipal development. The external origin lay in the real conflicts and instability of her environment, which actualized both the oedipal drama and her worst fears based on her pre-oedipal traumas.

The central fantasy that her oral sadistic urges killed her mother, with the ongoing fear that her urges, needs and affects will kill all those who become important to her, has now made her oedipal wishes and rivalries extremely dangerous, particularly in the context of the real vulnerability of the adults’ relationship. Thus Emmie is as yet unable to fully resolve her oedipal dilemma. The treatment is ending prematurely as the family is moving to another state.

In this beautifully written paper, Dr. Wright helped us understand how early loss of the parent of the same sex may negatively impact a child’s development. While the patient has made many gains, more is needed. Hopefully the groundwork has been laid for further therapy in their new home.

Deborah N. Tucker, LMSW

Plenary Meeting, concluded from Page 13 . . .
Keeping the Treatment Alive: Working with Affect Intolerance in a Boy, His Family, and the Mental Health Community

Victoria Todd’s presentation on a challenging child analytic treatment began with an initial description of the 3-1/2-year-old boy who would become her analytic patient for more than three years. He was a child who had not yet stepped out of toddlerhood and whose parents and teachers were at a loss to help him. His inability to achieve mastery over his body, emotions or reactions impeded learning, engaging in friendships and more loving interactions with his parents. He felt anxious, sad and confused, and expressed these in the only way he knew how: by being a messy, angry baby, stuck in various phases of oral, anal and phallic development with little progress. His parents themselves came from families where emotional health was limited. Thus, emotional difficulties in the patient’s early life began almost immediately, with the boy being taken into the parents’ bed, followed by a separation from the mother at 6 months when she suffered a severe depression and required emergency hospitalization.

Initial descriptions of the parents revealed that they had been unable to establish routines for the patient in gaining toilet mastery and that they were unable to move him out of the family bed. Ms. Todd worked with the parents to set up a structure in which he could learn and practice bodily controls, and she persevered in working with the parents to move him out of their bed, where he had witnessed at least one incident of parental intercourse. What became clear in Ms. Todd’s presentation was that the family struggled greatly to create a situation where the boy could grow up without the interference of over-stimulation and fear, and with support on the side of progressive development, rather than prolonged infancy. Both parents and the school were unsure of how to deal with his frequent affective outbursts, most often giving in to the defensive regressed behaviors. Then, in the third year of the analysis a visit to a concerned pediatrician led to a referral to a Behavioral Specialist.

Limitations in the father’s and other professional’s understanding of the analytic work eventuated in psychotropic medications for the boy and regular visits to a behavioralist, with plans to terminate the analysis. The new interventions had consequences for both...
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boy and analyst: further regression in the boy, and the need for the analyst to preserve the treatment and continue to help the child, now with new stressors. Yet, these new stressors had unintended effects in bringing more directly into the boy’s awareness his feelings about being experienced as someone with a “syndrome,” as a disgusting baby, and as someone who is treated like he can’t do any better - someone humiliated. Much work was done to encourage his desires to manage his impulses and affects, to develop his capacity to verbalize feelings and be aware of his own disgusting behaviors, and to allow his own conscience to be his guide.

Workshop discussion by Dr. Sydney Anderson offered a number of insights. First, that one must consider parental negative therapeutic reaction when a treatment is in jeopardy. Second, that there is agreement among analytic writers on “the ubiquitous detrimental impact of primal scene exposure” and how exposure affects a child’s internal object representational world and ability to fantasize, to use his creative mind. Lastly, how can interpretations be seen as transitional objects that “offer the patient’s ego an opportunity to stand outside the ‘bedroom of his mind’” and take steps towards psychological growth?

Many of those in attendance at the workshop agreed that what saved this child’s treatment was a direct and detailed letter written by Ms. Todd for the father, but which was shared with the other professionals involved. The many requests for copies of this letter make including excerpts of it here important.

Dear . . . ,

As we all know, A suffers from pronounced anxiety…he has shown behaviors typical of a toddler…so it is imperative that everyone in A’s life support his desire to be ‘mature’ (his word)…some of the issues that A and I have been working on:

1. Impulse control: learning how to use his ‘inside stopper’. A, you feel so much better if you can stop yourself, rather than having me stop you. Can you use your inside stopper?

2. Conscience: learning how to use his ‘inside helper—that little voice inside that helps you know right from wrong and congratulates you when you do the right thing.’ Hold him to age-appropriate expectations…don’t be his conscience.

3. Affect modulation: it’s very hard for A to be an angry boy…he regresses and uses defense mechanisms instead of letting others know with words that he is angry. ‘Are you big, medium or a little mad?’ A’s trouble with affect modulation leads to a lot of his fears.

4. Verbalization of feelings: ‘You’re showing me that you’re mad, but I’d like you to tell me about it.”

5. Awareness of infantile behavior: Point out when A acts in an infantile way…remind him of his wish to be a mature boy and don’t let him get away with less. A has to be seen by all as capable.

6. Disgusting behavior: I label his disgusting behaviors as ‘angry behavior’, which invites rejection and ridicule…when A is angry he gets back at peers by being disgusting… But is that working? I thought you wanted to make friends.”

Kimberly Chu, LCSW
**Plenary Session**

Affect Regulation, Impulse Control and Ego Development in Child Analysis: Two Studies of Bereavement in Pre-Latency

**Summary of Plenary Introduction**

Dr. Jill Miller introduced the Plenary Session on *Affect Regulation, Impulse Control and Ego Development in Child Analysis: Two Studies of Bereavement in Pre-Latency*. She began by giving an overview of emotions in general, explored the process of regulation of feelings and explained how impulse control also involved regulatory capacities.

Dr. Miller explained that social communication is the purpose for the expression of feelings, but we also use feelings to help us maneuver through the challenges that life presents. Affects signal us to initiate self-regulatory capacities and defenses. Dr. Miller commented that, “affects both regulate and are regulated.” She spoke about the complex layers of self-regulation that develop by the time a child is five and how this ability to regulate one’s emotional states affects the way one experiences the world, relates to others and finds meaning. On the other hand, emotional dysregulation impairs development and compromises the child’s ability to find adaptive and organized responses to the internal and external environment. Dr. Miller also showed that impulse control was similar to affect regulation and that impulse control is linked to frustration tolerance and the ability to delay.

Loss also has a significant impact on the regulatory processes as does the developmental level of the child at the time of the loss or trauma. Both children presented at the plenary lost a parent at around the age of three. In trauma, affect regulatory capacities are overwhelmed and there is an influence on development itself. Dr. Miller explained how the grieving process takes a long time and requires a nurturing environment. Grieving is also revisited with each developmental level.

Addressing analytic technique, Dr. Miller pointed out that while certain aspects of mental life may be more available in the pre-latency child, their internal world is more fluid. These very young children are also more vulnerable as self-regulatory capacities are just developing. Thus, the analytic techniques are adjusted to meet the developmental needs of the young child. Not only strengthening, but also building ego functions may be a primary task of the treatment. “Helping the child develop a capacity to self-regulate means that the analytic dyad becomes the regulating agent.” Assigning words to feelings makes them more understandable and provides a way for the child to represent them internally. The analyst’s interventions assist in the development of self-regulation. The conscious reflection on unresolved reactions to loss promotes integration. The cases presented give a unique opportunity of seeing the impact of parent loss on a three year old, including the consequent effects on affect regulation.

“Treatment of a Three-Year-Old Boy with Multiple Losses,” Dr. Sarah Birss discussed Jason, who was born in another country, and lived with a foster mother there until he was adopted at age six months and brought to the US. Shortly after his adoption, his father became terminally ill, and died when Jason was two-and-a-half years...
old. Jason experienced difficulty with affect regulation and impulse control shortly after his father died, and was referred for treatment with Dr. Birss several months later. In her presentation, Dr. Birss explained how she came to understand the effect of these losses on Jason’s development, and how she was able to be helpful to Jason and his mother.

Jason appeared to have been attached to his foster mother, who seemed to have provided him with a sense of consistency, security, and containment of affect. His adoption meant leaving his foster mother at six months of age, at a time in his development of heightened sensitivity to separation from his primary caretaker. That this experience left Jason vulnerable to great difficulty managing intense affect, particularly around times of separation from important people in his life, was masked by his apparent good adjustment until his father’s death two years later. This additional loss, occurring as Jason was entering the oedipal phase of his development, triggered feelings related to the original loss, as well as of excessive guilt and responsibility from his developing, massively punitive superego. Jason’s feelings about his father’s death were complicated by anger at his father during his father’s long illness. After his father’s death, Jason became unable to manage feelings of sadness, fear, anger and guilt. His sustained episodes of yelling, defiance, hitting, and at times impulsively risky behavior overwhelmed his grieving mother, and made it difficult for her to help him contain and regulate his feelings. Overcome by his feelings, Jason believed he was bad, responsible for driving away and killing those he loved, that he should be punished and deserved to die.

Dr. Birss worked with Jason for over five years in intensive psychotherapy and psychoanalysis. For nearly four years, Jason’s mother stayed with Jason during his sessions, although if Jason’s nanny brought him for the appointment, Jason was able to meet with Dr. Birss by himself. During the fifth year of treatment, Jason was able to come in for individual sessions alone. Dr. Birss understood Jason’s resistance to separating from his mother as a manifestation of his experiencing Dr. Birss as a bad parent, needing his good parent, his mother, for comfort. Jason also seemed worried he would hurt his mother if he became close to his analyst. In addition, Dr. Birss saw the joint sessions as an opportunity to work directly on the relationship between Jason and his mother.

Over the course of treatment, Jason’s expression of feelings and behavior could become intense and quite agitated, particularly around the anniversaries of his adoption and his father’s death, and around times associated with separation from or loss of important objects in his life. Work began by helping Jason observe and identify his feelings of grief and anger, and to organize his experiences. Psychotropic medication was required to assist with affect regulation so that Jason could work in treatment and function at home and school. In the third year of treatment, after revealing his intensely held belief that he had killed his father, Jason asked his mother and analyst to tell him, and act out in play, the story of his leaving his foster mother and coming to the US to meet his adoptive parents. This led to improvements in his management of feelings and in his behavior control at home and school. Jason became more able to express anger towards his mother and his analyst, and experience that they could survive his destructive affect. He grew more aware of certain of his convictions, such as that he killed his father, and began to understand that he was not responsible. He developed a more integrated view of his multiple mothers, and of good and bad objects. Jason came to judge himself less harshly, and to believe he could be loved.

Dr. Birss observed that although Jason’s intense affect caused great difficulty for him and those around him, its intensity engaged her and facilitated her attuning to his inner world. She appreciated that his intelligence and ability to communicate his distress and rage helped others connect to and try to understand him.
Dr. Josephine Wright presented the case of a five-year-old girl, Emmie, who had lost her mother when she was three. The paper described three stages in the traumatic impact this had on the patient. Dr. Wright stated that parental loss is not just about a grieving process but also about the possibility of trauma. There were phase specific effects on this child’s development, both due to the loss and its fantasies, but also as a result of the lasting absence of the mother’s crucial role in ongoing development.

The first traumatic period was at the age of 10 months when Emmie’s mother, Ann, was diagnosed with stomach cancer. This resulted in the abrupt weaning from both the breast and from sleeping in the parents’ bed. Emmie cried and screamed nightly to the point of vomiting for one week following these changes in her life. As the result of surgery, Ann remained well enough to fully care for Emmie for another year and a half. Her development proceeded normally. However, these events at 10 months led to a period of unremitting excitation and overwhelming mind-body organismic distress, that interfered with the development of affect regulation. Dr. Wright stated that affect regulation ideally occurs within the context of mother-infant attunement. The mother, serving as an auxiliary ego, titrates the frustration and stimulation to that which the infant can endure and integrate.

By the time Emmie was two-and-a-half, her mother was too ill to care for her. Dr. Wright described this period as the second traumatic stage. Ann remained in a hospital bed at home until she died six months later. She had little to do with Emmie who was cared for in the living room by babysitters and various extended family members. During the terminal weeks, Emmie would have been aware of her mother’s cries in the next room, of her excluding Emmie from her bedside, and of the comings and goings of her mother’s attendants. The father, Brian, was grief stricken and emotionally unavailable. Babysitters and relatives showered Emmie with attention, food, and gifts. The father threw himself into developing his business, left parenting to babysitters and teachers, and refused to disappoint or discipline his child. Dr. Wright conjectured that Emmie experienced her affects, her age appropriate urges toward autonomy, and her bodily functions as threatening and dangerous. Superimposed on the earlier trauma, this anal phase trauma probably had significant effects on her ability to self regulate.

A third period of trauma brought Emmie to Dr. Wright at the age of five. The father had been persuaded by his girlfriend, Linda, to bring his daughter to Dr. Wright as Emmie had become increasingly fearful, demanding, jealous and envious of others, and emotionally labile. She wanted to eat excessive amounts of food and had become seriously overweight. Emmie erupted into affect.

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storms of rage and anxiety when she was frustrated which usually ended in inconsolable weeping and expressions of longing for her dead mother. These overwhelming and non-specific affect states disrupted her capacity to use fantasy or higher level defenses. The family had not been able to set up a consistent holding environment which could allow a gradual tolerance for disappointment or frustration to develop. The father agreed to four times per week psychoanalytic treatment.

The theme of Emmie’s initial play was always children and their caretakers going through daily routines of meals and sleep. Eventually the children’s noises, play, and loud snoring or crying at night disturbed the caretaker who got a bad stomach ache and died (like her mother). Sometimes Emmie would run around the office squealing noisily as if she were testing Dr. Wright. She needed to know if the analyst could tolerate her wild behavior and remain alive. The first months of treatment were dominated by repetitive playing out of fantasies about her mother’s death. This included thoughts of her own responsibility due to her own excessive affect and neediness. Dr. Wright emphasized that Emmie’s creativity and exuberance, as well as her relatedness to the analyst, suggested that this repetition in play was a reparative attempt rather than a rigid compulsion.

As the analysis continued, Emmie’s play involved homeless, motherless dolls and animals in need of adoption. Dr. Wright was the mother while she was the abandoned or bereaved child. They had many adventures together with the theme of abundant supply dominating the play: the toy store owner gave her his entire inventory. Aggressive impulses and voracious dangerous needs were safely projected onto animals or characters who would get out of control, become wild and exhibit murderous or cannibalistic behavior. Usually, however, the mother and daughter duo won the day and celebrated with eating together or performing for each other.

As the treatment progressed, Emmie was becoming increasingly attached to her father’s girlfriend, Linda. She asked to nurse at her breast and to call her Mom. Her struggles about food had intensified and she showed increased sexual excitement. Emmie told Linda, “Please don’t die, I don’t want a mother number three, I love you.” We hear Emmie both expressing her longing for a mother as well as her jealous wish for Linda to die.

In an attempted resolution to the real oedipal dilemma she faced, Emmie staged a play wedding between her father and Linda. She pronounced them man and wife and instructed them to kiss. She told Dr. Wright about all the things she was making Linda for Mother’s Day. They talked about her desire to show Linda how much she loved her. She expressed her wish that Linda would do Mom kinds of things with her. Emmie said she wanted Dad and Linda to get married so she could call her Mommy and then she’d be her ‘real’ Mom.

Uppermost in Emmie’s mind was the need to secure Linda as her real mother. If this meant relinquishing oedipal wishes and sublimating her own oedipal and pre-oedipal longings into age appropriate latency development, it was a price worth paying. This proved to be a complicated process. There was a stormy period in the treatment between the ages of six-and-a-half to seven in which the parental relationship was deteriorating and Emmie wanted to stop coming to treatment. Due to the father’s insistence, the frequency of sessions was cut back to once per week when she was seven years old and continued to the time of this presentation in May 2010 when the patient was seven years four months. In spite of this change in treatment there were many forward developmental steps, including a rapid growth of cognitive, academic, and social accomplishments. However, Emmie’s progress was often disrupted by a resurgence of her affect storms, periods of demandingness, hostility to Linda and voiced grief over the loss of her mother.

The home environment began to change.

Continued from Page 12 . . .

Concluded on Page 7 . . .
People, Psychoanalysis, and Huckleberry Finn, Dr. Stanley Leiken takes us on a journey of discovery as we cruise along the Mississippi River following the adventures of Huck Finn, Mark Twain’s infamous character. It would seem rather odd that Dr. Leiken would choose to end the annual meeting with such a tale, but what follows is a wonderful retelling of a coming of age story. At first Dr. Leiken opens our minds with playful tales from the pages of children’s books that illustrate the unfolding of normal and pathological child development through the fictional adventures of characters that we are all familiar with from our own childhoods. In the spirit of this weekend with colleagues and friends, Dr. Leiken reminds us of the importance of play and being playful. Creating a “play space” in our minds and in the mind of the other becomes the starting point for Dr. Leiken’s talk.

Taking the lead from Anna Freud who Dr. Leiken contends at times “played in her mind and was not burdened with rigid rules and theories,” he describes how he uses children’s literature as one way to illustrate critical developmental tasks faced by the child along the way. Dr. Leiken’s own experiences with supervisors like Hanna Fenichel and Rudolf Ekstein helped him learn to play with children using metaphors that capture their own inner struggles. Drawing on such tales as Goodnight Moon, The Cat in the Hat, A Fish Out of Water, Yertle the Turtle, Extraordinary Tug of War, Jack in the Beanstalk, and The 500 Hats of Bartholomew Cubbins, Dr. Leiken enlivens our study of child development in humorous and playful ways that help deepen our understanding of the children that we encounter in our consulting rooms.

It is in the spirit of inquiry and playfulness that we begin the journey alongside Huck Finn who travels from latency to preadolescence. Children in these phases are faced with the challenges of achieving increasing separation/individuation, developing and consolidating a superego that is neither too permissive nor too punitive, establishing skills necessary to understand the world around them, and beginning to see parents as real people with strengths and weaknesses.

Drawing on excerpts from Mark Twain’s classic novel, The Adventures of Huckleberry Finn, Dr. Leiken emphasizes the importance of the child proceeding along the developmental line from narcissistic to true object relationships which entails the ability to mentalize leading to feelings of care, concern, compassion and empathy for the other person. From the beginning of the novel,
Mark Twain introduces us to one of the major themes - Huck's superego. Dr. Leiken notes that Huck points out the inconsistency and relativity of morality, a common theme during preadolescence and adolescence. We also see the development of object love through Huck's relationship with Jim, a black slave who has escaped from his plantation owner. Huck treats Jim as if he were a toy, an object of humiliation. As their relationship deepens, Huck moves from narcissism and parallel play toward object love, a predominant theme during latency development.

Huck's relationship with his father also illustrates how Oedipal themes re-emerge during latency and Dr. Leiken reminds us that the door never completely closes on any developmental phase. It is in reaction to his father's attempt to imprison Huck that he manages to escape by faking his own death. "Separating" from his father, Huck begins the voyage of latency as he floats down the Mississippi with Jim. Along the journey, Huck experiences several adventures as he goes ashore from time to time which Dr. Leiken parallels with the "natural voyage of normal development. It stops and starts, proceeds forward and regresses backwards." He also notes that children who never regress, and who have rigid, non-flexible defenses reveal their underlying obsessional character development.

Jim, the Negro slave, becomes a new object for identification as illustrated in the following quote: "Pap always said, take a chicken when you get a chance because if you don't want him yourself you kin easy find somebody else that does, and a good deed ain't ever forgot. I never see pap when he didn't want the chicken himself, but that is what he used to say, anyway. Pap always said it warn't no harm to borrow things if he was meaning to pay them back sometime; but the widow said it warn't anything but a soft name for stealing, and no decent body would do it. Jim said he reckoned the widow was partly right and Pap was partly right so the best way would be for us to pick out two or three things from the list and say we wouldn't 'borrow' them anymore."

Huck gradually develops concern for Jim and is forced to question whether helping Jim escape is right or wrong. Challenging what he's been taught, Huck is free to "think for himself" which Dr. Leiken points to as the relevant issue in the struggle for individuation, something that we all struggle with throughout our entire lives.

Dr. Leiken has tapped a rich treasure of children's literature, and through our journey we have come to appreciate the value in our own learning and teaching, drawing from the work of such noted authors as Mark Twain who managed to capture an enduring tale that is as relevant today as it was in his time.

Julio G. Calderon, M.D.
us to become acquainted with and learn from the work of colleagues here and abroad.

The ACP Newsletter also has provided accounts of members’ varied efforts to participate in the wider community through outreach programs, psychoanalytic schools or classroom settings, and consultation initiatives. The newsletter has been a source for informative updates on activities related to child and adolescent psychoanalysis at APsaA and the IPA.

The publication of the minutes of our executive and business meetings has provided open access to our own organizational and committee work. Each “President’s Message” offers a glimpse into the issues of the day and each reflects the affection and dedication the ACP inspires. In short, the newsletter stands as a record of who we are.

Maintaining and expanding membership

According to the first newsletter there were 178 members in 1966. Today we number 592. The minutes of past secretaries’ reports indicate that, in 1992, 23% of our members were “senior” (over 70) up 3% from the year before. By 2002 we had added a new category of “emeritus” for those 75 and older who, together with the increasing cohort of “seniors,” then made up 27% of our membership. In 2010 the combined categories of senior, emeritus, and emeritus candidate represent 210 of our 592 members, or 35%. Our candidate members represent another 27%. It’s no news to any of us as individuals that we’re getting older and clearly being a candidate does not mean one is young.

One consequence of having only 38% of us as regular members is financial, as there are either no dues or reduced dues for the other categories of membership. Thanks to the generous donations of many, this problem is minimal. A greater problem is that of diminished energy.

I encourage everyone to take the time to read or re-read two exceptional discussions regarding our membership. The first is Paul Brinich’s President’s Message in the Summer 2003 newsletter titled, The Problem of Membership in the ACP. This masterful essay provides us all with another important historical perspective on who we were and who we want to be. Paul asked Kerry Kelly Novick and her Membership Committee to review and refine our membership criteria. The ACP Executive Committee accepted their recommendations and, as a result, the original pathways to ACP membership have been augmented by additional pathways for individuals who have shown a commitment to child analysis through the formation or founding of psychoanalytic institutions (such as clinical trainings, schools, clinics, applied programs, and academic departments) or via the creation of psychoanalytically-informed programs of research. This change allows us to think broadly about colleagues and candidates whose participation might strengthen the ACP.

The second essay related to membership that I would recommend focuses not on who can be a member of the ACP, but on what ACP members should be doing in their home communities. Marty Silverman wrote in these pages in June 1998: “It is important that we in the ACP do our part to nourish and strengthen child and adolescent psychoanalysis. We need to be active in the community at large and to be a vocal, active, productive force within the mental health community. It is incumbent upon us to present papers at meetings of mental health organizations, locally, nationally, and internationally, and to make contributions to psychoanalytic publications, and, where possible, to publications addressed to other readerships to whom we want to show what we have to offer...” These are difficult times for psychoanalysis, and when times are hard in general, children tend to suffer in particular. We need to pull together so that we are not pulled apart.
Case finding

Jack Novick addressed the issue of case finding in the report of his Future Planning Committee (December 1999):

“... with no cases to treat, we have no reason to exist and for many members and in many regions, there are no cases to treat.”

Mali Mann and Sydney Anderson, during their tenure as candidate councilors, inaugurated a special candidates’ event for discussing the finding and developing of child analytic cases with senior child analysts. This followed the efforts of Catherine Henderson and Virginia Kerr, co-chairs of the Clinical Practice Committee established a decade ago by Erna Furman (Summer 2001) to address concerns about the decreasing number of analytic cases. They organized a workshop, “Developing a Child and Adolescent Analytic Practice,” led by Arthur Rosenbaum and Ruth Hall at the 2003 Annual Meeting. Catherine and Ginny also sent out questionnaires to try to establish the number of children being seen in analysis. In December 1999 they reported that 90 of 135 members who responded had 133 cases in analysis and another 57 children were seen three times per week. Five years later they reported that 94 of 147 respondents had one or more children in analysis and the total number of children in analysis was 167.

I believe that it is time for us to look squarely at our practice realities once again – with neither false optimism nor false pessimism. I will be bringing before the Executive Committee my goal of re-constituting the Clinical Practice Committee and the earlier Case Registry Committee established by Moisy Shopper and chaired by Robert Galatzer-Levy (June 1995). We can consider whether these can be combined or whether each has unique functions that are best served separately. I believe it is important to take a fresh look at the cases we are treating and where they come from, not to prove our imminent demise but to show us what we have to do to prevent it.

Conclusion

Hope – does it spring eternal or infernal? Marianne Kris ended her remarks in 1965 with the following words, “I do hope each of you will bring to our attention his or her special idea regarding the future of this association and how these hopes can best be fulfilled. I may perhaps later add my personal fantasy to it, too.” I can think of no better way to close as we celebrate the 45 years since she gave us a home to hope from.

Denia Barrett, MSW
E-mail:  deniabarrett@gmail.com

Save the Date!

On April 29 – May 1, 2011 please join the Association for Child Psychoanalysis, Inc. as it hosts its 2011 Annual Meeting at the Westin Cincinnati Hotel in Cincinnati, Ohio. This year’s meeting topic is Techniques of Dealing with Aggression in Child Analysis.

Overlooking historic Fountain Square, The Westin Cincinnati boasts a convenient and central downtown location. You’ll be blown away by sweeping views and unique experiences. Take in a game with America’s first professional baseball team. Stroll through one of the nationally recognized museums or art galleries. Be inspired at the National Underground Freedom Center. Or taste a dish you won’t soon forget, Cincinnati-style chili. Whatever your taste, you’ll find it in Cincinnati USA. Watch your mail and e-mail later this year for new information.

Hotel Information:

Westin Cincinnati Hotel
21 East 5th Street
Cincinnati, OH 45202
(513) 621-7700
Room Rate: $139.00 / Single or Double
# Welcome, New Members!

The following individuals have been sponsored for membership and have accepted their invitations to join the ACP. We are happy to welcome these new members and look forward to others in the process of joining us soon.

## Candidate Members

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<tr>
<th>Candidate Members</th>
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<tr>
<td>Tom Avery, LCSW</td>
<td>Jill Miller M.D. and Rex McGhee, M.D.</td>
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<tr>
<td>Ami Berkowitz, M.Ed.</td>
<td>Ruth Fischer, M.D. and Dewitt Montgomery, M.D.</td>
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<tr>
<td>William Braun, M.D.</td>
<td>Susan Sherkow, M.D. and Ruth Karush, M.D.</td>
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<tr>
<td>Sharon Gerber, LCSW</td>
<td>James Bennett, M.D. and Sam Rubin, M.D.</td>
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<tr>
<td>Deborah Gunton, Ph.D.</td>
<td>Dewitt Montgomery, M.D. and Frances Martin, Ph.D.</td>
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<tr>
<td>Adam Libow, M.D.</td>
<td>Ruth Karush, M.D. and Susan Sherkow, M.D.</td>
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<tr>
<td>Catherine Phillips, LICSW</td>
<td>Catherine Henderson, Ph.D. and Robert Tyson, M.D.</td>
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<tr>
<td>Adam Raff, M.D.</td>
<td>Ruth Karush, M.D. and Christian Maetzener, M.D.</td>
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<tr>
<td>Rebecca Shaffer</td>
<td>Delia Battin, LCSW, BCD, FIPA and Laura Kleinerman, M.S.</td>
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<tr>
<td>John Tisdale, D.Min.</td>
<td>Kerry Kelly Novick and Don Rosenblitt, M.D.</td>
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<tr>
<td>Gail Van Langen, Ph.D.</td>
<td>Carol Austad, M.D. and Kay Campbell, Ph.D.</td>
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## Regular Members

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<th>Regular Members</th>
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<tr>
<td>Sydney Anderson, Ph.D.</td>
<td>Sara Knox, M.D. and Edward Kohn, M.D.</td>
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<tr>
<td>Thomas Byrne, M.D.</td>
<td>Adele Kaufman, LCSW and Paul Holinger, M.D.</td>
</tr>
<tr>
<td>Ellen D. Glass, M.D.</td>
<td>Ruth Karush, M.D. and Leon Hoffman, M.D.</td>
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<tr>
<td>Maida Greenberg, Ed.D.</td>
<td>Martin Miller, M.D. and Allen Palmer, M.D.</td>
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<tr>
<td>Keith Kanner, Ph.D.</td>
<td>Alan Sugarman, Ph.D. and Stephen Gould, M.D.</td>
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<tr>
<td>Nels Magelssen, Psy.D.</td>
<td>Charles Mangham, M.D. and Werner Schimmelsbusch, M.D.</td>
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<tr>
<td>Norka Malberg, M.S., Ed.M.</td>
<td>Viviane Green, M.A. and Patricia Radford</td>
</tr>
<tr>
<td>Mali Mann, M.D.</td>
<td>Ruth Karush, M.D. and Stanley Leiken, M.D.</td>
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<tr>
<td>Charles Most, Psy.D.</td>
<td>Laura Kleinerman, M.S. and Marion Gedney, Ph.D.</td>
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<tr>
<td>Patricia A. Nachman, Ph.D.</td>
<td>Ruth Karush, M.D. and Leon Hoffman, M.D.</td>
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<td>David Pollens, Ph.D.</td>
<td>Ruth Karush, M.D. and Helene Keable, M.D.</td>
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<tr>
<td>Donna Roth Smith, LCSW</td>
<td>Kerry Kelly Novick and Jack Novick, Ph.D.</td>
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<tr>
<td>Victoria Todd, MSSA</td>
<td>Thomas Barrett, Ph.D. and Carl Tuss, LISW, LPCC, LICDC</td>
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<td>Josephine Wright, M.D.</td>
<td>Ruth Karush, M.D. and Leon Hoffman, M.D.</td>
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**Please note:** These members were invited to join the ACP after the conclusion of the previous two six-week comment periods. The first one ended December 8, 2009 and the second ended April 8, 2010. The next comment period is scheduled for October 2010.

## In Memoriam (As of June, 2010)

We are very sad to announce the following members have passed away since the last edition of this Newsletter:

- William Adams, M.D., Cleveland Heights, Ohio
- Stanley Greenspan, M.D., Bethesda, Maryland
- L. J. Byerly, M.D., Voorhees, New Jersey
- Arlene Sylvers, Ph.D., Sherman Oaks, California
The breakfast meeting on Sunday, May 2, 2010 was another successful event following the pattern of the past three years. This year there were over 20 candidates participating in the discussion, with Drs. Jack Novick, Susan Sherkow, Tom Barrett, Lee Ascherman and Jill Miller serving as the seasoned child analysts who joined to facilitate the group discussion. The focus of conversation was aimed at helping candidates work through internal and external barriers to develop their child analytic practice.

Dr. Jack Novick believes that once the candidate develops a sense of conviction that analysis is an effective therapeutic modality, the message to the parents is more convincing and powerful when analysis is recommended. He stressed that analysis is a most effective treatment; and he gave very interesting examples of how to communicate that sense of conviction to the parents who come to us for help. His case of an adolescent analytical case from the previous day was an excellent example of how Dr. Novick worked so brilliantly and with analytical conviction helped his patient.

Dr. Barrett stressed the importance of building an alliance with parents in the initial evaluative process. Parents come to us for our opinion and guidance. We know that what they say is what they want, even though there are defensive aspects to their expectation. They need to hear from us that we need them in order to help their child since we need to access their knowledge about their offspring. This initial phase of evaluation is in the service of building a trusting relationship and building blocks for the future work.

Dr. Barrett reminded the audience that while there is value in taking a comprehensive history, what is more important at the outset is to listen to the parents’ worries. A true history can only be learned over time. He calls this time when he meets with children and their parents “figuring out time.” He believes children ought to be included as active participants. Recommendation for analysis is not for telling the parents that he or she is broken, but to communicate the child’s “strength and real ability.” The recommendation is a “strength based recommendation.” He stressed the importance of translating the analytical ideas and language into “de-jargonized words” making it understandable to parents (for example, “two way feelings” instead of “ambivalent feelings”).

Dr. Novick concurred with Dr. Barrett about first finding “strengths” in the child and understanding his or her conflicts. He offered the use of the term “emotional muscle” as a useful metaphor when talking to parents, helping them understand the meaning of their strength.

Dr. Sherkow suggested that it is necessary to include both parents in the evaluation phase and in obtaining developmental history. She also recommends meeting with the child to get his or her version of the presenting problem. All of the discussants were in agreement that evaluation is an essential, vital and deciding factor for shaping the fate of analytical work with children.

Dr. Miller highlighted the importance of analytic formulation, finding out what is disturbing to the child and explaining it to the parents. She uses the metaphor of a house foundation which is shaky, and explains that parts of the mind that neither parents nor the analyst know about at the start of evaluation is a reference to the unconscious part of the mind.

Dr. Ascherman agreed that the process of child evaluation is a critical phase which sets the tone for treatment follow-up and parental col-
-laboration in child analysis. Involving the parents helps to empower them to become engaged as active members of the treatment team.

All five child analysts offered very useful metaphors in order to help communication with parents be more effective and convincing in recommending analysis as the treatment of choice.

There were several good questions from the audience, and the discussion was very lively with unanimous agreement that the discussion group should continue at future ACP annual meetings. Since our terms as candidate councilors (Sydney Anderson’s and mine) ended at this point in time, we hope that incoming elected candidate councilors will continue encouraging such events for child analytical candidates in the future.

Respectfully submitted,

Mali Mann, M.D.