Association for Child Psychoanalysis NEWSLETTER

June, 1994

President's Message

Moisy Shopper, M.D.

Dear Fellow Members,

As the ACP grows and conditions change, hopefully we will be aware enough to respond creatively and appropriately. This issue of the *Newsletter* will attempt to create a record of the many fine prepared presentations and less formal discussions at our annual meeting. Abstracts have been rounded up by Kent Hart, riding herd on the many reporters who volunteered to be accurate, succinct, and prompt with their summaries. Our appreciation to Kent and to all involved. It is our secondary intent that many members and candidates, reading of the abstracts, will get a sense of the excellence of the Washington, DC meeting (informative, erudite, informal, relevant, etc.) and be motivated to attend the 1995 meeting in Toronto.

As an outgrowth of Peter Blos, Jr.'s interest and efforts to influence the decisions in the current health reform labyrinth, I have asked Peter to form and chair a new Committee on Governmental Issues. Several of our members, working from their own legislative and organizational contacts, and from within their own communities, have already represented the interests of long-term analytic and psychodynamic care of children and adolescents. I believe it makes sense for the ACP to coordinate all these efforts under Peter's own Committee.
In the meantime we hope you enjoy and use this Abstracts issue of the *Newsletter* and have an enjoyable summer holiday. ⌘

From the Editor . . .

The recent annual meeting of the ACP was lively, well-orchestrated, and well-attended: A tribute to Marty Silverman, Herman and Mary Staples, Rachel May, and the many others who made it into an especially good meeting. Washington, too, had its many attractions. The sudden snowfall that surprised many of us on Friday was not enough to dampen our enthusiasm for this increasingly-interesting city.

The Marianne Kris Memorial Lecture which brought the meeting to its close was presented by Bob Furman. This paper was remarkable for its range — from (1) a conceptualization of how some analysands adaptively use their analyst as a "custodian" of realities so painful that the analysand must deny them, (2) reflections on the applicability of "chaos" theory to the complexities of human behavior (as observed through the psychoanalytic looking-glass), and concluding with (3) remarks regarding the analyst as a "developmental object."

Our outgoing President, Peter Blos, Jr., chaired a special President's Workshop which focused on the mental health needs of children and how these might be met — or remain unmet — in the National Health Plan currently being debated in the U.S. Since many other countries are also reviewing the ways in which health care services are supported by national and/or private insurance, James

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Abstract Issue — 29th Annual Meeting — Washington, DC

From the Editor . . .

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Hutchinson's report of this workshop will be of interest to many of our members.

Applied analysis was well-represented in two workshops. One of these had to do with consultation in nursery schools. This is an area in which our Cleveland colleagues have led the way but in which many others — here represented by Roy Aruffo, Arthur Farley, and Penelope Hooks from Houston — have become quite active. Dr. Nover's summary captures the lively interest spurred by this topic.

The other workshop devoted to applied analysis was that chaired jointly by Bob Galatzer-Levy and Moisy Shopper and reported by Randi Finger. This focused on the child analyst's involvement in forensic work. Issues related to (1) the custody of minor children and (2) the psychological effects of traumata (e.g., physical and sexual abuse) were prominent. The fortuitous inclusion of an attorney — the spouse of one of our members — added to the usefulness of this workshop which likely will be continued at future annual meetings.

The clinical implications for child psychoanalysis of biological contributions to behavior were the "forbidden topics" addressed by Sam Wagonfeld, Carla Elliott, and Jill Miller. As reported by Joseph Silvio, the participants in this workshop took a hard look at the tendency by some analysts to overlook the part played by biological factors in learning disabilities, attentional disorders, depression, and so on.

The most theoretically-oriented of the workshops was presented by a group of Philadelphian members whose deliberations on the topic of narcissism in children are reported by Hossein Etezady. They brought several perspectives to bear on the topic, including classical drive theory, ego development, object relations, and self psychology. Their observations make it clear that this topic

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Note to contributors: Send contributions to the Editor at the address above. Deadlines fall one month before our publication dates of March 1, June 15, and October 15. If possible, send both hard copy and word processor files on floppy disks (3.5 or 5.25 inch 🖬). MS-DOS format files (e.g., WordPerfect, MS Word) are preferred (including those created under Windows) but Macintosh format files are also acceptable. Contributions can also be sent via E-mail. Our CompuServe address is 73727,3654 and our Internet address is

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can still profit from the attention of our members, grounded as they are in a developmental perspective.

This issue of the *Newsletter* includes two reports which, strictly speaking, do not belong to the Washington meeting. The first is Lilo Plaschkes' report of her trip to Vilnius this past March. This is part of our continuing attempt to attend to the development of child analysis around the world. Since many ACP members have family ties to Eastern Europe, Lilo's report on developments in this part of the world are especially interesting.

Finally, as a bonus, we publish in this issue an abstract of a paper which was submitted to the ACP several years ago, when we were trying to put together a volume of abstracts. This is Erna Furman's "On feeling and being felt with" — the 1991 Marianne Kris Memorial Lecture from our meeting in St. Louis. It seems especially appropriate to include this paper in the present issue as Erna and Robert Furman are, we believe, the first spousal "team" to be so honored —each in her/his own right — by the Association.

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— Reminder — Psychoanalytic books and libraries needed

Dr. Moisy Shopper notes that many of our colleagues in other parts of the world would be most grateful for donations of books or collections of books which have been unavailable to them for political and economic reasons.
He suggests that Members who are interested in this contact him or Lilo Plaschkes, Chair, Committee to Coordinate Assistance to Child Analysis in Eastern European Countries

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Abstract of the 1994 Marianne Kris Memorial Lecture
Washington, DC — The Association for Child Psychoanalysis — March 20, 1994

Some Aspects of the Analyst-Analysand Relationship

Robert A. Furman, M.D.
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The Department of Psychiatry, Case Western Reserve University School of Medicine, Cleveland, Ohio

[The paper was preceded by an introduction that related something of the history of the beginning of the Association and is reproduced in full below. The paper itself, "Some Aspects of the Analyst-Analysand Relationship", is then abstracted by the author. The full text is to appear next spring in Volume 6 of the journal *Child Analysis*.]

Introduction

It has become the custom over the years for the Marianne Kris Memorial Lecture to begin with some personal remembrances of Dr. Kris or, perhaps, an explanation of the way the topic of the paper relates to an interest of hers.

I had but a few contacts with Dr. Kris over the years before she spearheaded the effort to get the American Psychoanalytic Association to establish a Forum which would welcome all child analysts, lay or medical. The only form in which this could be presented to the membership of the American for a vote contained provisions and restrictions of such a nature my wife always said the only limitation they had omitted was setting up separate bathrooms. Maybe it was fortunate that the American rejected the proposal, but if one were a child analyst, one ended up feeling an unwelcome citizen, and if one were a lay child analyst, one ended up feeling not even a citizen. At this point, when morale was so low for so many of us, came the news that Marianne Kris had incorporated a new organization, The American Association for Child Psychoanalysis, and that its first organizational meeting would occur shortly. I believe it is correct that all the papers for the incorporation had been drawn up in advance of the vote of the American, if not actually implemented before that vote. That, however, is not important. What is important is that all of a sudden there were a lot of child analysts who started to feel that after all we were somebodies, that someone cared for and respected us enough to incorporate an organization for us.

We had the stature of having an Association of our own, recognized legally. We were recognized in law even if not by the American. My respect and admiration for Dr. Kris were very great indeed.

It was but a year or so later that I deliberately and very consciously imitated Dr. Kris by incorporating our Cleveland Center for Research in Child Development. Locally we had something of a repeat of the national situation in that child analysis and child analytic programs were being bureaucratically abused and if they were to survive, we had to become active in providing a new shelter for them. By incorporating our Center, we conveyed to all that we were somebodies with status and stature and I think the boost in morale that followed rallied all the child analysts to pull together and that did much to ensure our survival.

In this same situation, same crisis, the Institute was soon to copy us with the same positive results. I think it is appropriate to say that both child and adult analysis in Cleveland have a debt to Dr. Marianne Kris never before acknowledged.

Some Aspects of the Analyst-Analysand Relationship

The purpose of the paper was to examine some aspects of the analyst-analysand relationship not often discussed but ones which have yielded helpful insights along with problems in integrating them with usual analytic concepts.

The thinking began many years ago with a young latency boy in analysis who, at the onset of his treatment, gave an anxiety-driven story of a seduction he had endured some four years earlier. Shortly thereafter he denied ever having experienced or told about the episode, a denial he maintained steadfastly for three and one half years. When he finally relinquished the denial, he said he had kept it for without it he could not have managed being a school boy and that he could deny it once he knew the knowledge of the seduction was secure with his analyst.

A somewhat similar experience occurred some years later with a child analysand's mother who was dying of cancer. Herself a victim of a cancer phobia prior to her own analysis, the mother did manage well until she became aware of her metastases. Her doctors could not substantiate her awareness and thought her neurosis had been reactivated. The poor woman was overwhelmed with anxiety for which there seemed no relief. When I confronted her with the possibility her perception was correct and her doctors wrong, she was initially enraged, but then belittled the thought and started a denial of her metastases she was able to maintain for the few remaining months of her life, functioning well and peacefully.

These two episodes provided the dilemma faced by the paper: what was the analyst's role with this child and with this mother. The phrase was coined of the "custodian of reality" because in both situations the patients gave the analyst realities they could not endure so that they could then deny without basic loss of reality testing. It did not seem possible to characterize the analyst's role as a transference one as there was no repetition of the past involved in either instance.

Despite not being able to technically characterize the

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Some Aspects of the Analyst-Analysand Relationship . . .

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analyst's functioning, it was possible constructively to utilize the concept of "custodian of reality" in three situations. Dying children cannot deny their coming deaths and obtain peace until those around them have accepted that reality. Seduced children often deny their own report of a seduction once they are certain their message has been heard. Finally, the thought was offered that in many analyses the analyst helps the analysand master a traumatic event or situation by becoming its custodian, reminding the analysand of it at appropriate times in the working through process.

As efforts continued to find a home for the idea of the "custodian of reality" within the structure of the transference, the focus shifted to the transference neurosis, then in ascendancy as the *sine qua non* of analysis. A concept of value to many, the transference neurosis did offer difficulty to others, perhaps to some child analysts in particular, because a parallel to the transference neurosis as the *sine qua non* of analysis was the feeling of many that children could not develop a transference neurosis. This thinking put the child analyst in trouble as an analyst and, if the child analyst also saw adults and could note the similarity of transference responses in both groups, he was in even bigger trouble.

These developments led the focus of interest now to what was the *sine qua non* of analysis, if not the transference neurosis. Soon oedipal conflicts began to come to the fore as the essence, the crucial essence, of analysis but even this proposition had some problems because no matter how central oedipal conflicts might be to the analyst, they were often not such for the analysand, even analysands who derived enormous benefit from their analytic work.

The conceptual problems that had started with the analyst as custodian of reality had by now led to the transference, the transference neurosis, and oedipal level conflicts, all in what had become perhaps a search for the essence of analysis. The author's thinking rested here, uneasily so as it is with all unresolved theoretical issues, until two new factors appeared: chaos theory and the idea of the analyst as a new or real object. Chaos theory seemed to have much to offer psychoanalysis as a way of approaching complex systems viewed over time, putting into focus trends or patterns that emerge out of apparent chaos in multifactorial systems.

This was helpful thinking as it allowed the focus to move to analytic process, the striving for integration and mastery, the centrality of organizing or core events or situations as the essence or core of psychoanalysis.

The analyst as a new or real object was initially not so helpful but it returned interest to the analyst-analysand relationship, to the question of what is transference, what might not be transference because no matter how clear it seemed at times that the analyst was functioning as a new or real person, it was inescapable that this had to be happening within a transference framework. This thinking led almost simultaneously to the work of the Finnish analyst Veikko Tähkä on the developmental object and to last year's case presentation by Judith Yanof of "The analysis of an adolescent girl". Yanof reported working as her analysand's "best friend" initially, clear she was serving as a new or developmentally appropriate object for her prepubertal analysand, but also clear the relationship was grounded within an early maternal transference. Through this work it appeared the girl acquired a tolerance for delay of gratification, an ability to observe herself and tolerate her affects that enabled the analysis then to proceed in quite typical fashion through the analysis in the transference of dyadic and then triadic conflicts. Tähkä's concept involves so very much more than this phase-appropriate relationship and it is core to all he writes about in his new book, *Mind and its treatment*. He sees a child's maturation emerging out of his relationships with his early or initial developmental objects, a process that can be revived within the analysis of most patients. In this context he sees the transference as crucially helpful in delineating just where and how progressive development got stalled.

This thinking seemed to integrate well with notions of some of the trends or patterns that emerge in analysis, as mentioned above, but more importantly in the context of this paper offered an explanation of where in the analyst- analysand relationship one could locate the analyst as custodian of the reality. In this role the analyst could now be conceptualized as fulfilling a function for the analysand which he was not able to manage developmentally at the point of arrest, a function he could in time take over from his analyst as his capabilities matured within that relationship.

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Nota Bene

Please take special note of the request by Ava Bry Penman and Carla Elliott Neely for vignettes which might be of use in various legislative contacts (see page 28); and of the "Guidelines for Sponsors" who wish to propose new members to the Association (p. 33).

Summary of the President's Workshop
Washington, DC — The Association for Child Psychoanalysis — March 18, 1994

Child Analysis, the Mental Health Needs of Children, and the National Health Plan

Chair: Peter Blos, Jr., MD
Reporter: James Hutchinson, MD

Dr. Blos opened by expressing the hope that we would be able to formulate a legislative agenda. As experts in child development we should speak for the special needs of children as they are effected by legislation. He gave as an example the impact child analysts had in modifying a state plan to end the welfare benefits of new mothers when their infants were 6 weeks of age. Simple clarification to legislators of the developmental implications of the policy led them to modify it.

Children need preventive measures and special techniques. For example, the child analyst often spends considerable time talking with teachers, parents etc. Children and adolescents have a special claim to confidentiality. They often do not choose to come to therapy. They are not the ones to sign for release of information. Health legislation must recognize these needs.

Dr. Thomas Barrett: (Cleveland) The experience of the Cleveland Center for Research in Child Development (CCRCD) in obtaining funding for an early intervention--day care consultation program might serve as a model for legislative education. TRW's president Joe Gorman had expressed his interest in kids in the media. He had often said, "every child deserves to have an advocate". As a member of the Business Round Table he had frequently expressed concern about how early events in children's lives interfered with education and thus subsequent employability. The Cleveland Center approached Mr. Gorman showing how their programs were a means towards the ends he sought. He and his corporation were subsequently of great help to the CCRCD programs. We may enlist some powerful, effective allies if we can articulate our agenda as much as possible as a specific response to the expressed concerns of those we are trying to convince.

Dr. Robert Gillman: (Washington, D.C.) The current call is for parity. "Parity" does not adequately encompass the needs of children. Children are much more in need of preventive measures.

Dr. Blos: "Parity" not only implies the adult model but the disease model. On the other hand, the current adult model was now starting to consider immunization, preventive dentistry and other proactive measures to preserve health as reasonable elements of a benefit package. This may make our task a bit easier

Mr. Buzz Bailey: It is difficult to make arguments for such programs on Capitol Hill because current budgetary rules won't allow even the most obvious money-savers such as immunizations to be calculated as anything but an expense. You cannot promote something as having a cost offset.

Dr. James Hutchinson: (Bethesda) In my brief experience on The Hill even though they can't count cost offset in calculating expenses, members of Congress seemed become interested when cost offsets and the concept of preventive medicine are presented to them.

Dr. Drew Clemens: (Cleveland) (From the Government Relations and Insurance Committee of the American Psychoanalytic Association) It is useful to go beyond the business model, which has a short horizon, and speak to the government's interest in taking a long view and a broad view and looking at the savings in legal, welfare, unemployment, lost taxes, added educational expense etc.

Dr. Kerry Novick: (Ann Arbor) Sometimes government's view seems shorter term than that of business.

Mrs. Erna Furman: (Cleveland) My experience suggests business is concerned about the quality of the work force. A Princeton economist -- his name escapes me -- has written extensively on the cost-effectiveness of adequate parental care. An almost unlimited number of psychoanalytic studies (e.g., Bowlby, Spitz, etc.) speak to the same issue. The data seems to be there, but there also seems to be a barrier taking it into account. If the data were recognized there would be special consideration given to provide treatment for children.

Ms. Mary Crosby: (Lobbyist for the American Academy of Child Psychiatrists) It seems to me there is a growing awareness of the need for preventive interventions for children in Congress. Today the Stark Committee proposed a very generous benefit for children and adolescents in their Medicare Plan, including all medically necessary visits for children and adolescents up to the age of l8 with a 20% copayment provision. Miller from California also plans to sponsor a special package for child and adolescent psychotherapy

Mr. Elliot Weiner: (Legislative Aid for Senator Boxer) It seems to me that each office responds differently. It is important for psychoanalysts to use their clinical skills to sense what is important to the particular legislative aid and to consider and circumvent if possible points of resistance. Most will be concerned with cost effectiveness, some have special interest in substance abuse benefits, some respond to case histories, some respond to statistical data.

Let me offer a vignette of how the legislative process can work. Mrs. Cardin has long been interested in mental health issues. Representative Cardin is thus particularly well-informed and interested in the issue. He brought up the issue of mental health benefits in his committee. When the Congressional Budget Office (CBO) costed out the plan put forward by his committee chairman (Representative Stark), they found there was some money left over. Cardin encouraged this be used for Mental Health.

Don't focus all your attention on those who are supportive to your cause. The outcome of legislation is often

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President's Workshop . . .

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determined by how tenacious the opposition to passage is. Even if a person is likely to vote against you, if you can diffuse the level of negativity against your position, you have done a major service to your cause.

Ms. Rebecca Jones: (legislative aid of Representative Cooper) On our side of the aisle (Republican), cost is a big concern. Republicans generally feel mental health treatment is vulnerable on these grounds. In Senator Cooper's plan a commission will define the benefits after the bill is passed. On the plus side the commission will have nine general guidelines to consider in writing a benefit. Adequate coverage for "severe mental illness" is one of the guidelines. Senator Domenici has defined serious mental illness very narrowly. This is partly the result of influence of NAMI. There are five categories of serious mental illness. They include schizophrenia, manic-depressive illness, psychotic depression, autism, panic disorder, and obsessive-compulsive disorder As a former Clinical Social Worker I am concerned that children may fall through the cracks. I have been addressing this issue with my boss and my colleagues. I could use any data or assistance that is available.

Mr. Weiner: The cost issue is influenced by the fact that this health program is an entitlement program. Every person in the US could demand this care and be entitled to it under the rules. The "Woody Allen" factor is a problem. It is important to make the point that kids clearly don't use psychotherapy in some kind of recreational way. When there is a special population with special needs a "carve-out" of benefits is very appropriate. NAMI now seems to be pulling out of coalitions to get "serious mental illness" carved out. There are serious internal and external debates going on in NAMI and with other coalitions.

Dr. Charles Mangham: (Seattle) The medical savings of what we do are pretty obvious. I have about a year's experience now in a conference with internists, and more recently pediatricians, with the purpose of using dynamic knowledge to decrease need for tests and to improve medical care. In one case a paraplegic had required $120,000 in hospital care over the prior three years for treatment of recurrent decubitus ulcers. Her doctor came to understand that her self-mutilations [for that was what the decubiti were] were her response to separations from him; he then modified his handling of vacations. There have been no further hospitalizations over the last year.

Dr. Gillman: I wonder how much of the new information on costs are getting into the CBO for consideration. The *Psychiatric Times* published a series of studies that seem to show actual costs are much less then HCFA has calculated.

Ms. Jones: I think many of my colleagues would be very interested in data. If you have good data get it to us.

Dr. Clemens: The American Psychiatric Association has commissioned a study which will cost out an adequate psychiatric benefit. CBO seems very skeptical of any data that doesn't come from actuaries. Some of the studies that are quoted in *Psychiatric Times* are not really very helpful. They describe mental health care costs as they would be under the worst kind of managed care (e.g., the AMBA study).

Dr. Hutchinson: (Bethesda) There is good data. The Australian/New Zealand study documents that restricting care to "the seriously mental ill" is substantially more expensive then providing a liberal outpatient benefit because it curtails early intervention and moves more patients into the extremely expensive inpatient modality. Australia, with a liberal benefit, costs 35% less per capita and provides almost five times more face to face care than New Zealand, which offers a "bare bones" state hospital system .

Dr. Ellen Blumenthal: I am just back from a trip to Australia. Australian child therapists are very concerned that children get very inadequate service. I wonder if there is a body of outcome research for preventive interventions.

Dr. Blos: Head Start has a good deal of data available but it doesn't get funded.

Dr. Furman: Actually Head Start is being funded very well right now.

Dr. Barrett: But they have lost track of the idea. They are trying to make it a 12-hour-a-day program which places the children under enormous separation strain and undermines the original intent.

Dr. Novick: We must consider what data can we usefully offer to Congress in its deliberations. We need a perspective that speaks to this issue of "serious" mental illness. The term may apply to adults but does NOT apply to children. Any mental illness in a child affects development. Thus all mental illnesses in children are serious.

Dr. Blos: How best can we convey our message that developmental needs must be taken into account when writing the benefit of the health care bill.

Mr. Bailey: It seems to me that right now your organization and most organizations like yours lack the power. The do not have lobbyists operating on The Hill. They do not have past relationships with these legislators, stemming from help given around election time. They do not have PAC Funds. This does not mean the situation is hopeless. Bob Dole has been suggesting his view that the solution to the health care problem in the country is likely to be incremental. The bill which passes now will not be the final answer. You should take a 3-year perspective. Organize.

The U.S. is supposed to have a flat budget over the next 3 years. This means the administration's package will be scaled back. The flat budget constraints mean that price scoring is very important. CBO head, Bob Reischauer, must have the "reasonable predictable cost" / "cost offset" case made to him. You need the data to turn your clinical recommendations into something that can receive an acceptable budget scoring. CBO work is most important and must be carefully documented.

Mr. Weiner: True, but it is hard to get a picture of how CBO works. In its current assessments it doesn't even break down what different benefits in the mental health area

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President's Workshop . . .

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will cost. Figures seem very solid, but different underlying biases can get you very different numbers. Let me offer an anecdote why logic doesn't always work. A few days ago I was sitting in my office with an actuary from CBO who had just come back from his podiatrist. The podiatrist's nurse had told him while she was caring for his foot that, "there is going to be a severe outbreak of mental illness in this country over the next 10 years". As he was remembering this he began to muse out loud about how important it would be to have restrictions on mental health to not have treatment of this "epidemic" get out of hand financially. I was able to give him some data that challenged the assumptions he was accepting and he changed his mind.

Mr. Jim Pyles: (Lobbyist for Coalition for Patient Rights) Nobody has good data and sometimes this process is frighteningly easy to influence. Staffers are trying to come up with the right package but they don't have much time. Deliver your message early and often. Assemble the data as you go on.

Dr. Kerry Novick: Issues of confidentiality make it difficult to perform outcome studies.

Mr. Weiner: I want to repeat: Where there are special needs, it is appropriate for Congress to carve out special programs.

Dr. Hutchinson: I have some concerns about the strategy of trying to "carve out" benefits. One of the tragedies of this political effort has been that different patient and professional groups have been pitted against one another. The myth is that we don't have the resources to treat everyone. Mental health costs are not excessive. Treatment saves so much money in other areas that the more the need is met, the more money government has for other problems. I think it is very important while making the case for children to emphasize that one is NOT speaking against the needs of other patients.

Mr. Weiner: True. When I say "carve out" I did not mean to imply a carve out of funds from another needy group, but just recognition of special needs taken into account. I wanted to return to the issue of tactics. It is extremely important that those who contact Congress really understand the positions of those they are dealing with. Just a few days ago a high-level group in the Mental Health field attacked Simpson for not having taken a stand on Mental Health. This was dead wrong. Simpson has been working on the issue of mental health for many years. The error was compounded by making the accusation in a forum where it could be used politically by his enemies. This is a terrible mistake.

Dr. Robert Furman: If you live in Cleveland who are you going to talk to?

Mr. Pyles: Calling and writing makes a great deal of difference.

Mr. Weiner: Don't try to talk to the Legislator. It is more important to talk to the staffer. Form a relationship with them.

Dr. Ralph Gemelli: (Washington D.C.) I have had experiences treating people from The Hill and found that they were afraid to support mental health for fear it would lead people to suspect they had received treatment and that this would affect their careers.

Mr. Weiner: That may have been the case five years ago. I don't think it is the case now. The former Republican and Democratic first ladies, the president's wife, and the vice-president's wife are actively supporting treatment of the mentally ill. There is lots of cover now for supporting treatment of mental illness.

Dr. Hutchinson: It is very important not to loose hope. Our data is not "just as good as everyone else's;" it is a whole lot better. My experience on The Hill has been that these are well-meaning people who are trying to do a good job and are hungry for information. They can sense who is there to speak for the good of the country and who is speaking for their own narrow interest.

Ms. Jones: There is an openness on these issues.

Dr. Blos: There has been a kind of nosedive of morale as we have been talking. You can kind of feel it. We all work alone and I think people feel particularly alone in doing this kind of work. We need a way to support ourselves.

Dr. Furman: I write a lot of letters. I have been writing the staffer. I'm never sure what happens to them.

Ms. Jones: I don't think letters are that effective.

Mr. Weiner: I agree. We answer l0,000 pieces of mail every month. I don't see any of it. I don't have time to see any of it.

Ms. Jones: Phone calls are much more effective. Call and ask to speak to the Legislative Aide on Health Care. Constituents have the inside track.

Mr. Weiner: And when you call, give me very brief, succinct pieces of data -- bullets. Better to call me 5 times for 3 minutes then try to hold me for l5 minutes.

Ms. Ava Penman: (Boston) Which bullets are most important?

Ms. Jones: Name the bill, quote the details you are concerned about. Give the data that applies to those details.

Dr. Novick: As a Child Analyst I am not going to deal in bullets. [Laughter.] We need the information about which bills are necessary.

Ms. Jones: If you aren't sure about specific bills you can ask what's going on. You can ask what the person is doing for mental health.

Dr. Novick: My experience with that is you can get some very general answers.

Mr. Weiner: There is 800 number where you can get a copy of bills. There is a vast amount of information to try to keep up with.

Ms. Crosby: Keeping up with events on The Hill is difficult for everyone involved in the process. Lobbyists from groups that tend to be supportive on one another often pool their data. I could put you on the mailing list for the Child Academy political newsletter. Getting back to the issue of how you communicate with Congress. Coalitions

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have put together a grass roots campaigns. These are very effective. You get a chance to communicate with your legislator every recess. They usually go home and meet with constituents.

Dr. Blumenthal: My husband was a staffer with Senator Kennedy. He always sought information from those he knew. We should make use of our friendly connections with staffers on The Hill.

Mr. Pyles: I wanted to return to the issue of members of Congress being afraid to support mental health. In the past there has been concern but now there is good cover. About 1/3 to 1/2 of those on The Hill are or have been in psychotherapy. This will get you some very good listeners. Especially on issues like confidentiality. Keeping up with the legislative process is so complex that a lobbyist is very useful. But there must be a two way flow of information. A lobbyist must have priorities and the case from his constituency. The members of the group who hired him must have data on the right people and right issues to engage. It is very important that your message be simple. Pick the 3 or 4 most important issues and focus on them. A great deal of thought and time should go into focusing your message.

Dr. Jacobs: That point of not focusing your efforts just on your friends in Congress seems like an important one to me.

Dr. Clemens: This is not a partisan issue. The Democrats aren't always our friends and the Republicans are not always our enemies. On the issue of freedom to contract out of the system for instance or concerns about confidentiality we often get better hearings from our conservative members.

Dr. Furman: Does anyone pay attention to mental health systems in other countries. Do they care how other countries--Finland, Sweden, Germany provide for their children.

Ms. Jones: There has been some investigation of how health systems are administered in other countries but the specific area of mental health has not been studied. This might be a useful source of data.

Dr. Kerry Novick: The services to children are one of the area of difference between the US and other countries. I think it needs emphasis that a child does not choose to go to therapy. They are taken by someone else.

Dr. Jack Novick: Almost all children have had other forms of intervention before. Teachers, pediatricians, parents. They have not responded to other forms of intervention or treatment including medication in many cases. I wonder if it is possible to make the point that this kind of intensive work provides a knowledge base that is extremely useful to the community. There was a rash of suicides in one of our high schools about 10 years ago. We gave a talk there to the staff and students. They made a videotape. They show the tape every year. There has not been a suicide in l0 years. We were useful because we have a detailed knowledge of the mind from our intensive work.

Dr. Weiner: Is Congress going to ensure the survival of psychoanalysis? — No. Will it ensure treatments of a certain kind? — Yes. How many people here have seen abused children? [All clinicians in the room raised their hand.] I think most people intuitively understand the needs for intensive treatment for abused children. If you make the case for them, you make the case for all children. No one is going to just treat abused children. Senator Boxer has been very much involved in taking this approach.

Dr. Clemens: People can understand intensive treatment for trauma and abuse. Psychoanalytic coverage in Ontario was threatened. They did a study that found a very high percentage of patients in analysis had been abused or traumatized. That was effective in convincing Parliament to preserve a psychoanalytic benefit. The American Psychoanalytic Association is now conducting a similar study. I would just encourage all of you to fill it out. I know it is onerous, but the data is vital. I would also like to underline that it is very important that psychoanalytic groups be involved with other mental health groups. We tend to be the guardians of long-term intensive outpatient treatments and there are forces in these other groups that are insensitive to the need for such treatments.

Dr. Gillman: I wanted to offer some encouragement on the data front. Peter Fonagy and Mary Target at the Anna Freud Centre have recently published two remarkable outcome studies of 760 cases that were treated at the Anna Freud Center. The papers will come out in the *Journal of the American Academy of Child and Adolescent Psychiatry*. The documentation is superb. In the first paper 350 cases were discussed. They had DSM-III-R diagnoses agreed to by 4 board-certified child psychiatrists. Very stringent criteria were used for improvement. Sixty per cent of those with Obsessive Compulsive Disorder improved. This is a disorder that gets worse without treatment. Many organic therapists say point blank that it is untreatable by psychotherapy. The improvement rates for other diagnostic categories were substantially higher. More severe disorders improved much more with psychoanalysis then with psychotherapy. There were markedly different outcomes with different length and intensity of treatment. They showed that the children with more then one diagnosis really needed psychoanalysis to get better.

Dr. Blos: I wonder if we can try to summarize the principle's that have emerged.

Mr. Coyle: Define the principles that are important to preserve. Get the right combination of data and anecdote. Start with stories. Then go to the data. Cost, Access, and Quality are the main issues of debate in Congress -- the second two don't count. Focus on easily understandable principles The Coalition for Patient Rights espouses the importance of having the capacity to contract outside of the system and the need for confidentiality.

Dr. Blos: When you are talking about principles you are discussing something far less broad then what we would normally consider a principle. You are talking more about

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focus or orientation of our political efforts.

Dr. Clemens: The American Psychoanalytic Association endorses four principles.

1 Nondiscrimination in mental health care.
2 Preservation of the environment necessary for dynamic therapies. This includes:
   a confidentiality,
   b continuity,
   c the patient's capacity to participate in treatment decisions
   d freedom to contract outside the system
3 Preservation of psychodynamic psychotherapy within the health care system. (Rules to ensure that certain modalities of treatment are not just ruled out by managed care.
4 Preservation of private practice (Any willing and competent provider must be able participate in a treatment panel if he accepts the financial requirements.

Dr. Hutchinson: Other points made include

- It is useful to mix anecdote and fact.
- It is important to work through the Legislative Aide.
- Arguments should be shaped to meet the Aide's and Legislator's interests and cognitive styles.
- The phone has advantages over writing.
- Be brief and focused in your data, specific in what you want, and repetitive.
- Get to the CBO with actuarial data
- Form PAC's, hire lobbyists, establish relationships with legislators by being of help to them around election time
- Maintain morale. This will be a long fight but it is winnable

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Some addresses of interest to ACP Members

The Anna Freud Centre
21 Maresfield Gardens
London NW3 5SH ENGLAND
☎ 011-44-71 794-2313 FAX 011-44-71 794-6506

The Child Psychotherapy Trust
21 Maresfield Gardens
London NW3 5SH ENGLAND
☎ 011-44-71 433-3867 FAX 011-44-71 433-1874

The Children's Defense Fund
25 E Street, NW
Washington, DC 20001 USA
☎ (202) 628-8787

The Cleveland Center for Research in Child Development and Hanna Perkins School
2084 Cornell Road
Cleveland, Ohio 44106 USA
☎ (216) 421-7880 FAX (216) 421-7880

International Society for Adolescent Psychiatry
Mary Staples, Executive Secretary
24 Green Valley Road
Wallingford, Pennsylvania 19086
USA
☎ (215) 566-1054 FAX (215) 566-2773

The Lucy Daniels Preschool
9001 Weston Parkway
Cary, North Carolina 27513 USA
☎ (919) 677-1400 FAX (919) 677-0095

The Search Institute
Thresher Square West
700 South Third Street, Suite 210
Minneapolis, MN 55415 USA
☎ (612) 376-8955 FAX (612) 376-8956

World Association for Infant Mental Health
Institute for Children, Youth & Families
2 Paolucci Building
Michigan State University
East Lansing, MI 48824-1110 USA

Zero to Three / National Center for Clinical Infant Programs
2000 14th Street North, Suite 380
Arlington, VA 22201-2500
☎ (703) 528-4300 FAX (703) 528-6848
TDD (703) 528-0419

Workshop on Applied Child Analysis
Washington, DC — The Association for Child Psychoanalysis — March 18, 1994

Child Analytic Outreach into the Community: Consultation in Nursery Schools

Presenters: Roy Aruffo, M.D., Arthur Farley, M.D. and Penelope Hooks, M.D.
Discussant: Donald Rosenblitt, M.D.
Reporter: Aimee Nover, D.S.W.

This workshop had a twofold purpose: 1) to offer a working model of day care consultation which can be replicated; and 2) to illustrate the validity and usefulness of psychoanalytic principles in the practice of day care consultation.

The Educational Outreach Program is a pro bono project of The Child Development Center (CDC) of the Houston- Galveston Psychoanalytic Institute (HGPI). CDC's consultants (including analysts as well as other mental health professionals) meet weekly or bi-weekly for 1 1/2 hours on site with teachers in 25 daycare centers which serve 2,000 children from 6 months to 6 years of age. Centers represent a broad socioeconomic range from upper middle class to homeless families. The program offers consultation to the day care staff and follows an educational, rather than a therapeutic model. The Houston-Galveston Psychoanalytic Institute developed this program as a prelude to establishing the Stedman-West Center, a therapeutic preschool, funded primarily from a grant to the Institute, and scheduled to open in the fall of 1994.

The presenters introduced their topic by offering an overview of salient impressions: 1) even though Directors agree to or even request the consultation program, initial resistance of directors and staff to the consultation is universal and can take months or years to work through; 2) the model must be flexible in providing various types of services to meet specific needs (e.g., teacher workshops; 1:1 staff consultation; consultation to the Board of Directors) and specific problems (e.g., overstimulating environment; a teacher infected with T.B.; how to work with Protective Services); 3) typically teacher turnover has been dramatically reduced after the consultation has been ongoing for about a year (e.g. turnover dropped from 80% to 20% at one of the centers); 4) teachers invariably have an abundance of raw material. The psychoanalytically oriented consultation allows them to organize the data in a systematic way that promotes understanding of a given problem and facilitates their arriving at useful intervention techniques.

In order to illustrate the principles and techniques of the CDC consultation, Dr. Aruffo presented the case of Dolly who attended School M, a day care center to which he consults in conjunction with Donna Kline, Ph.D., a candidate at HGPI. Dolly, age 3 1/2, was brought to the consultants' attention because of teacher concerns about daily episodes of ostensibly unconflicted vigorous masturbation in the classroom. The teachers told the consultants that Dolly had transferred to School M in the fall because her parents were dissatisfied with her prior day care center which she had attended full time (10 hours/day) since she was 9 months old. In particular, her parents disagreed with the school's "laid back" attitude toward Dolly's open masturbation, a practice she'd exhibited at the Center and at home for at least two years. Other behaviors which concerned the teachers were: her seeking physical affection from random adults, and intense clinging to adults so that she would have to be "peeled off;" her inability to play with other children and concomitant tendency to play alone; her pervasive sadness; and her telling one of the teachers that people put salve in her vagina.

In presenting Dolly to Dr. Aruffo, the teachers wondered if Dolly was being sexually overstimulated or even abused. In a crisis-like atmosphere of intense concern on the part of the teachers, fueled by their worry about Dolly, their frustration in not being able to help, their anxiety about their legal responsibility and their own countertransference reactions to such a vital and provocative situation, Dr. Aruffo was able to help them see the masturbation as a symptom that could stem from a variety of causes. Dr. Aruffo's questions elicited the teachers' observations and speculations which then led to their recognizing the need to get more information from Dolly's parents.

The teachers and director met for a regular conference with Dolly's parents. Dr. Aruffo had previously been working with the staff to allow parents to "tell their story," i. e., to promote gathering information rather than advising and instructing them. He had also provided a model through his style of consultation with the staff. The L's impressed the teachers as pleasant, reasonable, caring and hardworking; the teachers heard no evidence of sexual abuse or overstimulation. By demonstrating an interest in Dolly, tactfully sharing their observations, and conveying respect for the parents, the teachers elicited the parents' trust and cooperation. The parents readily accepted the teachers' invitation to meet with the consultants.

In a spirit of trust and openness the L's shared their concerns about Dolly's excessive masturbation at home, her alternately tender and aggressive play with the family dogs and her tendency to turn affectionate gestures into hurtful ones. They also talked about Dolly's not playing with others kids and sometimes striking out at them. Most surprising to the consultants and teachers was that despite Dolly's status as an only child and the availability and regular caregiving of her two grandmothers, since the age of 9 months, Dolly spent probably less than 1 hour/day on weekdays with anyone who gave her undivided attention; all the adults in her life had competing obligations and interests.

Looking at the data, Dr. Aruffo helped the teachers (and parents) interpret it in the context of normal child development. Drawing on the psychoanalytic theory of psychosexual development, Dr. Aruffo talked about early

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object relations. In practical terms, this involved wondering with the teachers about the development and quality of Dolly's close relationships given her history as an infant and then toddler in day care 10 hours/day and, at other times, with limited access to her parents who offered only partial emotional availability.

The teachers, with the benefit of the consultation, now regarded Dolly's symptomatic behavior as understandable in the context of her being a "lonely little girl" whom "no one had taken in and made theirs." They could see how without a stable emotionally available primary love object, Dolly's relatedness and attachment to others, as well as her developing sense of self, would be compromised. Dr. Aruffo helped the teachers to appreciate the fact that Dolly's full time care was abruptly shifted to a group situation with multiple caregivers at a particularly vulnerable stage of development (i.e., 9 months of age, when a child has libidinally cathected the primary love object and is particularly sensitive to disruption of this tie). This change seemed to create a developmental interference. Dr. Aruffo talked about how an infant/toddler needs a physically and emotionally close relationship to his or her parents in order to form a secure base for becoming psychologically separate and for individuating. An infant would depend on his or her primary caregiver for example, to modulate affection and aggression. Dr. Aruffo described how the initial relationship with mother evolves into a more complicated two person relationship and then into a three person relationships. Dolly, they decided, focused on teachers but not peers because she sought 1:1 attention and close physical contact from an adult, behavior more appropriate to a much younger child. Also she could not be interested in a teacher and a classmate at the same time just as her parents had described her as not being able to play with both of the family dogs at once, but insisting on only one at a time. Teachers and parents could better understand Dolly's asocial behavior; she did not "give out the kinds of signals that make other kids want to play with her. . . and constantly [felt] rejected and hurt by them [because she didn't] understand the part she played in it."

The developmental framework further provided a context for understanding Dolly's symptomatic masturbation. Dr. Aruffo explained how autoerotic behavior evolves into masturbation. Both teachers and parents were concerned about Dolly's masturbation because it was exhibited openly, without apparent conflict. It also seemed to take the place of more age appropriate gratification such as that gleaned from friendships and constructive play. It had a compulsive, addictive quality. In all of these respects Dolly's masturbation differed from age appropriate oedipal masturbation. Dolly, emotionally alone so much of the time, seemed to turn to her own body for stimulation, and also for soothing. Dr. Aruffo speculated that she may have found her genitals before she was emotionally ready for such intense stimulation.

Both Dolly's teachers and her parents wondered about the extent to which she could have any internal prohibition against masturbation since her previous school had told her that everyone masturbates and that it was O.K. so long as she did it in private. Apparently Dolly made some effort to comply as her mother noted that she often asked for "private time." It became apparent to everyone that no one had ever suggested to Dolly that she stop masturbating.

An important component of the CDC model of consultation is helping teachers (and parents) develop intervention strategies. Given the insight and understanding that the consultant fostered in Dolly's teachers, what action could they then take to help Dolly? Should Dolly be referred for treatment, e.g., formal evaluation, child analysis? Should the L's be referred for parent counseling?

The CDC model emphasizes the consultation as teacher education. Their approach is incremental 'from the outside in.' Initially they work with the teachers (and parents) to see what changes can be effected in the child's environment in school and at home. With the benefit of the new perspectives and insights resulting from the consultation, teachers often generate their own intervention strategies. At follow-up consultation meetings they assess how these changes seem to affect the child's behavior and development. In Dolly's case, her teachers (and parents) decided that when they saw her masturbating they would actively discourage her by telling her to stop.

A follow-up consultation three weeks later indicated dramatic changes in Dolly's behavior which were suggestive of intrapsychic development as well. Only one brief episode of masturbation was noted. Teachers reported Dolly's active efforts to control her impulse to masturbate as if she were struggling to internalize an external limit. For example as she apparently seemed to be resisting an urge to masturbate she said "God is watching us." She also stopped herself from grabbing onto a visiting adult saying: "I can't do that. That's a stranger." The teachers helped her to use words to express her feelings without acting on her impulses. They also noticed that satisfying verbal interactions with her teachers seemed to reduce the need for physical clinging to them. Dolly was also playing more with other children. The three week period brought a blossoming of imaginative play and representational art, neither of which had been in evidence before.

In discussing these exciting changes with the teachers Dr. Aruffo emphasized "the role gratification and frustration play in structure formation, . . . and the way in which structural growth arises as part of a resolution of conflict, first with the parents and later internally. He pointed out "the personality growth which is flowing from conflict with parents and teachers and tie[d] this to conscience growth seen in the 'God is watching idea'."

General discussion among workshop participants initially focused on the common challenges faced by consultants. Day care staff, typically overworked, underpaid and not adequately acknowledged as professionals, are often resistant to the consultation despite their conscious spirit of cooperation. Factors underlying the resistance include:

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teachers' misconceptions about the consultant (e.g., he/she is there to judge, criticize, take over); discomfort because of the perceived discrepancy between the consultant's status and their own; anger and frustration over their own sense of helplessness, which then becomes channeled into competition with the consultant; an action orientation(as opposed to a reflective one); embarrassment over their own lack of knowledge about child psychology.

Dr. Rosenblitt's discussion addressed two questions. In answer to the first, 'What makes day care consultation good?' he identified two major factors:

1) The model of consultation needs to be clearly defined. There are many different types of consultation, e.g., educational vs. therapeutic; staff oriented vs. child oriented; individual vs. group. The specific model, for example, will determine whether the consultant offers advice to the staff about how to help a child in the classroom or whether he/she advises the parents or evaluates the child, etc.

2) The consultant needs to provide support for the teachers. Dr. Rosenblitt emphasized that the staff/ consultant relationship gets solidified around the help we can offer. This help takes the form of offering explanation and insight into challenging issues (especially around teachers' own feelings of guilt, frustration, rescue fantasies) and practical suggestions that can be implemented in the classroom.

The second question Dr. Rosenblitt addressed is: 'What makes the consultation analytic?' He lists key features of an analytic approach which are highlighted in the consultation process: the role of unconscious factors in motivation; the recognition and understanding of resistance, transference and defense; the use of a psychoanalytic developmental framework to understand external behavior vis a vis intrapsychic dynamics. Dr. Rosenblitt also emphasized that we should be aware that in imparting information to teachers we challenge their base of conceptualization. Teaching an expanded conceptualization should proceed slowly and be regarded as enrichment, rather than as supplementation. He also cautioned consultants about the tendency of teachers to idealize the consultant, a transference attitude which he feels should be addressed early on. Dr. Farley, however, thought that there was some value in not interpreting the idealizing transference too quickly because initially it can serve to engage the teachers.

Dr. Farley added that like psychoanalysis, consultation is an ongoing process that effects meaningful change over a period of time; consultants are "in it for the long haul."

The discussion turned to whether children like Dolly should be referred for evaluation right away. It can become an ethical dilemma for the consultant. Dr. Farley reiterated the approach of their model, i.e., consultation to the staff which works from the outside in, i.e., from environmental modification to child treatment. Referral for evaluation is suggested when other methods are not sufficient to help the child. Dr. Farley also said that the recommendation for clinical evaluation of a child usually works best when the teacher makes the recommendation. Referral for evaluation or treatment, including psychoanalysis, is part of an ongoing process and may evolve over time. The ethics of self-referral by the consultant were discussed. The general feeling was referral to someone other than the consultant avoided any appearance of conflict of interest.

Dr. Hooks presented vignettes from her consultation experience at School T, a center for homeless children, which dramatically highlighted the overwhelming task of teachers who provide day care for children who live in abject poverty and who have, or are at great risk for, concomitant social and emotional problems. She emphasized unique challenges and demands on the staff for resourceful and ingenious strategies and also poignantly illuminated issues of teacher countertransference.

For example, the teachers patiently nurtured an initially detached, bleak 2-year-old who, over 6 months at the Center, gradually became energetic, engaged and cheerful. When he abruptly "disappeared," they were stunned and angry. The consultants helped the teachers to work through their grief and feelings of anger at the system which penalized a child for her parents' failure. They helped the teachers to accept the limitations on their ability to do more. Their rescue fantasies served as a defense against the frightening concerns for the child's welfare.

A 3-year-old with a history of physical abuse pulled the leg off the class pet rabbit. The teachers were aghast. The consultants helped them to understand his behavior as a discharge of his anger, an identification with the aggressor, and a projection of his own hostility onto the rabbit. They helped the teachers to think of techniques which would allow him to control his impulses. For example as a way of providing control for him the teachers decided to allow him contact with the rabbits only under supervision. They also encouraged him to use words to express his feelings as a way of encouraging him to inhibit his impulse to act.

Another situation involved an abrupt unwelcome change in a 4-year-old's behavior. Formerly chatty, warm, and friendly, she became withdrawn and uncommunicative. After some exploration the teachers figured out that the family was temporarily living out of a car. They learned that the mother, fearful of being reported, had told her daughter not to talk to them. The Center staff was able to successfully reassure the mother of their support. The child could then resume her enthusiastic participation in the Center.

Dr. Rosenblitt summarized the workshop, emphasizing how the presentations and discussions illustrated the complexity of the consultation process and the sophisticated skills required of consultants. It is clear that there is an increased interest in and demand for mental health day care consultation. This consultation is an example of a very efficient and economical model of applied psychoanalysis. A single consultant relates to the staff of a center potentially affecting scores of children.

Dr. Rosenblitt suggested that the time may have come for serious scholarly attention directed toward day care

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consultation, perhaps including the establishment of a journal.

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Maurits and Anny Katan Foundation

In January of this year the Maurits and Anny Katan Foundation was founded in Amsterdam. The objective of the Katan Foundation is to promote and initiate projects which contribute to the improvement or enhancement of child psychoanalysis, especially in The Netherlands and continental Europe.

The Foundation hopes to achieve this objective through organizing seminars and symposia at both undergraduate and post-graduate levels, as well as through producing scientific publications, such as a monograph in honor of Dr. Anny Katan, together with Dr. Robert Furman and Mrs. Erna Furman.

The first project the Foundation has begun is the organization of a summer course at the Amsterdam Summer University, together with the Amsterdam School of Social Research.. The first Summer University class is scheduled for the Summer of 1995 and will be concentrated on the European Child Psychoanalytic Network.

Prof. J. P. Teuns, Secretary
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On Feeling and Being Felt With

Erna Furman
The Cleveland Center for Research in Child Development and Hanna Perkins School
The Department of Psychiatry, Case Western Reserve University School of Medicine, Cleveland, Ohio
[This paper was presented to the ACP in St. Louis as the 1991 Marianne Kris Memorial Lecture]

Since my analytic training in the late 1940ies, I have admired and learned from B. Bornstein's work, especially her ability to feel with her patients' most warded off feelings, to assist them in getting in touch with them, and to use this approach, not only as an introductory device, but as the ongoing basis for the child analytic work. During more recent years, the understanding of the role and development of feelings has received little attention. Of the few notable exceptions, two have been especially helpful to me. The first is A. Katan's (1961) "Some thoughts about the role of verbalization in early childhood". She stresses the importance of a mother helping her toddler to name feelings and express them in words and describes how this developmental step channels motoric into verbal discharge, enhances behavioral control, and has a marked effect on the developing functions of thinking, reality testing and integration. With case examples from the Hanna Perkins School, she shows how preschoolers who had missed out on this developmental step could be helped by the teachers and parents, through treatment-via-the-parent (R. A. Furman & A. Katan, 1969). The second, to me very important contribution, was by R. A. Furman (1978). In "Some developmental aspects of the verbalization of affects", he uses two cases of treatment-via-the-parent to illustrate how verbalization of feelings is but one step in a complex developmental process. First, verbalization has to occur in the context of an emotional milieu in which the caring adults appreciate feelings and respond to them with relieving actions. Second, it has to be followed by helping the child to endure and use his feelings as his own, even to forego relieving action, including verbalization, whenever this would be the appropriate way of coping. The mother's multifaceted and changing role is essential throughout the developmental unfolding as it is with every ego function.

The present paper focuses on the first and ever after most crucial aspect in the development of feelings, namely the sense of being felt with, traces some of its beginnings in toddlerhood, applies it to the analytic work with patients, and concludes with some of its effects on personality functioning and the analytic relationship.

The development of feelings and the mother's role during toddlerhood

The achievement of feeling good and of feeling bad, and of using the latter feeling to protest pain and to seek and accept comfort, date to the first year (Hoffer, 1950). I described the mother's role in helping her child to experience both these basic feelings; her own ability to feel and contain them sufficiently to initiate appropriate responses on one hand and, on the other hand, to invest her infant with a phase-appropriate balance between narcissistic and object elements to feel and do for him what she can feel and do for herself while, at the same time, recognizing and appreciating his feelings when they are different from hers and valuing and supporting them as his, not making them her own (E. Furman, 1985). At best, the infant's first feeling acquisition of knowing and using bodily pain remains vulnerable for years but requires special help during the toddler phase, as observed in the Hanna Perkins Mother-Toddler Group (E. Furman, 1991).

Chris, a healthy infant, had, from early on, suffered much discomfort from teething. At 18 months, and with the help of his mother, they related that morning's experience: Chris had called his Mom, looked teary and unhappy, pointing with his finger inside and to the back left of his mouth, and reached out to her. She picked him up for a hug, told him she understood he had a toothache and was so sorry it hurt. He then took her to the refrigerator where he pointed out the bottle with a local analgesic they kept for relieving teething pain and took part in applying it. They could both feel the bump. The medicine helped, but throughout the day Chris remained aware of his discomfort and alerted Mom to it. She offered him a Tylenol she had brought along and at one point he took it. Mom sympathized and praised his choice of cold soft foods to eat. She also told him how nice it was that he knew it didn't feel good, that the hurt was coming from a new tooth, that he could tell her and find the right things to do for it. Although Chris was subdued, he maintained his usual good functioning.

Kent, also a healthy and loved infant, had suffered several strep throat infections. When he was over two years old, I noticed him one day as listless, irritable, poking his hand into the back of his mouth, yawning. I shared my observations with his Mom. She was aware of them, added that he had not eaten well and woken during the night. She thought a tooth might be bothering him, but she had not talked with him about it, nor was she solicitous of his to me evident discomfort. I told her I thought Kent was not feeling well and had a sore throat. She disagreed, then suddenly and matter-of-factly asked him "Does your throat hurt?" He resented the intrusion and pushed her away with an angry "No". This and the next day Kent's functioning deteriorated. He fell twice, screamed and kicked with the least frustration, messed with his snack. When Kent at one point coughed as if choking and grabbed at his neck, mother phoned the doctor at once and rushed him off to be examined. Had I not interfered, she would not have stopped

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to explain all this to her boy and to prepare him. It was a very sore strep throat and Kent was put on antibiotics which Mom administered conscientiously. When she complained that he spat out his medicine and pushed away the squirter she used to insert it, I sympathized with mother and child how hard it was not to feel good and not to be able to make it feel good and, since both of them wanted to make the throat better, perhaps Kent would like to suck the medicine off a spoon himself and Mom might have a candy ready for afterwards, to help with the bad taste. This helped with the medicine and with the hard feelings between them. The mother's deep distress and hurt at having failed to diagnose the illness prompted her to work on this in the treatment-via-the-parent and this led her to a beginning appreciation of her child's feelings as well.

We have found that the mother-child attitudes to bodily pain are carried over to the development of other feelings, such as anger, shame, envy, fear, helplessness. It is noteworthy that in the above and in most other instances the children had not simply taken over their mothers' feeling or lack of feelings. When that happens, the development of the child's own feelings is bypassed and leads to lasting inner confusion and uncertainty as well as inability to use his feelings as a guide to action. We sometimes see this unfortunate outcome in older patients. In rudimentary form it is illustrated by some developmental psychologists' designed experiments to investigate the role of affects in early mother-child interaction (Emde and Sorce, 1983). True feeling with, by contrast, implies assisting the child in crystallizing his own feelings and coming to know them with the help of her validation and appreciation of them as his. He can then identify with mother's means of containing, differentiating and using them, and verbalization is among those means.

When toddlers have not been helped to make affective mental sense of their sensations and motoric discharges and to know and value their own feelings, they may persist with bodily manifestations, or may adopt mother's feeling responses, or may use a variety of primitive defensive maneuvers (as described by Fraiberg, 1982) or a developmental continuation of them. However, even toddlers who are well able to experience a variety of feelings cannot trust and accept them or themselves, when mother does not feel with them. They then use defense mechanisms to ward off feelings, but most clearly noted are their poor bodily and mental self-regard, lack of trust in themselves and the world, and increased dependence on mother.

Feeling with children in analysis

Most of our child analytic patients have developed the ability to feel but they defend against it because their feelings arouse so much unpleasure or anxiety. Interpretation of the defenses brings this unpleasure or anxiety to the fore, does not enable them to tolerate the underlying or briefly emerging affect, much less to use it to explore its appropriate ideational content and relevant connections in his past experiences. Our first task therefore consists of helping the child to value, bear and contain his feeling, and we achieve this by feeling with him, whatever route we take or words we use.

Some of our patients have not even reached the developmental level at which feelings are warded off. Like some of our toddlers, they are arrested at earlier stages of experiencing bodily sensations or discharges which have not yet crystallized into mental feelings and need the analyst's help to achieve this.

Martha, a healthy, intelligent 10-year-old, could not feel. Vaguely distressed, she would curl up on the couch, twirl her hair, suck her thumb, complain of being cold or of something hurting. I sympathized how hard it was not to feel good, but also suggested that her body was, in its own way, saying that there were uncomfortable feelings about other things. Feeling with Martha enabled us gradually to pinpoint an unhappy or alone feeling, an "everyone- is-mean-to-me" or an "I feel mean" feeling. As bodily symptoms subsided, she communicated non-verbally intense primitive terror, pain and rage, testing all along my ability to feel, articulate and contain these feelings with her. She then took to getting under the couch and signaling to me only with hand gestures. It was not just another test. After weeks of it, we were able to reconstruct an early experience of being in pain, confined in a crib and trying to reach someone to be with her bodily and mentally. I finally wondered about a hospitalization which the parents confirmed, although they had until then forgotten all about it: At 11 months, Martha had undergone an emergency operation which had kept her isolated in a hospital crib, the doctor having forbidden parental visits. On her return home, she seemed all right and proceeded with crawling and some first words. The parents never mentioned the whole experience to Martha. The mother recalled missing the nursing which had stopped during the separation, but she was unaware that she had lost being in feeling touch with her child.

Helping patients with uncontrolled behavior

Feeling with our patients and gauging the developmental level at which they feel, is hardest when they express themselves through motoric discharge, assaulting our senses and bodies and endangering themselves or the office and materials. Physically aggressive patients are invariably most frightened by their impulses and by the least evidence of damage they cause. Their often unconscious terror (usually a fear of annihilation) stems from the etiology of their behavior, regardless of whether it is defensive in its current form. They are either the victims of real or perceived aggressive/destructive behavior of others and/or function at a level where their sensations and discharges have not crystallized into mental feelings,

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perhaps not even reached the ability to protest pain and seek comfort. Feeling with them, we can sense that they cannot trust a differentiation between inner and outer reality or that a contained feeling will serve as a barrier between impulse and action. These fears overshadow all else to such an extent that they cannot work on and integrate other psychic contents, even if they bring them as analytic material. The analyst's task therefore is to provide utmost safety in order to create a productive analytic milieu, one in which these basic fears can be explored and understood. To achieve this, I spell out and maintain my basic analytic rule with my patients "You, I and everything here has to be very safe." I am always amazed that the initially most uncontrolled patients later reveal themselves as the most astutely aware of the most minor damages. Feeling with the patient's earliest anxieties about safety and protecting him as well as helping him to protect himself, supports the analytic work. It does not interfere with it.

Role of feelings in ego growth and in the analytic relationship

Developmentally as well as in analysis, feeling with and facilitating the child's ability to feel, has wide ranging effects on all ego functions, especially on the organizing function, i.e. integration and differentiation. It also plays a special role in the patient-analyst relationship and working alliance. Child patients are mostly motivated by the wish to be felt with and helped to master. As child analysts we respond by bearing the ego strain of tapping into our earliest, most primitive feelings in empathy and, like parents, assist our patients to bear, own and use their feelings at the same time. It is the real gift the child analyst gives, generously and unconditionally. Our patients reciprocate, because feeling with provides a deep rich satisfaction and helps us to learn more about analysis and about ourselves.

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Book Notice

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An Account of a Trip to Vilnius, Lithuania

Lilo Plaschkes

In pursuit of my task on behalf of the ACP to familiarize myself with the needs of Eastern European countries in their quest for the development of child analysis, I accepted the invitation to participate in the fifth Eastern European seminar held in Vilnius, Lithuania, March 3 to 6, 1994. The Eastern European Federation Committee consisted of the chairman, Ero Rechardt, M.D., from Finland, Michael Rotmann, M.D., Treasurer, from Germany, Alan Gibeault, M.D., from France, and Han Groen Prakken, M.D., from Holland. The IPA was represented by John Kafka, M.D., from Washington, D.C., and David Sachs, M.D., from Philadelphia. Anne-Marie Sandler and Joseph Sandler,Ph.D. ,M.D., were participants as were about 100 people from different countries--Great Britain, Sweden, Finland, Holland, Switzerland, France, Italy, Germany from Western Europe, and Estonia, Latvia, Slovenia, Ukraine, Yugoslavia, Russia, Lithuania, Rumania from the Eastern European countries. Obviously, in this group there was a great divergence in the various countries represented in their ethnic background and their work as well as their familiarity with and levels of training in psychodynamic and psychotherapeutic work. All of the Eastern European countries and many of the western European countries had in common the Nazi era and the Nazi and Communist persecution. Regimes of totalitarianism, demand for conformity to the group were the atmosphere in which people were raised. Cruel and strict group and individual superego was the pervasive monitor of groups and individuals. Obviously, individuals by nature and by history had other horizons. It is by this tradition and by opposition to the other than the quest for psychoanalysis had been molded and built. The emphasis on and the value of education have also stimulated a great deal of reading. Hence there is a hunger and need stimulated by that which was forbidden and now also is felt to be a road to the West, which is highly idealized and ambivalently sought after. My original assignment was to go and investigate, but it clearly also evoked for me my own past and thoughts about that.

Jean Amery wrote, "No one can become what he cannot find in his own memories," but what were my memories? In fact, as I talked to people from the non-Eastern countries, many said, "Oh, my mother came from here, my grandmother came from here;" in other words, original ethnicities and identities were part of the curiosity. As for myself, I was born in what was then Czechoslovakia and at a young age saw armies of Nazi soldiers with loud voices, singing and accompanied by hundreds of swastika flags invading the streets and causing fear and destruction. From my life in England, yes, I do remember the Blitz, the evacuation, some of the fears and insecurities, but I also remember my mother, father, brother, cousins, uncles, and aunts at the end of each day totaling up as an adventure how many miles we had been walking, I not knowing at the time that we were walking because there was no money for bus fares.

Maybe this is what resonated when I saw the people in Vilnius in the cold, gray, bleak streets with deep snow and with very little food being so warm, friendly, gracious, and enthusiastic. The dancers in their costumes one evening at the sanitarium where the symposium was held were full of life and enthusiasm. The opening of the meeting with chamber music, the decorations of the banquet party with its style, elegance, and artistic taste -- these were people who have retained and drawn out of grave, difficult times a certain essence that is very moving,

I walked the streets of the Old Town of Vilnius, which is composed of very small streets, tiny shops, some art galleries, and the oldest university in Eastern Europe. It has charm, and when filled with people, as it was for a spring festival, there were flowers and crafts and joyfulness that was a very great contrast to the gray, cold aspects of part of the city. The one art gallery that I was struck with was a cooperative of several artists. The characteristics of the art that I saw were both in sculpture, drawings, and paintings, but in particular in the sculpture a synthesis of primitive and medieval religious themes. One young medical student who walked with me on one occasion told me that he had recently seen the play "Ghetto," done on the site of the old Vilnius ghetto, which of course had been exterminated by the Nazis. I had seen this play done by an Israeli and Arab group from Haifa in New York City. How amazing that it had been performed here on this site which it chose to commemorate!

As an analyst and as a child analyst going to Vilnius, which had been part of my exploratory assignment, I was excited when, after a bus ride from my hotel with fourteen other people from Western European countries, we arrived at the site of the meeting, a sanitarium, in the deep snow and ice. We had passed small, black spots in the ice that, we were told, were fisherman ice-fishing. We arrived in a large room that was warm and filled with the lively murmur of people and a breakfast meal. To my amazement, as I walked in, someone came over and said, "Are you the child analyst from the United States?" To my affirmative response, I was asked whether a group of Lithuanians could meet with me in order to discuss child analysis in America and the possibility of training in this field. Who could resist such a welcome? Anne-Marie Sandler was asked the same from a group regarding training in England.

We decided to hold this meeting together and hence Anne-Marie Sandler, Dr. Joseph Sandler, and I met with a group of twelve people, mostly Lithuanians, but also representatives from Latvia and Russia. Also there were representatives from Italy who had had some training from visitors from the Anna Freud Centre in England. It was a lively, enthusiastic discussion and sharing of possibilities and options.

I was then asked to do two study groups on two consecutive days. these consisted of ten people meeting

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together in a small room, from various countries, predominantly Lithuania, but also from Russia, Ukraine, and Latvia in each workshop. One person had been asked to prepare a child therapy case presentation. It was a lively discussion with many contributions from everybody, and it afforded some perception of the work being done, the thinking and enthusiasm that were prevalent, the self-reflection that was available, and also some opportunity for teaching some aspects of child development and some techniques related to the treatment of children as distinct from adults. In particular, the case of a three-and-a-half-year-old boy was presented. We were able to discuss the therapeutic value of play and its technique.

It was my impression that the teaching and knowledge of child development, together with its implications for the treatment of adults, were sorely needed. It was also very striking that analysts are lacking to analyze the people who are in training or doing work with children and adult. Also it is of concern that there is a great deal of reading being done and everybody is eager to learn, but in fact what is sorely needed is the clinical experience to synthesize with the theoretical book knowledge.

It also became evident that the knowledge, experience, and training have been somewhat different in different countries. Some have had more opportunities than others. The IPA is involved in assessing, stimulating, and aiding the training of new groups and the formation of study groups in an attempt to standardize the level of psychoanalytic teaching and training. Some of the executive members were present at this and other symposia in order to do this. There are, of course, conflicting and conflictual aspects in the individual countries amongst themselves and their different groups and between different countries and their groups. There are attempts at status-seeking and rivalry as to who is approved of or not approved of, who is in the "inner circle" and who is not. It reminded me of the history of psychoanalysis itself.

With regard to the synthesis of theoretical and clinical material, an excellent example was presented to the symposia by Anne-Marie and Joseph Sandler. Dr. Sandler outlined the theoretical issues very clearly, and Mrs. Sandler gave some very excellent clinical case material as an illustration; it was a very clear teaching presentation. The paper was titled "Therapeutic and Counter-therapeutic Factors in Psychoanalytic Technique." This to me was an example of the kind of work that is needed.

To return again to more personal reflections about the memories. The first night, looking out the window of my hotel I saw a Russian church similar to those I had seen in picture postcards and paintings. It was surrounded by snow, by gray, bleak buildings, and by people walking in a solitary fashion. Where I had walked earlier, I saw that there was almost no food, and it occurred to me that talking about child analysis was totally incongruous. I have a strong negative feeling about colonialism. Why wouldn't I, having lived part of my childhood in England? Not surprising. I do not feel that we have a missionary goal to accomplish, but we in some ways have been more fortunate with things to share and learn from other parts of the world, These were the thoughts I had following the several days in Lithuania, not like my first night, when I saw child analysis as something totally incongruous to what I was seeing out of my hotel window.

There is one aspect of my thoughts, feelings, and memories that I would like to tell about. In planning the flight for this trip, the stop-overs were Berlin and Warsaw and thence to Vilnius, Lithuania. Those three towns evoked in me a sensation of discomfort that suddenly discolored the feelings of enthusiasm for this venture. It occurred to me, What was I, as a Jew, doing going to Berlin, Warsaw, and Vilnius? As I described earlier, my childhood memories of the Nazi occupation were in pictures and sounds mixed with some anxiety. Now, thinking of Berlin, Warsaw, and Vilnius, it was associated with something horrible: Death, betrayal, destruction. It was really not uppermost in my mind, but clearly haunted me on some level of my being.

Andre Schwartz-Bart, in the book *Texture of Memory* by James E. Young, wrote the following: "For the smoke that rises from the crematoria obeys physical laws like any other; the particles come together and disperse according to the wind which propels them. The only pilgrimage would be to look sadly at a stormy sky now and then." I was really not that aware of the strength of my feeling — that we cannot leave forgotten the atrocities that had taken place in these cities — until I heard in my mind the echo — "Berlin, Warsaw, Vilnius." I would characterize this trip for me as one of multiple perceptions and feelings. Moshe Safdie, the Israeli architect for the Yad Vashem, created a monument to the specific crime of the children's murder. It is described in the book by James E. Young, *Holocaust Memorial and Meaning*, (p. 528), and I quote: "The dancing light of five memorial candles splintered into millions of sparks, like stars reflected in the dark hall by five hundred angled mirrors on the walls and ceilings. It is disorienting, this all-encompassing star-speckled heaven. At first the strange music impairs meditation, makes you feel a little self-conscious . . . our own response of wonder and awe comes back to haunt us as almost unseemly somehow."

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The first requisite of civilization . . . is that of justice.
Sigmund Freud , *Civilization and Its Discontents* (1930), *S.E.,* Vol. 21.

The Vulnerable Child Discussion Group
Washington, DC — The Association for Child Psychoanalysis — March 18, 1994

The Development of Narcissism in Children

Chair, Theodore B. Cohen, M.D.
Presenters: Herman D. Staples, M.D., Isaiah H. Share, M.D., Shirley R. Rashkis, M.D., Bertram A. Ruttenberg, M.D., and M. Hossein Etezady, M.D.
Discussant: Leon Hoffman, M.D.
Reporter: M. Hossein Etezady, M.D.

In his introductory remarks, Dr. Cohen noted that this workshop is now in its 25th year. He also announced the publication of the first of a series of volumes of the Vulnerable Child by the International Universities Press. The first volume contains the first paper from the Philadelphia ACP Study Group; written by Margaret Stewart Temeles, it is titled "A Developmental Line for Narcissism, Path to Self Love and Object Love." The Philadelphia Study Group on Narcissism consists of child analysts from both of Philadelphia's analytic groups; the members of the group have focused on the subject of narcissism in children for the past 12 years.

Dr. Staples gave a brief history of the twelve-year effort by the study group to understand the development of narcissism. He remarked that this is the first time, to his knowledge, that an ACP study group has reported the result of its deliberations to the ACP. Since its origin, the group has met on a monthly basis, ten times a year, for two hours at the home of its Chairman-for-Life, Ted Cohen. Attendance has been relatively constant, members dropping out only when they have moved away or retired.

The original purpose of this group was to study the development of narcissism, with emphasis on infancy, childhood and adolescence. In reviewing the literature, considerable disagreement arose. Issues were debated and ancillary subjects were considered. Efforts were organized around understanding what narcissism is, how it relates to object relations, the difference between the healthy and pathological forms, its vicissitudes, whether it entails a single or double track, etc.

M. Temeles formulated a most cogent line of development for narcissism which she presented at the meetings of the American Psychoanalytic Association in December 1986. Since then, to our knowledge, no other organized description of how narcissism develops has appeared elsewhere. Since Freud's 1914 paper, our view of narcissism has been influenced by expansion of our knowledge in many directions. Stern, for example, questions the validity of stages in development all together. Self-psychology eliminates the term narcissism as in narcissistic character pathology and replaces it with disorders of the self. Paraphrasing a grandmother who said, "I am glad I raised my kids before there was such thing as adolescence," Dr. Staples stated, "we are glad to be able to report on narcissism while there still is such a thing as narcissism."

The next presentation was "A Developmental Approach to Narcissism" by Share, Rashkis and Ruttenberg. The authors elaborated on their view that, since Freud's 1914 paper on Narcissism, significant aspects of narcissism, including the clarity of its definition and our understanding of its function and developmental course, have remained unsettled. In this context, they noted the role of narcissism in normal development is underestimated. Assertiveness, exploration and mastery are examples of adaptive behavior which are contingent upon adequate narcissism. Emphasis here is upon the adaptive potential of narcissism as contrasted with Kohut's view or other perspectives which emphasize pathology.

Narcissism -- currently defined as the libidinal cathexis of the self-representation -- brings to mind qualities of force, direction and object which are generally associated with drive theory. In his 1915 paper, "Instincts and their vicissitudes," Freud began to consider narcissism more in cognitive and affective terms, i.e., the infant's view "of the origin and sources of pleasurable experiences" (D. Smith). This presentation proposes that an approach to narcissism in its cognitive and affective dimensions provides a more comprehensive account than does drive theory alone.

Early infant observations demonstrate the infant's impressive capacity for discrimination, for cross-modal information processing, and for social and affective behavior. Stern's data in particular may demonstrate the beginning of the infant's internalized object-representation and experiencing of the relationship with the primary caregiver(s). Kernberg questions the concept of a self or ego (as self) "predating the psychic experience of the actual relation of the infant with the primary object."

Narcissism and narcissistic, both in analytic and lay terms, connote multiple meanings, often deprecatory. The pejorative use of the term and its association with pathology has contributed to a disinclination to assign it a role in normal or normal neurotic mental functioning. As Ornstein points out, the idea of narcissism as basically normal had clearly been stated from 1914 on by Freud, but its position in the single axis theory of libidinal development -- from autoeroticism to narcissism to object cathexis -- caused it to be regarded as something to be overcome and as pathological. Freud's economic model of narcissism is too general and vague, as pointed out by Pulver, and lacks the explanatory power to describe specific developmental complexities. These difficulties become especially noticeable in establishing a relationship between normal development and pathological manifestations as seen in narcissistic and borderline disorders or psychoses. Also, there is a need for a widely and consensually accepted interpretive framework for such data.

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Self as a construct provides a useful context for considering the meaning of narcissism in relation to affective experience and mental functioning. Emde describes self as an organizing mental process and a regulator of experience. Spiegel considers self as offering a frame of reference for inner experience along with a sense of continuity in time. Facilitated by what he postulates to be an inherent ego ability to compare and compute, the self, in a schematic way, is assembled from the resulting "constancy" of a small group of representations derived from the pooling and averaging of separate states of tension and discharge; it acts as a steadying flywheel to overcome the disturbing discontinuity of intermittent self-representations. Emde refers to the "affective core" as guaranteeing continuity of experience across development in spite of the many ways we change.

Considering self as including the affects and associated experiences which are encoded into relatively stable self-representations, some of the more stable self-representations which are directly related to narcissism may figure in the cognitive-affective mental processing of current and recalled past experiences and could influence or determine the affects associated with these experiences in both conscious and unconscious self-perceptions.

Dare and Holder define narcissism as the "positively colored affective qualities associated with self-experience which subsequently become an integral part of the self-representation that derives from such experiences." Using this conceptualization, the authors infer the mental operation of a computing, registering and comparing process, functioning over time. This could utilize cognitive and affective memory traces deriving from those aspects of the self-representation relevant to narcissism and could introduce a motivational dimension that Freud's reservoir analogy cannot accommodate. The unconscious processing of affective experiences is conceptually similar to procedural learning. There are obvious psychobiological implications. Memory traces of earlier experiences could continue to influence the affective investment in new self-representations and self-perceptions.

Normal narcissism would seem to be largely dependent upon a confluence of factors present at birth. These include genetic endowment, maturation of the central nervous system, and adequacy of emotional sustenance. The baby's affective responses in conjunction with inborn adaptive faculties provide the conditions to evoke attention and affection from others. Early affective investments in caregivers also have significant self-protective and object relations functions related to narcissism. In our current state of knowledge, we can only hypothesize concerning individual differences in evoking and retaining positive feelings about the self and about the relative role of maturational achievements and mastery in sustaining these attitudes.

M. H. Etezady's presentation was titled, "Narcissism: Primary- Secondary, Fundamental or Obsolete." He observed that since Freud first introduced the concept of narcissism, our language and theory have undergone a veritable course of metamorphosis. Consequently, vestiges of older notions can create confusion and controversy. For example, Temeles has questioned the validity of Freud's designation of primary vs. secondary narcissism. She regards narcissism as a unitary entity evolving during the course of development. In her view, a distinction between two varieties of narcissism is therefore not justifiable. Opposing this view, Etezady proposed to describe Freud's designation of primary vs. secondary narcissism in our contemporary language. Far from obsolete, this distinction is fundamental in constructing concepts of internalization and self-regulation.

In today's language, we might say that narcissism is the libidinal cathexis of the subject, i.e. the bodily self and its internal components and states. Initially the newborn experiences himself as the source of all gratification. Gratifying interactions with the care-giver stimulate and gradually integrate the surface sensations. The libidinal cathexis is drawn from the core to the rind and from the body itself towards the care-giver. The mother actively woos this shift from the center to the surface and from the subject towards the object. With the mother as the beacon of orientation, the infant begins to seek the mother with directed intentionality in an expanded realm of subjective experience, sharing in the maternal omnipotence through the illusion of symbiotic unity. With advancing development of the ego and enhancement from incremental doses of tolerable frustration, the illusion of unity with the mother gives way to the process of differentiation. The advent of stranger anxiety is an indication that child is becoming aware of both his separateness and the vulnerability of his infantile omnipotence.

In distinction from primary narcissism, secondary narcissism can be thought of as the libidinal cathexis of the self-representation subsequent to the formation of ego boundaries when self and object representations are adequately differentiated. During the extended period of separation-individuation, this transition from a primary to a secondary mode of narcissism proceeds along a continuum towards self and object constancy.

Secondary narcissism was originally defined by Freud as withdrawal of object libido and its reinvestment into the ego (self). This was to be accomplished through identification and introjection. Hartmann, Jacobson, Mahler, Kernberg and others have elaborated on the process of internalization and structure formation. Representations of interaction with the object world are internalized through libidinal cathexis of part objects and their subsequent introjection. Repeated recycling and integration of these introjects leads to higher degrees of self and object differentiation and to structure formation.

The notion of healthy narcissism implies the capacity to maintain a sense of well-being, confident expectation, and a background of safety. This complex capacity involves

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constitutional, environmental and structural elements. Disruptions in "selfobject functions" -- depending on their severity, duration and the phase of development -- may result in fixation or regression and can lead to the persistence or reactivation of archaic introjects, compensatory megalomanic or hallucinatory and restitutive phenomena characteristic of primary narcissism and primary process.

The distinction between primary vs. secondary narcissism resembles that between primary vs. secondary process thinking. Primary process thinking, similar to primary narcissism, is the primitive mode operating before the establishment of ego boundaries and before the differentiation of inner from outer, self from object, and wish from reality. Secondary process thinking, not unlike secondary narcissism, develops as a byproduct of development through the process of selfobject differentiation, consolidation of ego boundaries, establishment of the reality principle and compromise formations, along with the relinquishment of magical thinking and infantile omnipotence.

Primary and secondary process thinking (similar to primary and secondary narcissism) operate in relative rather than absolute terms. They exist side by side, and may be evoked in the service of the ego adaptively or creatively. They may be operative in normal states -- e.g., dreams, jokes, problem solving, and parapraxes -- as well as in pathological circumstances -- e.g., psychoses, hypochondriasis, drug-induced states, etc.

It is in the context of normality vs. pathology that primary vs. secondary narcissism as theoretical constructs can be particularly useful. The two are distinct in both quality and mode of function. They originate in different stages of development and are characterized by distinct epigenetic and clinical features.

Freud's original definition of narcissism predates the advent of his "dual instinct theory" and, therefore, makes no allowance for the role of aggression in the vicissitudes of narcissism and its self-regulatory attributes.

Self-object differentiation on the one hand, and, on the other hand, the fusion of libido and aggression proceed incrementally through the course of separation-individuation and the critical subphase of rapprochement, in particular. Normally by about the end of the third year, the beginnings of self and object constancy have been established. Under optimal conditions, "maintaining a state of self-experience colored by a positive affective tone" becomes a matter of homeostasis under the executive province of ego functions. This is approximated through relative dominance of pleasurable and libidinally derived experiences initially made possible through modulation of aggression by the caregiver. When, in the absence of libidinal availability of the caregiver, adequate modulation of aggression and resulting libidinization of selfobject experiences fail to take place, the emerging sense of self is painful and intolerable. Primitive defenses cannot be relinquished. The development of the ego, superego and ego-ideal remain arrested. Archaic selfobject states and narcissistic structures, characteristic of primary narcissism, persist.

In his discussion of these presentations, Dr. Hoffman wondered if it is possible to generate abstractions about a concept that is so difficult to specify. He also felt that the theory of narcissism is affected by an inherent conundrum as result of attempts to integrate analytic data with developmental schema. Freud's elaboration of the libido theory and the concept of narcissism was prompted by the need to counteract defections by Adler and Jung. His struggles led to a line of theorizing which began with narcissism and culminated in the structural theory. Freud did acknowledge that Adler made a contribution to the psychology of the ego and Jung to that of ethics. The concept of narcissism offered an alternative to Jung's non-sexual libido and Adler's masculine protest. Freud stated that the development of the ego occurred as a departure from primary narcissism and subsequently the individual attempted to recover that primary narcissism state by a displacement of the libido to an ego ideal. Freud maintained that object love and narcissistic love were diametrically opposed. Decrease in one led to an increase in the other. Kernberg stresses the intimate relationship between the libidinal investment of the self and that of the object. Temeles stresses that positive interactions with objects are essential for the generation of narcissistic supplies. Narcissism is not depleted when there are interactions with the object.

The concept of narcissism involves a sense of oneself as a subject. Temeles asserts that the sense of the infant as subject predates the sense of the infant as a self. Temeles describes a fourth state in the development of narcissism which she calls "awareness of awareness: self-centeredness" that occurs after the consolidation of subject constancy and object constancy, entities that occur sequentially. Dr. Hoffman contended that these two constructs, subject constancy and self-awareness, are inseparable and can only be conceptualized in a linguistic, self-reflective frame. Temeles' notion that considers the pre-linguistic infant as his or her own agent poses philosophical and epistemological problems. The demonstration that the infant is capable of particular cognitive functions indispensable for later development does not allow us to infer essentially linguistic constructs such as intention.

Regarding narcissism in normality vs. pathology, Dr. Hoffman wondered if the members of the Philadelphia group consider narcissism to be equivalent to a global mental health construct. Kernberg points to Freud's idea of the "dialectic relationship in normality and pathology." Freud stressed the ubiquitous fluidity between normality ant pathology in discussing two types of object choice, anaclitic and narcissistic. The idea that normal and pathological narcissism do not have distinct borders seems more consistent with psychoanalytic data.

Regarding the affective-cognitive underpinnings of

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narcissism and its similarity to the procedural learning described by Share, Rashkis and Ruttenberg and proposed by Clyman, Dr. Hoffman noted that Clyman does not adequately address how one can differentiate whether a complex reaction is secondary to an unconscious declarative memory or whether the reaction is secondary to an affective procedure. Regarding the shift from primary to secondary narcissism addressed in Etezady's presentation, Dr. Hoffman suggested that the capacity of a child to attribute meaning to another person's actions, beliefs and feelings, as described by Mays and Cohen, 1994, may be helpful. For Freud, secondary narcissism was a hypothesis attempting to organize actual clinical data. In contrast, the concept of primary narcissism was nebulous and did not seem grounded on clinical data. He hypothesized its existence because of, for example, the omnipotence of thought in children and primitive people.

Dr. Hoffman felt that the role of aggression vis-a-vis narcissism in these presentations was not clear. Freud always lacked an adequate theory of aggression. When he acknowledged the need for an aggressive instinct in psychoanalytic theory, he differentiated his instinct from Adler's by calling it the destructive or death instinct. He eventually stressed the role of defense against aggression in the development of Little Hans' phobia with his reformulation in "Inhibitions, symptoms and anxiety." In "Civilization and its discontents," Freud acknowledged Melanie Klein's influence in understanding the role of the suppressed retaliatory aggression towards a frustrating object in the formation of the superego. Kernberg states that a general integration of the developmental schemata of libido and aggression has not yet been done adequately. An adequate theoretical understanding of the vicissitudes of aggression would greatly further our understanding of narcissism.

Dr. Hoffman cautioned against the danger of attempting to completely synthesize developmental observations with a theory derived from treatment of children and adults. Attempts to draw sharp boundaries between normality and pathology or one stage and another oversimplify the complexities of life.

Dr. Cohen recalled that when Freud was writing his first paper on narcissism, he was struggling to help his disciples, some of whom were having sex with their patients. An example was Jung and his psychotic patient, Spielrein. Jung helped her to become a training analyst (who later treated Jean Piaget). Ferenczi was having sex with one patient and also became sexually involved with the patient's daughter. Freud was helping Jung and Ferenczi with these and other narcissistic issues he confronted with his own patients in their treatment.

Dr. Etezady offered a clarification in response to Dr. Hoffman's discussion to the effect that he considers the infant's earliest internal states and awareness of its experiences as a subjective world which evolves and expands through the various stages of development.

In his response, Dr. Share praised Dr. Hoffman's discussion and agreed that the position taken by the paper does equate narcissism with a global view of mental health, although this position was reached completely unexpectedly. Although we had been concerned that the existing theory did not sufficiently explain all the data available to us, we had not anticipated these conclusions. Freud starts off imaginatively and brilliantly, clinically and theoretically, but might have been unduly influenced by his struggles with Adler and Jung. He himself wasn't satisfied that his theory covered all areas and he was struggling with concepts much as we have been.

Dr. Rashkis observed that in the literature on narcissism, one finds many papers confined to Freud's original formulation while others require additional parameters. Beres has cautioned against reification of self and making abstractions entities. Freud recognized that his theory was far from a final synthesis and that manifestations of narcissism varied tremendously in various forms of pathology, at different developmental stages, and in the same individual at different times. The pertinent issues are as important and fascinating today as the day Freud first came upon them. We need to be adventurous enough to continue to explore these concepts. We can't confine the total realm of the psyche to the notion of the self and the maintenance of its positive affective tone, but on the other hand, if we remain static in our views, we won't be doing justice to Freud's admonitions. Observations of early childhood combined with the knowledge we have gained from our clinical experience can only move us in the right direction.

Dr. Brody objected to the statement by Dr. Etezady that stranger anxiety was an indication of differentiation. She elaborated on the formation of awareness of self as a separate entity at the same time when there is recognition of mother in the first six months. Stranger anxiety occurs in the eighth and ninth months. A great deal happens in the second 6 months and the development during this period is far from seamless. If the infant has not attained a clear picture of the mother and an emerging sense of self by this time, severe confusion, chaos and disturbance can be expected.

Dr. Don Silver referred to his work in a project in Michigan involving 80 infants and their disturbed teenage mothers. In their first, second and third months, these infants would respond aversively to their mothers' attempts to hold them, but not if someone else was holding them. This would suggest that the infant is aware of the mother and the difficulty with mother's mode of caregiving. These babies were strongly attached to their mothers and slept with their mothers.

Dr. Ruttenberg, reflecting on the history of the group, recalled that at the beginning the group polarized into two views. One considered narcissism as a function of libidinal cathexis. The other thought of it as an ego function. These two views were melded together as expressed in Margaret Temeles' paper with an economic view in which the object

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did not deplete self of energy, but enriched the self with narcissistic supplies that could be stored for subsequent stability and resiliency. The capacity to elicit libidinous responses from the mother is inborn.

Narcissistic supplies fuel ego functions and motivation and provide for affective attunement which is the vehicle for affective exchange in development of object relations. Pathological narcissism is based on depletion, insufficiency or inappropriate use of these supplies.

Dr. Cohen commented on the significance of the notion of depletion of narcissistic supplies. When Spielrein was sent to Freud, he spoke against Jung's sexual exploitation. Jung believed in free marriage and unlimited sex outside of marriage. In response to Freud's disagreement, he resigned as the president of the International Psychoanalytic Association and became psychotic. Eventually he became a consultant to Hitler. Spielrein was later killed in Rostov in 1941 by the S.S. Our group has been involved with the notion of narcissistic depletion in failure-to- thrive infants. Dr. Beres reported to us regarding such depletion in babies from New York orphanages.

Dr. Hoffman reiterated his concern about attempts at describing preverbal material. For example, the terms self, subject and agent are used variably as distinct, similar or interchangeable. Even though the capacity for some discrimination is present in infancy, it cannot be equated with the cognitive capabilities which are available in the verbal period.

In his concluding comments, Dr. Etezady stated that narcissism ranks amongst Freud's most significant concepts. It arrived at a time when Freud was moving from his earlier theories on to his dual theory of the instincts, to aggression, to his final theory of anxiety, and to his contributions on ego psychology, internalization, structure formation and self-regulation. It extended into all the major areas of psychoanalytic thought and came into further prominence later, e.g. object relations, separation-individuation, attachment, self-psychology, etc.

Expressing this continuity in a theoretical discourse may sound deceptively seamless, but the actual experience in the course of development and within the clinical situation are far from seamless. Our abstractions and simplifications have their merits and can facilitate understanding and communication, but they also have their limitations and may at times result in confusion or polarization. Attempts at integrating multiple models are valuable and necessary, but we need to be cognizant of their shortcomings as well. We should not leave the impression that stages of development are sharply delineated or that pathology and normality are always distinct. In medicine we can recognize instances of severe pathology easily, but the notion of normality and its boundaries are much more elusive and less well-defined.

Dr. Ruttenberg concluded that one of the contributions of this group concerns the role of narcissistic supplies in fueling ego functions and motivational capacities towards mastery, achievement and competence.

Dr. Rashkis made it clear that the group may have not adequately addressed the role of aggression in these presentations. On considering narcissism, one immediately confronts the challenge of integrating the role of aggression. Another issue is the question of how narcissistic vulnerability directly affects the work of analysts with their patients. This has always been a central concern for analysts though general interest and attention are relatively recent.

Dr. Staples reflected on the group's earlier attempts to track a line of development for narcissism. Frequently, it was difficult to distinguish what was narcissistic rather than related to the realm of object relations. A line of development for object relations was formulated so well, for example by Mahler and others. We could not, however, find such formulation in the literature describing a line of development for narcissism.

Referring to Dr. Hoffman's suggestion that narcissism was Freud's alternative theory to Jung's non-sexual energy, Dr. Share wondered why such an alternative was needed. He hazarded a guess that Freud needed to describe and elucidate material we confront in adults and children that relate to the preverbal and pre-oedipal periods. Too sharp a distinction may lead us to overlook valuable clinical clues that have been ignored in our daily work until now. ⌘

A strong egoism is a protection against disease, but in the last resort we must begin to love in order that we may not fall ill, and must fall ill if, in consequence of frustration, we cannot love.

Sigmund Freud, *On Narcissism* (1914), *S.E.*, Vol. 14.

Workshop on Applied Child Analysis
Washington, D.C. — The Association for Child Psychoanalysis — March 18, 1994

The Child Analyst, the Child, and the Law — Involvement in Forensic Work

Chairs & Presenters: Robert Galatzer-Levy, M.D. (Chicago, IL) and Moisy Shopper, M.D. (St. Louis, MO)
Reporter: Randi Finger, Ph.D. (Washington, DC)

Drs. Shopper and Galatzer-Levy opened our session with accounts of their entry into the field of forensic consultation. Dr. Shopper noted his long-standing interest in the law, membership in the ACLU, and participation in enactment of civil rights legislation. Over the years, his forensic consultations as a psychoanalyst have comprised cases that ranged from murder, to rape, to child abuse. (The latter included his serving as an expert witness in the Edenton "Little Rascals" child abuse case (North Carolina), which was the basis for a television movie, Innocence Lost.)

Dr. Galatzer-Levy "fell into" forensic work as a Candidate via a bitter custody battle involving a child he had in treatment. Starting as a trauma (for himself as well as for the child) his experience of the judge's open-mindedness, receptivity to and appreciation of his input led to a turn around in his own attitude. Since that time, he has maintained an active hand in forensic work, sought by the courts for his ability to portray and articulate the internal subjective world of the child at different developmental stages. Dr. Galatzer-Levy made an impressive case for the mutual benefit of such involvement, citing first, that court participants and even other mental health professionals do not have the child psychoanalyst's highly trained expertise in the world of the child and second, that attorneys and judges, as very bright people with a different way of looking at the world, ask us questions that expand our own thinking and application of psychoanalytic principles. He added that it can also be a useful experience in humility for us to learn that questions of critical importance to legal decisions may not be those we even think to pose as psychoanalysts.

At this point, the remaining thirteen participants briefly introduced ourselves and described our experience and interest in forensic applications. Participants included a mix of practicing psychoanalysts, candidates, allied mental health professionals, as well as an ER physician and a divorce attorney (with a specialty in Mediation) who were attending the conference with their psychoanalyst spouses. The stated interests of the group (custody, abuse, murder cases; impact of court involvement on the provision of treatment; maintenance of one's focus on the best interests of the child; dealing with parental agendas that seek to exploit the psychoanalytic situation; providing "expert" opinions that differ from those of other highly trained experts; adversarial experts versus court-appointed status; and our frequent reluctance to get involved in forensic situations) also represented a wide range, beyond the scope of a single workshop, and, thus, offered an abundance of possible topics for future sessions.

With regard to conflict of interest as the treatment provider, Dr. Shopper has found that this can be prevented by giving a clear message to parents pressing for his court involvement that he would not be a cooperative witness, nor likely to help their case, as well as that such a role is detrimental to treatment. With this, he has had no problem in re-directing parents to a separate professional who can provide forensic consultation while he maintains his role as the treating psychoanalyst or psychotherapist. On the other hand, he has not had much success in securing a neutral position with the court and usually finds himself serving as "hired gun" for one side or the other. He admires those, as Dr. Galatzer-Levy had described himself, able to delimit their role to court appointment with cooperation assured in writing by both sides. Dr. Shopper wondered whether variations in the level of sophistication of the courts may impact on the feasibility of such an optimal arrangement.

Dr. Shopper agreed with Dr. Galatzer-Levy's point that a courtroom perspective can provide interesting and different questions than those which we, as analysts, are likely to pose, but was more guarded as to the harmoniousness of this collaborative union. Not only may we find our theoretical offerings measured stringently against standards of legal utility, but even viewed as antithetical. In fact, Dr. Shopper warns, entrance onto forensic turf may see one taking his or her professional life in their hands — a ready antidote to "counter some of [our] patient's idealizing transferences." Here, clarity and practicality become important factors contributing to whether or not we are valued or ignored. Dr. Shopper observed that training in child psychoanalysis tends to enhance our efforts — not only because it provides the developmental framework we have to offer but because it teaches us to convey what we understand at the down-to-earth levels necessary for child work. Dr. Galatzer-Levy added that child training, itself, tends to raise our level of education and expertise considerably beyond that of most expert witnesses.

For all of our training, however, we may well become trapped within our own visual transformations of what we are told in contrast to direct observation of an actual situation. Dr. Galatzer-Levy recalled an eye-opening experience of evaluating the varying child case situations of each parent in a custody dispute. He had been impressed by the father's report of his having a home office that allowed for his ready availability to his child as well as the presence of a live-in nanny. A fortuitous comment by a mutual social acquaintance, however, shifted Dr. Galatzer-Levy's perception considerably when he learned that the actual physical set-up was a studio apartment; the nanny, the father's live-in girlfriend; and the couple's erotic relationship, very much in the constant view of the child.

Dr. Bob Nover (Bethesda, MD) invited the group to return to the subject of maintaining separate our roles in custodial evaluation from those as treatment provider. Dr.

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Morris Stampler (Newton Centre, MA) described an awkward situation in which one of his treatment patients accidentally gained access to Dr. Stampler's report (re: an unrelated case) which made direct recommendations to the court but bolted from treatment without any opportunity to explore the meaning to the patient of having seen his therapist in a non-neutral role. Dr. Galatzer-Levy reported success in having his firm position as one who is concerned with the best interests of the child and fair preserve his reputation in the community as neutral and trustworthy. Dr. Irwin Rosen (Topeka, KS) emphasized making our self-presentation as a "diagnostician of the situation" in contradistinction to our role as a treating clinician. In the former situation, we offer all that we know whereas, in the latter, what we know may not be relevant or appropriate to the court's questions.

Confidentiality takes on a new — and very different — complexion when our role is specifically to provide information. Dr. Rosen noted the importance of knowing the laws of the jurisdiction within which one practices. (Further complications of multiple jurisdictions such as in our locale, the D.C.-Virginia-Maryland metropolitan area, and continuous changes in law and custom are noted by this reporter although these were not discussed at this workshop.) Dr. Shopper introduces his role as a forensic expert by making clear and explicit up front that clients will not have the usual doctor-patient relationship, that confidentiality will not apply to their disclosures, and that they are encouraged to refuse (without prejudice) to answer anything they do not wish to reveal. With this in mind, he does not access any previous therapy records whose information would not then be voluntarily obtained, particularly because of the likelihood of court pressure to make these available. (Dr. Carol Austad, (Ann Arbor, MI) drew parallels to the pressures for information release to insurance companies, noting that patients, or parents of patients, frequently add their own pressure in order to ensure reimbursement.) Dr. Galatzer-Levy reminded us of the importance of clarifying the laws governing disclosure rather than assuming and bending to requests, particularly when aggressively made.

Discussion then focused on what of our clinical notes are subject to disclosure and how best to limit exposure of confidential material. Dr. Marion Gedney (New York, NY) proposed limiting notes simply to dates seen and whether or not payment had been completed. Dr. Rosen wondered whether "as clinicians, dare we take notes?; while as potential litigants, dare we not?" Here, our divorce attorney member, Mrs. Diana Gittelman (New York, NY), was a welcome presence. She informed us that most everything is subject to subpoena and that "the best interests of the child" will almost always override confidentiality. She recommended talking with the attorney, and making clear that the information they are pressing for would not be in the best interests of their client; almost certain to result in an end to any further press. Dr. Galatzer-Levy agreed, citing his own experience of saying explicitly that, if they persevere, he will testify to a parent's willingness to force this, despite being told of its hurtfulness to their child.

Dr. Bob Prall (Austin, TX) raised the issue of requests for information about our treatment patients that come many years after treatment, often sought by our former patient — as in the case of obtaining security clearances. He has handled this by providing a report to the patient which can be used now or in the future as they wish. Dr. Nover wondered about such involvement which offers opinions about our patients — especially, but not only, those in ongoing treatment. As analysts, this action moves us away from our position of neutrality. Alternatively, he has offered to write to the agency requesting the information, providing an explanation of what psychoanalysis is and how it works, specifically why (and how) such information might be better obtained elsewhere. This allows us to remain neutral but also cooperative with such agencies, drawing on our mutual respect for privacy/secrecy.

At this point, our group opted to shift focus to case material and each of our Chairman presented detailed vignettes in which their psychoanalytic expertise was brought to bear in legal matters. Dr. Shopper presented the case of a child who was 4½ at the time of referral. The family sought damages against a pediatric surgeon who had performed neonatal surgery to remove and restructure a congenitally malfunctioning section of the infant's bowel due to Hirschsprung's disease. The surgeon's incorrect reversal of the ends of the repair resulted in complete obstruction; the error masked and compounded by the procedures and additional diagnoses applied to deal with subsequent symptoms. At 18 months, the mistake was finally but secretly diagnosed (i.e., without the original mistake being made known to the family) and a second surgery successfully completed. The truth of the error was finally revealed when the insurance company refused payment (because the surgeon would not make available the records explaining the necessity for a repeated procedure) and the surgeon continued pursuit of payment by the parents via a collection agency (differential diagnosis masochism vs. narcissism? or see "chutzpah").

The case centered on whether the child's problems with articulation (at best 50% unintelligible at age 4½) and developing masochistic character problems could be demonstrated to stem from these early traumas. The opposing side sought to capitalize on the paucity of specific literature, the erroneous though widespread belief that incomplete myelinization renders the neonate insensitive to pain, and a psychological test evaluation finding the child to be OK and without evidence of trauma. Difficulties were hypothesized by opposing counsel to result instead from traumatic life experiences (around feeding and toilet training) within the family. Dr. Shopper's ability to relate the child's symptoms to developmental interferences stemming from the first surgery's aftermath (e.g., naso-gastric tubes and feeding disturbances preventing pleasurable oral cathexis leading to the articulation problems) resulted in the

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judge's decision and very large settlement in favor of the family.

Dr. Nover suggested the importance of our knowledge of the literature of psychological effects of physical trauma (disorganizing effects of pain; impact of burn trauma) and, as a corollary, our openness to relevant literature from colleagues in non-psychoanalytic fields.

The proving of fault is complicated. Dr. Galatzer-Levy cited a case where a priest and teacher were known to have systematically abused 6-year-old children who, nonetheless, at age 12 were "not complete messes," raising the question of how one demonstrates damage. Dr. Rosen pointed out that the concept of damage may be becoming less important than in the past; that one's strength in withstanding hurt doesn't negate wrong done. Dr. Nover again returned us to our analytic wisdom, where our theory of multiple function which emphasizes the complexity of experience cautions us to remember that, without an analysis, we can't say for sure what the impact or relative impact of an event may have been.

Dr. Austad was impressed with the good fortune of the outcome of Dr. Shopper's case, noting that judges are often less likely than juries to render such a decision as well as the ready access by opposing counsel to alternative experts and statistics whose weight might swing the impression in an opposite way. Dr. Stampler added that courtroom decisions are more about adversarial presentations than about truth. To this end, we must learn how to render effective expert testimony that is unambiguous, something antithetical to our usual notion of complexity and uncertain outcome. Dr. Galatzer-Levy again cautioned the importance of our humility here. As opposed to our importance, even control, in our offices, we are only minor players in the courtroom, i. e., one of many voices to be heard.

Dr. Galatzer-Levy then offered some case material of a less dramatic but more typical nature, presenting a child custody case in which he was called as an expert by the mother's attorney but accepted by both sides. The mother presented her view that her husband, who had been living with his mother up until age 40 when they married, was not fit to be a custodial parent for their 4½-year-old child. She described her husband as a compulsive shopper and cluttering collector of fishing equipment and guns. Promising, but never making good of it, to clean things up, he responded to her doing so while he was away by putting his fist through the wall, refusing to speak to her, and filing for divorce. She felt that her husband should be allowed regular visitation but not custody. Dr. Galatzer-Levy was struck by her depressive style, tendency toward generality, and absence of knowledge of the specifics of her child's life but already very definite plans as to the best child care subsequent to the divorce. The father in the case, in fact, was challenging his wife's fitness because of her intense depression manifested by her staying in bad, having constant headaches, exhibiting little energy to care for their child, and verbalizing her wish to be dead. His account of his own habits presented them as more normal, citing absence of any financial problems resulting from his "compulsive" shopping.

At this point, Dr. Galatzer-Levy turned to the group to ask how others would proceed with the case. Several members asked the same question: How had the suit been initiated? Dr. Galatzer-Levy informed us that it had been the father who first challenged his wife's competence to care for their child and, only then, did she counter-sue. He added, however, that she, too, had "defensible" explanations for her husband's challenges (medical problems and an unhappy marriage). Group members wondered what observations had been made of the child with each parent. Mrs. Gittelman informed us that the reality is that much of such decisions would rest, not with the substance of the case, but with the luck of the draw of judge. Dr. Galatzer-Levy supported this, citing a course held by his Institute for domestic relations court judges in which one judge had said flatly, "I'm Italian. The mamma gets the kid." In the particular case under discussion, however, his own influence and the judge's preference to avoid such choices rendered his, Dr. Galatzer-Levy's, opinion the deciding factor.

Dr. Nover urged that parents (where character pathology does not prevent) be helped to recognize that a joint decision by them should be far preferable to that from a stranger without an interest, i.e., a judge's, and that their sensitivity to each other's point of view offers hope of the least amount of damage to the child. Dr. Galatzer-Levy has told parents outright that "this litigation will hurt your child" and that a judge's decision is likely to be made with little or no knowledge of matrimonial law or child needs. His experience, however, has been that these words of counsel have no impact on parents caught up in the heat of custody disputes. Wisdom and equality not always at one, Dr. Shopper winced at the frequency of court and parental comfort with decisions for joint custody which see very young children subject to one week with one parent and the next with the other.

At this point, our session was ending and Dr. Galatzer-Levy observed that none of the data presented thus far was actually relevant to his recommendation which was, instead, based on the child's subjective experience of greatest structure, security and safety as still more dependent on his mother's than his father's presence, making her the best candidate for current custodian.

Our group was unanimous and enthusiastic in its wish to continue this workshop at future conferences. The fortuitous inclusion of an attorney, particularly with a specialty in divorce, was believed to have added considerably and thought to be well included in the actual planning of future workshops. Participants also felt that pre-circulated cases would enhance our focus and depth of exploration.

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Forensic Work . . .

Notice — Call for Papers

Psychoanalytic Institute, New York University Medical Center, are editing a case book of
psychoanalytic patients with learning disabilities
(adults, children, and adolescents).
If you have such a case and would be interested in contributing to the volume, please contact
Dr. Glenn at (516) 482-6302 or
Dr. Rothstein at (212) 496-0808.

Book Notice

Caring for Infants and Toddlers in Violent Environments: Hurt, Healing, and Hope

Zero to Three /
National Center for Clinical Infant Programs

This volume, written and distributed with support from the Ford Foundation, will help readers to understand the meaning of violence for the very young child. It was written for parents, child care providers, teachers, police officers, health care professionals, and others who work with families in violent environments. The publication presents research findings and case reports illustrating what is known about the impact of early experiences of violence on development. It suggests ways for adults to cope successfully with their own experiences of violence, so they in turn can help very young children to master potentially devastating traumata.

For a copy send $4.95 plus $2.50 for postage and handling to **Zero to Three**
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Request for clinical vignettes showing success in consultative interventions (for use by the Children's Defense Fund)

Ava Bry Penman and Carla Elliott Neely

As you probably know, the Children's Defense Fund (CDF) in Washington, DC is one of the nation's strongest voices for children and families. CDF suggests and influences legislation in Congress and seeds and feeds community-action projects across the country. CDF works with numerous other organizations helping them get together to help children.

Mary Lee Allen of CDF has told us that it would be useful to have stories from clinicians demonstrating the interventions which have been successful in addressing the troubles of children.

Ms. Allen requested that the stories of "good news" include the following:

1 What was the problem? (the point of pain in the child, relationship, or "system")
2 What worked? (the specific intervention)
3 Why did it work? (explanation of thinking regarding dynamics, development)
4 How do you know it worked? (follow-up, changes)

From these stories, the analytically-informed ways of thinking about children and addressing their needs and the needs of those caring for them should become clearer. It may be that those creating and influencing programs and policies on a national level might turn to us to help think through problems to find new paths to follow. Through descriptive vignettes, CDF can understand how we think and act with children and the people who take care of them. Please, in one page, describe a successful consultative experience with a child and/or adult in a day-care center, nursery school, regular or residential school, judiciary system, teen-age mother program, pediatric hospital setting, etc.

Stories can go a long way, at times, to make an impression. As it is often said: A picture is worth a thousand words; our contributions are the pictures, even if they are in words.

Please send your stories to: Ava Bry Penman, 121 Summit Avenue, Brookline, MA 02146

Workshop on a Basic Clinical and Theoretical Issue
Washington, DC — The Association for Child Psychoanalysis — March 18, 1994

Forbidden Topics: Child Analysis and a Biology of Behavior

Authors: Samuel Wagonfeld, MD, Carla Elliott, PhD, and Jill Miller, PhD.
Discussant: Martin A. Silverman, MD
Reporter: Joseph R. Silvio, MD

Dr. Wagonfeld introduced the panel topic by relating anecdotes from two cases that focused his attention on the crucial importance of analysts taking into consideration the recent data from neurobiological disciplines to understand the symptomatology of their patients. The first case involved a young woman who sought consultation when her depressive symptoms got worse in analysis with a colleague who appeared to have missed the central issues in her psychodynamics. The patient found the new interpretations extremely helpful and began analysis with the consultant. Despite 3 years of analysis that focused more correctly on her core conflicts, her symptoms still did not improve. At this point, she sought a psychopharmacology consultation and was started on an antidepressant. She got better within a month. She felt the analysis had helped her with many issues, but it failed with regard to the depression.

The second case was of 7-year-old boy hospitalized with profound disturbances, who did much better in school and home with analysis. Despite good analytic treatment, he continued to bounce off walls and alienate people through his behavior. The analyst became convinced the child had ADHD and recommended medication, which the parents refused for over a year, acquiescing only after the child exhibited unmentionable behavior. Once the boy started on Ritalin, he improved dramatically within a month.

Dr. Elliot added that she became interested in this subject when she noticed that the parents of her children's friends were talking more about medication than psychotherapy and so began looking into the literature and collaborating with Dr. Wagonfeld.

Paper presentation: Based on clinical experience, the authors feel that new findings in neurophysiology and biology must be integrated into psychoanalytic thinking and raise significant therapeutic, ethical and technical questions that need to be thoughtfully addressed. They discuss the advances in several areas important to child psychoanalysis.

Learning disabilities (LD) manifest themselves early in life, and, if missed by parents, are usually picked up by teachers. They can be categorized as psychogenic, neuropsychological, a mixture of the two, or limitations of intellect. The bias in the psychoanalytic literature on the etiology of LD is towards psychological conflict as opposed to neuropsychological factors, which has crucial implications for decisions about technique. The authors quote Nagera on the effect of somatic deficits on ego development in children with minimal brain damage (old nomenclature for LD or ADHD), and how failing to take into account organic factors and indiscriminately applying formulations derived from normal or neurotic adults can lead to serious misconceptions about the true nature of children's basic disturbances. The authors raise questions about how well analysts avoid focusing exclusively on intrapsychic conflict and psychosocial stress versus deficiencies in neurophysiological elements in understanding the disturbances in a child's behavior, how well we employ appropriate adjunct services based on a more integrated understanding, and what effect utilizing such additional therapeutic interventions has on the analytic work itself. A clinical illustration was given of a 12-year-old boy in analysis for obsessive compulsive rituals who made steady progress but continued to have academic difficulties despite superior intelligence. When the analyst recognized that the school problem stemmed from the patient's poor graphic skills and made a school intervention that allowed the boy to do his classroom work with a computer, school performance and relationships with teachers and peers improved dramatically and the more traditional analytic work was enhanced.

Attention Deficit Hyperactivity Disorder (ADHD) spectrum disturbances have a profile of incidence and response to medication strongly supportive of constitutional etiology. ADHD occurs in males three times more than in females, has a high incidence in male relatives, is often accompanied by soft neurological abnormalities on psychological testing or neurological exam, and can show dramatic response in a matter of hours to specific medications. This syndrome is characterized by "short attention span, inhibitory dysfunction, motoric and cognitive impulsivity, motoric restlessness, and poor peer relations." Studies show that medication alone results in poor long term outcome, despite the impressive symptom changes, because of the persistence of low self esteem and poor social skills. These sequelae are better addressed with psychotherapy, which enhances the possibility of a favorable end result.

Given the high incidence in the population, reported up to 14.3% in certain studies, the authors ask if the diagnosis is often missed in evaluations and recommendations for analysis; if a bias against medication results in children with mixed problems being denied appropriate medication for ADHD or other subtle organicities; if such appropriate interventions are being successfully utilized, why are they not being described and discussed in the literature or in training programs; and is the appropriate prescription of medication understood as a positive aspect of analysis.. The model of work with children with diabetes or other chronic organic illnesses was offered as a more appropriate one to reflect the reciprocal effects of the disease, psychic conflict, and psychological development.

Affective disorders are being investigated for neurochemical and neuroanatomical etiologies, and the current findings question traditional analytic views. The

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authors limited their focus to current research on memory for its impact on analytic theory. These is good evidence that the first major affective episode is associated with clear major psychosocial precipitants, but that subsequent recurrences become autonomous of such events. There is also evidence that the encoding of the memory of stressors makes an individual more reactive to later stressors, and that the phenomenon of kindling predisposes to further spontaneous episodes of depression. These findings strongly suggest that initial events can lead to neuroanatomical or neurophysiological changes that become independent of the original event. Such possibilities would have significant implications for analytic technique, since verbal interpretations addressing the initial events might have little effect on the later elaborated depressive mechanisms, but medication or behavior modification might. On the other hand, these finds would highlight the need for early diagnosis and treatment of depression in children, since intervention in the beginning of the disorder could prevent such later developments and alter the course of the illness.

Research on the Anxiety Disorders is revealing a complex interaction between intrapsychic conflict and neurophysiologic factors in their etiology and pathogenesis. The authors cite Gabbard, who looked at disorders that highlighted the interaction between mind and brain and concluded that "psychological influences result in permanent alterations of a neurobiological nature. Similarly, psychological interventions in a treatment context may have a profound impact on neurophysiology." Research in panic disorder suggests evidence for a neurobiological vulnerability which can be triggered by a stressor endowed with unconscious meaning and intrapsychic conflict. Panic disorder has been found to be responsive to psychodynamic treatment, as well as to medication. Similarly, generalized anxiety disorder may share a similar interaction between neurophysiological vulnerability and unconscious conflict and a responsiveness to different treatment modalities. The decision about which modalities to use, either alone or in combination, should be made on an individual basis, and in children consideration must be given to the child's capacity to use and tolerate analytic work, the effects of medication on physical development, and the effect of crippling anxiety on ego restriction and ongoing psychological development. With regard to Obsessive Compulsive Disorder, studies show that analysis is not an effective treatment, but medication is. Psychodynamic treatment can be very helpful with psychological difficulties that lead to resistance to medication and poor compliance.

Other neuropsychiatric disorders, such as autism, aphasia, and Tourette's Syndrome also provide important areas for the study of how derailment of normal developmental processes can profoundly affect the way afflicted individuals feel and behave. Donald Cohen and colleagues, in studying such disorders, are finding psychoanalytic insights into the complex interaction of constitution and experiential factors that affect the development of the sense of self. In particular, the use of medication which can significantly reduce symptoms can also adversely affect the child's sense of agency if the child no longer experiences himself as the one who determines what he desires and feels. The authors also refer to Willick's review of the psychoanalytic formulations about schizophrenia and his conclusion that evidence strongly suggests that abnormalities in the frontal lobes cause the negative symptoms of schizophrenia, not early deprivation, conflict, or vicissitudes of the aggressive drive. Such findings suggest a need to rethink analytic theories on the etiology of schizophrenia, in the same way that analytic understanding of female sexual development was reassessed in the light of new data from the studies of human sexuality and child development. And such an approach should be applied to reexamining and generating a more accurate theory of homosexual development, where currently acrimonious debate often surrounds the controversy over biological versus psychodynamic contributions.

The authors conclude by stating that "psychoanalysis has an important role to play in the lives of children who need help to maintain a sense of self in the face of their own frightening behavior which may feel quite foreign to them. For psychoanalysis to assume, however, that exploration and understanding of unconscious conflict can alone solve the problems of many neuropsychiatric disorders is a great mistake. Psychoanalytic treatment can make an essential contribution toward the well being of such affected children when it seeks to make meaningful the behaviors and affects deriving from these disturbances in the context of each child's overall humanity." To illustrate the authors' approach towards integration of neurophysiological factors into psychoanalytic understanding and technique, the detailed case history of Julia was presented.

Julia began analysis at age five and a half when she became acutely anxious and unable to separate following a series of surgical procedures for failing ventriculoperitoneal shunts, which had been necessary since shortly after birth because of hydrocephalus secondary to a bilateral intraventricular hemorrhage. Despite this early and severe physical trauma, excellent parental and medical care helped her to proceed along relatively normal developmental lines until 5 shunt failures in fourteen months overwhelmed her previously adaptive coping mechanisms. At the time of her initial assessment 3 days after the last surgery, Julia was "in a state of panic, couldn't be left alone and was inconsolable at times. She had become clingy and fearful, would only sleep in parents' bed, had nightmares, would walk in the wrong direction and had difficulty finding things at home and school. The assessment revealed how confused and disoriented Julia was internally. She felt lost, couldn't make sense of things, and was frightened she was crazy and damaged. In addition, she was terrified of abandonment and anger." Her development was also lagging and in jeopardy.

At the beginning of four times a week analysis, the

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analyst first dealt with reality problems, consulting with the school to have Julia placed back in preschool because she was not up to handling kindergarten with her state of confusion, which could not be clearly attributable to internal disorientation or neurological damage. The analyst then focused on helping Julia identify her constant anxiety and the defenses against it, such as her playing lovely games so as to not think about scary feelings about dying or being operated on without being told. She helped Julia to work through the trauma of a frightening MRI which she had feared would be an operation by identifying and verbalizing her many painful feelings and worries. The analyst also interpreted Julia's anger at mother, which was defended against by projection, and her magical thinking that her fantasies would become reality, which led to her trying not to think. The analyst explained how attempting not to think caused confusion, forgetting and nightmares, and thinking and talking together about these matters would help her feel better.

Julia's analysis became further complicated when, seven months into the work, she developed epilepsy with absence seizures only partially responsive to anticonvulsant medication and seemingly triggered by her anger. When defenses against the anger were interpreted and Julia was brought back to it, she would have a barrage of absence seizures. The analyst interpreted from the play Julia's fear her anger at mother would cause mother harm or cause her to lose mother in her mind. She emphasized Julia's need to let herself feel her anger and talk about it, and provided reassurance and comfort, along with hope and encouragement. As the anger was brought into focus, Julia developed a more elaborated sadomasochistic system based on the erotization of the physical trauma she endured with her numerous surgical and medical treatments. In the midst of this work, the analysis was faced with another interruption. Because of the poorly controlled epilepsy, Julia's parents opted to try a new and unconventional treatment, EEG Neurofeedback, for which she needed to travel to another state every other week. The analyst chose to direct the work at helping Julia contain her rage so she could participate in the treatments. The unconscious sadomasochistic fantasies then sought expression in enactments of self injurious behaviors at home, such as cutting her hair with garden shears and trying to shave with father's razor. The establishment of firm limits and restrictions for her protection at home and interpretations by the analyst that Julia was trying to cut herself as others had done to her brought a cessation of the enactments and successful cooperation with the new treatments. Following their completion, the analyst helped Julia verbalize and work through the state of internal disorganization caused by the overwhelming internal and external experiences with which Julia had been forced to contend. When she then reorganized and reconnected with the analyst, her seizures abruptly stopped, due to the combined action of the interpretations and the EEG neurofeedback treatments. Julia then began to sort through with her analyst her fears that her brain was damaged when she felt lost and confused. This involved identifying when her confusion was due to her brain and when it was employed as a defense against intolerable affect and helping her to honestly assess what she was good at to offset the dominating feelings of being damaged. With this work on helping her to understand how her mind worked and how to better use it for mastery and development, Julia began to take pride in how she could think, to retain events in her mind, and to remember things from the past. "Her increased abilities in this regard were due to the ongoing analytic work on both her defense against thinking and remembering and the ways in which her anxiety interfered, and by engaging her thinking and the use of ideas, as well as the contribution of the EEG Neurofeedback treatments. It was the focus on these areas which made the analytic work move forward as her self-representation and self-esteem strengthened."

In his discussion, Dr. Silverman focused on three cases to illustrate his central concern, that neurobiological factors can be easily missed unless they are actively looked for because symptoms can be so often readily explained by convincing psychodynamic formulations. The first case was of a 13-year-old boy with increasing episodes of objectionable behavior, which was attributed to adolescence and family stress and therefore treated with psychotherapy. When the symptoms did not improve, a recommendation for a neurological consultation was made, but taken only reluctantly by a mother who wanted desperately to believe that her son was just going through a stage. Through extensive tests carried out over many months, including a special EEG procedure, psychomotor epilepsy was diagnosed and a temporal lobe tumor found and surgically removed. The very complicated second case was of a 22-year-old woman whose mother had died of a malignancy with metastases to the brain when she was a child. During a time of anxious uncertainty about crucial career and marital plans, she developed symptoms similar to those suffered by her dying mother, which included "blinding headaches, at times accompanied by knots in her stomach, nausea, and vomiting." When she sought a second opinion after a year of psychotherapy without improvement in her symptoms, she was referred to a neurologist. Despite having had repeated examinations and laboratory tests by her internist and a consultation by a gastroenterologist which failed to reveal any physical abnormalities, the neurologist found severe papilledema indicative of increased intracranial pressure. An ependymoma, benign tumor causing blockage in the flow of cerebrospinal fluid, was diagnosed and treated surgically, leading to complete recovery. Dr. Silverman cautioned that this case shows that "lightening can strike more than once."

The third case was of Bobby, a seven-year-old boy who entered analysis for intolerable behavior which had begun after the birth of his first sibling, a sister, when he was five and a half. His parents had separated shortly before his birth, and he had had a very close, warm, and

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exclusive relationship with mother, who remarried when he was four. Dr. Silverman detailed the intricate psychodynamics that came to be understood and successfully worked through in the two and a half years of child analysis, including the boy's sibling rivalry, oedipal conflicts, castration and separation anxieties, and over identification with mother. The analysis was brought to an end after two and a half years because of Bobby's marked improvement and the parents' serious financial pressures from an expanding family. The analyst felt pleased with the course and outcome of the work and was surprised to hear from the parents 10 months later that Bobby was having trouble in school because of restless behavior, outspoken forwardness, and difficulty mastering more demanding academic tasks. ADHD and a mild learning disability were diagnosed, and he responded very well to learning assistance and interventions with his teachers. This aspect of Bobby's problem had been missed by an analyst very experienced with ADHD and LD because of the intensity and excitement of the analytic work and the impressive gains generated.

Dr. Silverman used this case to illustrate that a comprehensive and inclusive diagnostic understanding of each patient can only be obtained if we actively look for difficulties that fall out of our narrowed area of professional expertise and interest. Analysts must look for neurological and physical factors that might contribute to or underlie their patients' symptoms. He also expressed his belief, in contradiction to the authors, that school systems are not reliable in picking up ADHD and LD because of the persistent bias that intelligent children should certainly be able to do well if they really try. He emphasized the far ranging consequences of a primary learning disability, and took issue with the authors' referring to an important distinction between problems of innate ego apparatus and internalized conflicts. Dr. Silverman stated, "It actually is a matter of much more than "distinction between." The various components of a learning disability and the defenses mobilized to deal with it can play an important role in shaping a child's defensive constellation and/or personality in general. The defensive avoidance made that is so common in learning disabled children can and very often does generalize into a predominating general, defensive mode, which also is true for those children who deal with the problem by becoming fighters or cleverly manipulative orchestrators and controllers of the people they need to get assistance from or even of the world as a whole." The difficulties encountered in academic areas can carry over into difficulties in social relationships, and "the defeats and humiliations suffered regularly by learning disabled children almost regularly contribute to damaged self-esteem and poor self-confidence in general."

Dr. Silverman ended with an admonition to analysts of the dangers of overlooking physically based conditions or components in childhood disorders because the defenses mobilized against them can mask or obscure them. He took issue with the often cited statistic that ADHD and LD occur more frequently in boys than girls, stating his impression that these disorders are just more noticeable in boys, who react to their academic frustrations through misbehavior and disruptive loss of control, while girls become "quiet, reticent, depressed, and avoid humiliation by fading into the background." He also emphasized that current medication treatments are still imprecise and inconclusive with regard to risk factors and specificity of efficacy. He urged all who treat children to become knowledgeable about current psychopharmacological approaches and to actively look for physical disorders in all cases.

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Notice

Grant Applications

As most of you know, the ACP has dispensed monies in the form of grants since 1982. We have granted over $85,000 during this time period, both to the Anna Freud Centre and to other training institutions to help support clinical low-fee psychoanalysis. Our grants have been modest, usually $1,000 to $2,000 per grant per year, and they have required a matching grant from the training institution. Most training institutions surprisingly have not ever applied for such support. Either they don't know about our program, or the candidates doing the low-fee analyses don't know about it, or the training institution does not want to participate in matching grants. The result has been that a very few institutions have repeatedly applied for and been granted monies to support low-fee analyses by candidates. They know a good thing when they see it. This notice is to draw your attention to this aspect of the ACP's activities. At the present time, we are relying on contributions from the membership to help fund these grants. In the past we used some of our investment earnings to do so. Those fell into a sad decline in recent years, and so we stopped drawing on our investment income for grant purposes. Our financial picture seems now to be improving again. We hope to generate a broader-based appeal to our Grants Program and to be able to fund additional worthy applications.

Application information and procedures may be obtained from Ms. Rachel May, our Executive Secretary, at P.O. Box 366, Great Falls, VA 22066 USA. ☎ (703) 759-6698 FAX (703) 759-6783

Guidelines for Sponsors

Two Regular Members of the Association must join in sponsoring any individual for any category of Association Membership.

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   b participation in seminars or independent study of three areas:
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      - child psychoanalytic theory and practice
      - child analytic case seminars
   c supervision by child analysts of child analytic cases that would be expected to include children of both sexes and, so far as possible, children representing pre-latency or early latency, latency, and puberty or adolescence. Child cases should be seen four or five times per week for an adequate duration.

The following outline may be of assistance in completing a sponsorship for membership. Sponsors are reminded that they may submit material in addition to that requested. Sponsors are also reminded of the availability of consultation as noted above regarding potential Collegial Members which is also available in like fashion for Candidate and Regular Members through the Membership Committee.

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3 nature of training program

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Please address
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3 seminars or independent study of:
   a psychoanalytic principles
   b child analytic theory and practice
   c child analytic case seminars
4 cases supervised by child psychoanalysts

age sex frequency duration diagnosis supervisor

* Case #1_____
* Case #2_____
* Case #3_____

Please send all of the requisite information to the Membership Committee Chair via the Executive Secretary, who will see that copies are forwarded to Committee members as appropriate.

Book Notice

Victims of Abuse

The Emotional Impact of Child and Adult Trauma

Edited by
Alan Sugarman, Ph.D.

This book addresses the growing trivialization of psychic trauma by such concepts as co-dependency or "the adult children of . . . ," which seem to blame all adult problems on the external environment. Certainly the growing awareness that certain forms of abuse are more common than may have been realized in the past makes the temptation to fall back on such clichés understandable. But psychoanalysis as a theory and technique that attempts to integrate concepts of inner and outer reality has much to offer toward clarifying the clinical and conceptual problems that afflict the phenomena of trauma and abuse.

This book will be of great help to practicing clinicians, both those who specialize in the treatment of such patients and those whose practices bring them into only occasional contact with them. It clearly shows the need to integrate an understanding of the inner and outer realities of these patients and to help them synthesize what are often compartmentalized dimensions of experience.

xi + 233 pages / ISBN 0-8236-6730-8 / $27.00

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But that's always the way; it don't make no difference whether you do right or wrong, a person's conscience ain't got no sense, and just goes for him anyway. . . . It takes up more room than all the rest of a person's insides, and yet ain't no good, nohow. Tom Sawyer thinks the same.

Huck, in *Huckleberry Finn* (1884),
by Mark Twain (1835-1910).

Book Notice

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Process, Development, Outcome

Edited by
Theodore Shapiro, M.D. &
Robert N. Emde, M.D.

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Book Notice

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Calendar of Events

July 24-28, 1994
13th International Congress, International Association for Child and Adolescent Psychiatry and Allied Professions
Violence and vulnerability
San Francisco, California
For information contact
Office of Continuing Medical Education
Room LS-105, Box 0742
University of California
San Francisco, California 94143-0742 USA
☎ (415) 476-5808 FAX: (415) 476-0318

September 16-17, 1994
International Society for Adolescent Psychiatry
Adolescence and Suicide: Beyond Epidemiology — Therapeutic Perspectives
Geneva, SWITZERLAND
For information contact
Ms. Christiane Bowen
Unite de Psychiatrie de l'Adolescence
P.O.B. 50
1211 Geneva 8 SWITZERLAND
☎ 011-41-22 327-43-15 FAX 011-41-22 781-46-97

September 23-25, 1994
West Coast Child Analytic Meetings
La Jolla, California
For information contact
Calvin Colarusso, M.D.
1020 Prospect Street, S-415A
La Jolla, California 92037 USA
☎ (619) 454-2473

November 19-20, 1994
Boston Psychoanalytic Society and Institute
New Psychoanalytic Perspectives on the Treatment of Sexual Trauma
Boston, Massachusetts
For information contact
The Boston Psychoanalytic Society and Institute, Inc.
15 Commonwealth Avenue
Boston, Massachusetts 02116 USA
☎ (617) 266-0953

April 7-9, 1995
Association for Child Psychoanalysis
Annual Meeting
Toronto, Ontario
For information contact
Mrs. Rachel May, Executive Secretary, ACP
P.O. Box 366
Great Falls, Virginia 22066 USA
☎ (703) 759-6698 FAX: (703) 759-6783

June 22-24, 1995
Fourth Congress, International Society for Adolescent Psychiatry
Trauma in Adolescence
Rome, ITALY
For information contact
Joseph D. Noshpitz, M.D.
3141 34th Street, NW
Washington, DC USA
or
Prof. Adriano Giannotti
via dei Sabelli 108
00185 Roma ITALY

March 29-31, 1996
Association for Child Psychoanalysis
Annual Meeting
Mexico [location to be decided]
For information contact
Mrs. Rachel May, Executive Secretary, ACP
P.O. Box 366
Great Falls, Virginia 22066 USA
☎ (703) 759-6698 FAX: (703) 759-6783

July 25-28, 1996
Sixth World Congress, World Association for Infant Mental Health
Early Intervention and Infant Research: Evaluating Outcomes
Lahti, FINLAND
For information contact
Helsinki University Development Services, Ltd.
WAIMH Congress 1996
Hollolankatu 2
SF-15110 Lahti FINLAND
☎ 011-358-18 892-514 FAX 011-358-18 892-524

The expectation that every neurotic phenomenon can be cured may, I suspect, be derived from the layman's belief that the neuroses are something quite unnecessary which have no right whatever to exist. Whereas in fact they are severe, constitutionally fixed illnesses, which rarely restrict themselves to only a few attacks but persist as a rule over long periods throughout life.

Sigmund Freud, *New Introductory Lectures on Psychoanalysis* (1933), *S.E.*, Vol. 22

Annemarie P. Weil, M.D.

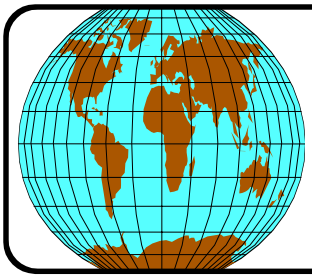
1909 - 1994

Dr. Annemarie P. Weil, a well-known child psychiatrist and psychoanalyst, died on April 15, 1994 after a long illness. Dr. Weil was born in Berlin in 1909 and studied medicine at the universities of Berlin, Leipzig, and Basel. Dr. Weil's training in this country continued at Bellevue Hospital with Dr. Loretta Bender. Infant testing with Dr. Rene Spitz at that period also played an important role in her career development. She was married to the late Dr. Frederic S. Weil, a native of Basel and also a psychoanalyst. With him she immigrated to America in 1940 and they settled in Manhattan where they both practiced for many years. Dr. Frederic Weil died in 1959. Dr. Annemarie Weil was in private practice until a few months before her death. She also served as a senior psychiatrist at The Child Development Center, was on the faculty of the Columbia University Center for Psychoanalytic Training and Research, and was a training analyst at The Psychoanalytic Institute. She was a key figure in the development of child psychiatry and for many years one of the prominent members of The New York Psychoanalytic Institute.

Dr. Weil made many fundamental contributions to child psychiatry in the many papers she wrote and the lectures she delivered. Her major contributions address the complex interaction between an infant's genetic nature and its external environment, particularly with regard to early infant-mother interactions. For her achievements Dr. Weil received many of the most prestigious awards in the field including the Brill Lecture, the Inaugural Award of the Journal of the American Psychoanalytic Association, the Margaret Mahler Literature Prize, the Lilly Gondor Memorial Award, and the Heinz Hartmann Award.

Dr. Weil is survived by her daughter Susan Caroline Weil, M.D., a hematologist at Thomas Jefferson Medical College in Philadelphia, her son-in-law Dr. Gideon Dreyfuss, a Howard Hughes Medical Institute Investigator and Professor at the University of Pennsylvania School of Medicine, her two grandsons Philip, 11, and Michael, 7, and her brother Albert, who lives in White Plains, New York.

Susan Weil Dreyfuss, M.D.



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