

Association for Child Psychoanalysis **NEWSLETTER**

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President's Message Mrs. Erna Furman

June, 1998

Dear ACP Members, Colleagues and Friends,

Although I have only just assumed office as your President, the ACP has been in my mind and heart for all of its over thirty years of existence. I am one of the 43 founding members, one of the 11 still living, one of less than a handful still regularly attending our scientific meetings, invested in the well-being of our organization. According to Jefferson's epithet for the old, this makes me "a relic in my own time". As such, I shall serve as a reminder of our beginnings, of the events that prompted the founding of this organization and of the ideas and practical goals it promised to serve. I hope, however, that a relic is not just relegated to the past, because I want to be a part of old roots which nourish and support the growth of new generations.

The basic premise of the ACP, its *raison d'être*, seems to me as important and crucial in the very late 1990ies as it was in the early 1960ies: to provide a child analytic forum in which medical and non-medical child analysts with comparable professional qualifications can share their clinical experiences and discuss the theoretical and technical implications in a constructive, collegiate, independent, apolitical setting, serving solely the ongoing growth of child analysis. Then as now, the ACP is the only organization that can meet this goal, even as larger national or international organizations seek to augment their membership by including non-medical child analysts.

Dr. Anny Katan, a co-founder not only of the ACP but of child analysis itself, used to stress that child analysis thrives where children are in analysis – as opposed to where people mostly just talk about child analysis. I would add another prerequisite, namely, the ongoing cooperation

between medical and non-medical child analysts in sharing and learning from each other's clinical work. Child analysts are a self-selected group. Despite considerable individual variations, this differentiates them from analysts of adults. Among child analysts, however, there is a further differentiation — again despite considerable individual variations, namely, between those who trained in the analysis of adults first and/or came to analysis with a self-selected medical background, and those other child analysts who opted for child analytic training to start with (perhaps going on to work with adults later) and/or came to analysis with a self-chosen background in the humanities, with or without professional training in education or mental health fields.

Those of us who have trained and worked with child analysts from both these different groups find the differences quite striking — and yet again despite individual variation — and this includes the different contributions each group can make. Without going into details, let me just mention the preferred dyadic analyst-patient treatment model of the analyst of adults as compared with the primary child analyst's readiness to encompass the triadic pattern of parents-child-analyst; or the medical analyst's inclination to view mental phenomena as a byproduct of neurological-somatic givens, compared with the non-medical analyst's focus on the primacy or mutuality of mental processes in relation to neurophysiological ones.

I believe we can learn best when both viewpoints are accorded equal value and weight and are considered in the light of clinical analytic data in a mutually respectful setting. We need each other's constructive contributions for knowledge and understanding to grow.

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President's Message . . .

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During the last four years I have become aware of an area of medical/non-medical difference which, by contrast, threatens to have an unfortunate impact on our organization and may impede the vital cohesion of our cooperative venture. The four years I have just referred to consist of the latter two, during which I served on the Executive Committee as president-elect, and the former two, during which I learned a great deal about my colleagues' feelings and reactions to my electoral defeat which, in turn, prompted me to run for president a second time. Four years ago, many concerned non-medical members told me, "If you don't get elected, we'll never get another non-medical president!" After I got elected, many non-medical members

approached me again, saying that, in their estimate, the enthusiastic spirit and zestful cooperative effort among members has diminished, a trend they hoped I would reverse.

Inquiring about the cause of my colleagues' concern, I learned that it lay not so much in the scientific meetings as in the measure of their participation in the Association's administration: During the ACP's 33 years there had been only three non-medical presidents, all serving during the 1970ies — Anna Maenchen, Peter Blos, Sr., and Ishak Ramzy. Similarly, the majority of Committee Chairs and Committee members have increasingly been medical child analysts, and this even applies to Councillors — despite the fact that, all along, the membership ratio has remained unchanged, i.e., around 54% medical, close to half.

No ill intent has been at work but these imbalances

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Note to contributors: Send contributions to Denia Barrett or Barbara Streeter at the address above. Deadlines fall one month before our publication dates of June 1 and November 1. Whenever 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, Microsoft Word) are preferred (including those created under Windows) but Macintosh format files are also acceptable. Contributions can also be sent via E-mail; indeed, this mode is preferred. E-mail should be directed to bustreeter@aol.com

President's Message . . .

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have taken their toll in diminished involvement experienced by many lay members. This has led to reluctance to run for elected office and to serve on Committees, which, in turn, heightens the administrative discrepancies and creates a sense of disenfranchisement for some. This is not a healthy trend.

I have spelled out some of our difficulties because I am certain that by facing them we can overcome them. There is only so much a president can do toward amelioration but, even before I took office I was greeted with many spontaneous offers of enthusiastic help, of willingness to work for our organization, of readiness even to risk defeat in election for the sake of involving us all in a cooperative effort — all heartwarming responses from

medical as well as non-medical child analysts. As for myself, I have taken some first steps to help preserve and revitalize the ACP's unique child analytic forum for all its members: In appointing Committee Chairs and Members I have tried to assure an appropriate medical/non-medical as well as geographical balance; in planning and locating our scientific meetings I am trying to assure that the needs of all members are kept in mind so that we do not price our meetings into a range many members cannot afford. Additional steps are described below, contained in my letter to the Executive Committee and Committee Chairs [p. 23] and in the memo to all of you from the Chair of the Nominating Committee and myself [p. 26]. Please read them.

Above all, it is my goal to open channels of communication, to share with you not just the decisions made by the Executive but the reasons for them, and, often, concerns related to them, and I trust that you will feel

Abstract Editor Comments

It seems to me that our meetings this year reflect an ongoing and increasing effort to elaborate and strengthen our commitment to the complementary series Freud spoke of early on. As child analysts, in particular, we have been fascinated with the role of the child's early interactions with mother and father as strong determining factors in shaping symptoms and personality. Currently, we have powerful forces impacting our understanding and our work. These forces include economics, shifting values, and a virtual explosion in our understanding of the biology of the brain.

The choice of addressing the obsessional child is, itself, an attempt to integrate the new research with our hard-won and useful analytic knowledge. In each of the reports, one can hear repeatedly an attempt to use the new knowledge to deepen our understanding of ego functions

and their deviations without losing our psychoanalytic perspective of listening to the inner child and the respect for the individual that that implies.

Many of the "new" discoveries re-invent the wheel. However, many of the discoveries give us new insight and new ways of understanding phenomena, much of which we've known about. It seems likely to me that this year's meeting, with its exchange of ideas can only help our field survive and grow. This comes at a time where the cultural shift away from the focus on the individual and our field's relative lack of contribution to research challenge society's valuation of child analysis.

Respectfully,

Kent B. Hart, M.D.
Abstract Editor

Passing the Baton

The *ACP Newsletter* has a bit of a history; my own collection of these light blue pages extends back to the early 1980s, about the time when Moisy Shopper took on the job of Editor. Moisy served in that position for at least a decade — the first issue I have in which he is identified as Editor is that of "Winter 1982" and his last was that of "Fall 1992." During that period Moisy shepherded some 16 issues — 264 pages — of the *Newsletter* to the printer.

Our membership has become more prolific and/or communicative in the past few years. During my 5-year tenure we have produced 15 issues — 382 pages — doubling the frequency of production and nearly trebling the pages per year.

Two important decisions contributed to this change. The first had to do with our shift to "desk-top" publishing. This reduced our production costs dramatically. The second important decision was that to publish the "abstracts" of papers presented at our annual meetings as promptly as possible in the *Newsletter*.

The *Newsletter's* regular frequency and enhanced

contents have promoted communication within the ACP. I am pleased to be turning what was once Moisy Shopper's "baby" over to new "parents" — Denia Barrett and Barbara Streeter — who bring new energy and imagination to the job.

The job of Editor is often humbling; you quickly learn that you will always spot a typo within the first five minutes after you pick up the final copies from the printer. You also learn that you will make other mistakes as well — of attribution or omission.

Nonetheless, the job has its rewards — not least because of the exposure it affords to a broad range of our members. And it is to you that I turn now, for the main strength and weakness of the *Newsletter* both lie at your fingertips. Write what you have to say to your fellow members and send it — via e-mail, disk, fax, regular post, or carrier pigeon — to the new Editors. Only you can give them the material they need to continue the *Newsletter's* evolution and to keep it a valuable benefit of membership in the ACP.

April 3, 1998 — Annual Meeting of the Association for Child Psychoanalysis — Boston, Massachusetts

Analytic Treatment of Obsessive-Compulsive Disorder in the Context of Multiple Therapeutic Interventions

Presenter: Steven Ablon, M.D.

Discussant: James Herzog, M.D.

Reporter: Bayard Clarkson, M.D.

In the workshop entitled, “The treatment of an eleven year old boy with the sudden onset of severe obsessive compulsive disorder,” Dr. Steven Ablon gave a moving and beautifully described account of his analytic work with a child suffering from multiple psychiatric and emotional problems. Dr. Ablon’s presentation was a compelling demonstration of how psychoanalytic treatment can be integrated into a treatment plan for children with the most severe psychiatric disorders, including those now thought to have “biological underpinnings,” like OCD, ADHD, and major depression with psychotic features. Furthermore, while children with such severe disorders may be greatly helped by psychotropic medication, parent guidance, psychoeducation, and cognitive behavioral treatments, Dr. Ablon was clearly the central agent allowing for this boy to begin to heal emotionally over the long term. The gains this disturbed child made over a period of years simply could not have taken place without Dr. Ablon’s analytic work functioning as the therapeutic cornerstone of a treatment which simultaneously employed multiple and complementary therapeutic modalities.

Dr. Ablon described how he was first consulted in the summer when the boy was eleven years old and was at overnight camp. The boy had become increasingly incapacitated by worries that there was a bomb in a letter he had written to his parents. He was afraid of having “God-like” powers and causing a catastrophe. He worried that if he kicked a soccer ball, it might change the course of history. When first seen by Dr. Ablon, he said he felt scared, couldn’t sleep, and had no one to talk to. He said that coming and talking to Dr. Ablon was more important than returning to camp.

A decision was made with the parents for the boy not to return to camp, and he began seeing Dr. Ablon daily. After several days, and after receiving psychopharmacologic consultation, the boy was started on Zoloft 50 mg./day. The patient’s symptoms rapidly progressed, however. He continuously wept and was afraid to eat or drink. He was afraid something was growing in his stomach and that he might jump out of the window and stab himself with the kitchen knife. If he went to the bathroom, he feared it would kill God. Sometimes, he worried that a voice he created told him these things, but he said the voice was not real.

Finally, the patient became so immobilized he could barely talk, and nine days after being first seen by Dr. Ablon, he was hospitalized for a two week period. During the hospitalization, he was begun on Clomipramine 125 mg./day and Trilafon 2 mg./day, in addition to the Zoloft 50 mg./day. At discharge, he had improved greatly, and a treatment plan

was agreed upon which included four times weekly meetings with Dr. Ablon, monthly parent meetings with Dr. Ablon, weekly meetings with a cognitive behavioral psychologist, and ongoing psychotropic medication. The patient also underwent an extensive battery of neuropsychological and diagnostic testing at a University medical research clinic where he received a DSM IV diagnosis of ADHD in addition to OCD. In the ensuing months, the Clomipramine and Trilafon were discontinued, and the patient’s Zoloft was increased to 200 mg./day. In addition, Ritalin SR 20 mg., twice a day was added to target the patient’s attentional difficulties.

During the first six months of treatment, there was one more hospitalization, but increasingly, the patient came to rely on his meetings with Dr. Ablon as a time when he could think the unthinkable and talk about feelings which previously had been unbearable. He brought “heavy metal” C.D.s to his sessions, and he and Dr. Ablon would listen to the music and talk together about the meaning of the lyrics. They listened to the band “Green Day” in their song “Basket Case” singing, “Sometimes my mind plays tricks on me. It all keeps adding up. I think I’m cracking up. Am I just paranoid?” Then they would play the C.D. from the band, “Offspring,” who would sing, “That’s okay man cause I like the abuse. I know she’s playing with me. That’s okay cause I’ve got no self-esteem.” Although Dr. Ablon chose to keep these communications in displacement, both he and the patient understood that the music was an attempt to make sense of his experience and to draw Dr. Ablon in as an ally in making this experience bearable.

As the treatment progressed, the patient began to talk more directly about his own dreams, fantasies, wishes, and fears. He said, “Steve, can you spray hair on the head like a mold? I have insomnia, OCD, ADD, and a shit bag of trouble.” He gave Dr. Ablon a note in a bottle: “Dear Steve, my self-analysis. Hello, it is me. I will get to the point. I think I have gone neurotic. I don’t know what to do. I want help, professional help All my parents do is punish me. I feel mentally dead I am scared. Please help. I am on the verge of suicide” The patient then spoke of his anger at his parents and his teachers and how people might say he’s psychotic, but if they do (said with some humor), he would kill them.

Over time, the patient increasingly felt comfortable talking with Dr. Ablon about sexual concerns he had — his fear that his penis was small and how this fear paralleled his feelings of being defective (“having OCD, ADD, and a shit bag of troubles”). The patient mused, “Did they throw fruit at Freud? I wonder why?” Dr. Ablon responded, “It was

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Analytic Treatment of OCD . . .

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because he said that even little children have sexual feelings." The patient then elaborated further by stating that he thought everybody was both homosexual and heterosexual and that sex roles were interchangeable. He spoke about his thoughts of "exploring the vaginal opening at night" and he asked Dr. Ablon, "Did you know that sex rules?" Dr. Ablon stated that he did know that. The patient continued, "Everyone thinks about sex and wants to try it but is anxious."

The analysis was also a forum allowing the patient to express his paralyzing conflicts around aggression and to begin to modify the extent to which his rigid and punitive superego functioning maintained this paralysis. The patient brought an ant in an envelope to a session. He said, "Its black. Red ants bite." He couldn't tell whether it was a male or female. Dr. Ablon wondered silently, "Would he kill it, or let it loose?" The boy began to torture the ant, dropping it in water. Dr. Ablon wondered out loud if the patient was showing him "the dark side." The patient asked Dr. Ablon if he had ever tortured animals, "Did you step on ants, kill them?" Dr. Ablon said that he thought the patient was asking if Dr. Ablon had a dark side and he said that he did. The patient asked, "how many did you kill?" Dr. Ablon said that he thought the patient wanted to know all about Dr. Ablon's dark side and that maybe that helped the patient feel okay about *his* dark side.

In this case report, Dr. Ablon demonstrated how therapeutic change required the analyst's immersion in overwhelming affects expressed by this child in the multiple modalities of music, drawings, play, and talking. The analytic process involved "the metabolism and

transformation of these affects in the container of the analytic dyad, eventually allowing the patient to be able to reclaim the affects in more integrated form." Providing a forum for the expression of affects, which had initially been profoundly disorganizing and of psychotic proportions, ultimately allowed the patient to build psychological structures which were stabilizing and organizing. Increasingly, the patient demonstrated that he had internalized Dr. Ablon's analyzing function and that he was able to rely on himself now to resolve conflict.

The patient was able to continue at a highly academically competitive school, to make lasting friendships, and to accept aspects of himself that previously he could not tolerate. He had learned that "sex rules" and that he had a "darker side," but he knew now that having certain feelings and thoughts was not the same as acting upon them. He still had "OCD and ADD," but he no longer had a "shit bag of troubles."

In his thoughtful discussion, Dr. James Herzog emphasized how medications such as Zoloft and Ritalin are often necessary for disorders like OCD and ADHD but do not help with the organization of meaning or with the building of psychological structure. He noted how the patient began the treatment basically saying that he needed Dr. Ablon's help in mastering and modulating extreme affects. The patient conveyed to Dr. Ablon that he could tolerate it if Dr. Ablon could do it with him. As the process deepened, the patient began by revealing his need, first for the analyst to be a homeostatically-attuned mother and then, as this role was met by Dr. Ablon, a need for a more paternal stance, which helped the patient to organize and structure his experience.

April 3, 1998 — Annual Meeting of the Association for Child Psychoanalysis — Boston, Massachusetts

Obsessional Manifestations in Children

Presenter: Judith Chused, M.D.

Moderator: Jill Miller, Ph.D.

Reporter: Karen Weise, M.A.

Dr. Chused began her engaging presentation by describing how she became interested in such children while a psychiatry fellow. During this period she became acquainted with a schizophrenic patient on an inpatient unit who had been analyzed for obsessional symptoms when younger, and she began wondering about the etiology of obsessions. After Dr. Chused read her paper, which described the analyses of three children who developed repetitive, ritualistic behaviors during the analysis, Dr. Miller outlined the main points for discussion. These included questions about the function of obsessional symptoms and the common threads among children with these symptoms. Some of these threads, as elaborated by Dr. Chused, are: a tendency to be overwhelmed by affect, a push to action when stressed, and an inability to use others

for help which leaves them feeling they must handle distress alone. The last, it was pointed out, effects a child's capacity for transference and Dr. Chused hoped that the discussion would address related technical issues.

The lively discussion began with a question about whether obsessional children are so frightened of their aggression that they do not approach others for help in an attempt to protect them. Dr. Chused thought that the dynamic was more primitive; that these children do get angry at their analysts for stimulating affect, but that they also are very disorganized and see others as not helpful in managing their affect. Their disorganization is not only a compromise formation, but an indication of a vulnerable ego. Someone noted that there was evidence of underlying

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Obsessional Manifestations in Children . . .

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aggression in the reactive irritation felt by their analysts during the sessions. Dr. Chused agreed aggression is a major component in these children's pathology but added that irritation also arises when the patient will not let the analyst be helpful. She sometimes finds it useful to get the patient to think about what they are doing to the analyst, and several participants were particularly interested in her notion of "analyzing the analyst". He elaborated that by this she meant the analyst must at times accept attributes ascribed by their patient and explore what the patient imagines their determinants to be rather than questioning them in a form which is a covert denial. This gives the child more control and by focusing on the analyst's thinking may aid them in their attempts at organization.

Several participants were interested in how the analytic situation itself may create obsessional symptoms, and asked whether a danger of analytic treatment was that by making elaborate interpretations, the analyst may be joining the patient in obsessively ruminating. Dr. Chused agreed, and pointed out that an analyst's mistaking emotional withdrawal for "neutrality" may inadvertently foster obsessional ruminations in patients and, when the obsessional patient's intense affect is not dealt with, analyses may be superficial and intellectualized. One workshop member wondered about patients who prefer their obsessional symptoms to the pain of strong affect, and warned that if symptoms are deconstructed and patients allowed to "unravel", analyses may also not have the desired outcome. It was stressed that it was important to think about how technique is or is not helpful and to consider the role of analyst as "container". The work of Dan Stern on the importance of "affect attunement" and Kohut's ideas about "mirroring" were also seen as connected, and it was suggested that some parents may be so mechanical that they fail to convey an authentic affective message to their children. Affect tolerance was seen as developing through the order and predictability that parental support provides. Dr. Miller gave the example of common bedtime rituals and wondered how we understood the common transitory obsessions of childhood. In response, a member presented a personal vignette, describing how her daughter resorted to constructing piles of her possessions in an effort to manage the strong feelings evoked by her father's hospitalization.

It was pointed out that one of Dr. Chused's patient's mother left when he was in the anal phase, and that the withdrawal of an ego-growth stimulating object at that time must have had an enormous impact. Dr. Chused gave additional background information on the case. Carl's mother had never really been there for him, and there was some more discussion of how affect tolerance is developed in early life. It was suggested that, in early life, children such as Carl developed an insecure attachment. A participant highlighted some relevant findings from attachment research. Children with disorganized

attachments become extremely controlling at about the age of five. This is thought to be because the mother becomes unsafe and unpredictable to them.

The development of the capacity for affect modulation was seen as an ego capacity built on both experience and identification, in addition to constitutional determinants. Thinking about identification thus involves a merger of psychoanalytic theory with the biological theory of development. Others had questions about the role of biology in obsessional disorders in children. Children with Pervasive Developmental Disorder, for example, panic when their rituals are interrupted because they lack the capacity for affect tolerance. It was also suggested that there was a relation between cognitive development and obsessional symptomatology. A question was raised about whether these children are intellectually precocious and so perceive more than they can understand or integrate, even with their parents' help.

The discussion concluded with agreement that there was a great deal of thinking to be done about the effect of our technique on these children and the importance of providing a setting in which better control structures are facilitated at the same time that the expression of affect is encouraged.

Erratum

In the November, 1997 issue of the *ACP Newsletter* we printed that Lilo Plaschkes had presented a paper entitled "Understanding Schizophrenic Patients." This was an error; the actual title of Lilo's paper was "Understanding the Child: The Mind of the Child."

A Handwritten Thank You to Our ACP Investment Advisor

April 5, 1998

Dear Joel Mangham,

This is the first letter I am writing as President of the ACP. The reason for my hurry is that I have for a long time felt greatly indebted to you for your excellent, dedicated and generous service as our investment advisor.

Some time ago an ACP colleague expressed the wish to be treasurer; "With our funds so well invested and cared for, it would be a pleasure" was given as the reason. Obviously, many of us are aware of your fine help, so I feel it's high time to thank you most warmly, officially and personally.

Sincerely,
Erna Furman

April 3, 1998 — Annual Meeting of the Association for Child Psychoanalysis — Boston, Massachusetts

The Vulnerable Child: Clinical Child Psychoanalysis: Tourette's Syndrome and Obsessive-Compulsive Disorder

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

Chairman: Theodore B. Cohen, M.D.

Presenter: Phyllis M. Cohen, Ed.D.

Discussant: Robert King, M.D.

In his opening comments, Dr. Theodore Cohen indicated that this is the 29th year for this workshop at the meetings of the Association for Child Psychoanalysis. The International Universities Press has published The Vulnerable Child, Volumes I, II, and III, containing presentations to this group since 1969.

In her presentation, titled Clinical Child Psychoanalysis: Tourette's Syndrome and Obsessive Compulsive Disorder, Dr. Phyllis Cohen referred to the research at Yale Child Study Center as a national resource for the evaluation and treatment of tic syndromes often associated with obsessive compulsive disorder, as well as, behavioral, personality and attentional] deficits. A cohort of children and adolescents have been provided with psychotherapy and child psychoanalysis. Most of these children have had previous attempts at treatment, with psychotherapy, cognitive-behavioral methods and medication. At times these are continued or initiated during the course of psychoanalysis. This presentation will exemplify the ways in which child psychoanalysis can be synergistic with other treatment approaches. Case presentations will show the benefits of child psychoanalysis in helping the children and adolescents cope with their symptoms, understand their inner life and move forward in their development. There will be a discussion of the therapeutic process, the role of the analyst and the relationship between bodily and mental experiences in these conditions.

Danny was diagnosed as having Tourette's syndrome at age seven. While reading aloud or writing he would repeat the same words again and again. He also erased compulsively. As a result, his homework was never completed. He had facial tics and touched things compulsively. If he touched something with his right hand, he had to also touch it with his left hand the same number of times. If he looked to the right, he also had to look to the left. With his parents, he was argumentative and tended to strike out. He was well liked by his friends and was artistic. Early in his analysis, Danny drew many pictures. Later, he became interested in basketball. He designated the analyst the coach while he himself became the captain. He discussed strategy, as well as the personal problems of each player. One could not play unless his mother was at hand. Another was being kicked off the team because he was doing poorly in school. A third was afraid of getting injured. The star player would have panic attacks and needed to hide under a chair. Gradually, Danny realized that the different players were different parts of himself. After the summer break, he became the consultant to another team. This was

his first move in separating himself from the analyst. His drawings became more imaginative He created many panels and made clay figures of the characters of these games.

After two years, the parents and analyst felt it might be possible to decrease the number of sessions per week. Danny's school work had improved, his obsessive compulsive behavior and tics had greatly diminished, and he was no longer so aggressive with his parents. At this time, a new type of play emerged. Danny became one of the characters, short and muscular, fighting a gigantic villain for the love of a princess. The villain was finally defeated when one of his own traps backfired. Danny was now unhappy about the decrease in the frequency of his sessions. He said he had left his Tourette's in his analyst's office each day he saw her. Now he was afraid it would recur on the days he used to have his sessions. The analyst reminded him of how much coaching he had done without her help. Using the metaphor of his play, Danny said with his newly found strength he need not fear that his Tourette's would recur. This indicated that his play had allowed him to synthesize the rich fantasies contained by his constricting obsessions (counting, drawing and sculpting) with the physical energy of his basketball] play. He was able to draw upon his creative energies in his dealing with the world around him.

David, in contrast to Danny, was nearly 13 and had received a variety of medications and behavior therapy. In the seventh week of his treatment, his mother called to cancel a session and wanted to reduce the frequency to one a week, saying David was nearly symptom-free and had no sign of depression. The analyst strongly encouraged the continuation of intensive treatment, noting that in addition to the symptoms there were other things that were important in David's life.

David wasn't tic free. Verbal yelps were less frequent and he seemed less fatigued. He asked why he was still coming since everything was good. The analyst explained that stress increased Tourette's, and understanding what made him stressed was part of what they did. David said he had no stress. The analyst commented that she wonders if it is true that nothing ever bothered him. She cited the example when his parents would not let him go to his favorite music club, saying he is so accident prone. David was then banging his leg. Focusing on this motor discharge as an affective outlet for anger, the analyst led the dialogue to touch upon his concern about his mother's wish to discontinue treatment, his concern about losing the analyst, the avoidance of painful affect, the conflict of activity vs. passivity and his self-absorbing singing during the session

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as a transitional device dealing with separation anxiety.

Alice was diagnosed with OCD at age fourteen. Parents were most concerned about her provocative sexual discussion with the father about his masturbation, particularly during his adolescence. Equally worrisome was her talk about suicide. Alice, a tall, sturdy and athletic adolescent reported her greatest difficulty was her sleep. Her bedtime rituals often took hours. She checked lights and door knobs, made many attempts at voiding and straining on toilet, wiping and examining her pubic hair. She carefully shaved her legs and under arms and plucked her eyebrows. Her school work was suffering. She had not had her first menstrual period.

During a session in the second month of her analysis, after going to the bathroom, she forbid the analyst from saying anything while she complained how terrible she felt, hated being there and that the analyst didn't help and didn't understand. Later she talked about family gatherings and her unhappiness with those events, that while she was away she started her period and showed the many sanitary napkins she had to have. She announced that her parents may be divorcing. Later, she confessed that while she was mad at the analyst, she was thinking "crotch." Later, she said she was writing a paper on therapy. As she asked permission to leave a minute early, the analyst asked if the anger, wanting to leave and the sexual thoughts were connected with what she had said about her parents.

In the next session, the analyst clarifies concern about the length of the sessions, as her feeling that the analyst is short-changing her and doesn't give her what she needs. She then discusses her problem in organizing her school work because of OCD. She then announces that she likes analytic therapy better than other methods. At the end, she doesn't want to leave and is compelled to say "crotch" and "penis." In another session, preceded by several weather-related cancellations, Alice said she had been feeling terrible, but now feels wonderful. She was feeling suicidal and thought about taking an overdose while mother had to be away visiting an ailing grandparent. Alice had to stay with her father which she didn't want to. A friend couldn't stay on the phone to talk and wouldn't be around for Alice to stay with her. Parents said her suicidal threat was merely for attention. Alice felt dismissed. She talked about kissing a girl and wondered if she was gay. Her father wants to kiss her on the lips, she doesn't permit it and he blames the analyst for Alice objecting to it. She is in a great mood and all her grades are better than expected. She remembers her first kiss, wonders about French kissing and becomes angry when her questions about the analyst's teen courtship are not answered. She acknowledges that she "had to say it" just as she had asked her father about his group masturbation experiences.

Before the anticipated summer mer break, when she would be away for the entire summer, Alice resisted discussing her feelings about the break. She claimed she

couldn't wait to go away, wasn't worried at all and the analyst was trying to keep her from leaving. Prior to her leaving, she was facing more pressure to spend more time at her father's. Gradually, she spoke of her worries. What if she couldn't sleep at night? Would there be a nurse to whom she could turn, just like talking to her analyst? She recognized even more now how much the obsessive and compulsive behavior was related to aggressive feelings, unfulfilled longings and separation concerns.

After her return, the usual non-stop battles between the parents and the sister recurred. Everyone was pleading for her help. She was able to stay outside the arena, rather than her usual way of feeling "trapped." "I can say no to the obsessive-compulsive symptoms."

These psychoanalytic treatments provided much information about how these children conceptualized their bodies. Fantasies about parents were closely related to fantasies about the body. The children would often provoke or attack parents and others to elicit retaliation. Eruption of symptoms and fantasies within the hours helped the children to understand their difficulties and to participate as active partners in the other concurrent treatment.

In his opening discussion, Dr. King commented that obsessive compulsive and Tourette's symptoms are ego-dystonic, intrusive, repetitive and interfere with one's sense of autonomy. Repetitive behaviors may be conceptualized in several ways. One group are the pleasurable variety, such as those repeatedly used in playing and games of mastery and learning new skills as normally observed in preschool and latency children. Another pleasurable variety include self-soothing or masturbatory repetitive behavior. Some children use rituals and repetition in the service of establishing control of one's anxiety or threat of separation, e.g., at bedtime. In addition to warding off danger in the face of thwarted aggression, some behavior serves to expiate super-ego retaliation for expression of instincts. Another group attempt to convert the passive into active as in cases of trauma. Latency children use repetitive behavior for the purpose of socialization and peer relations.

Bonding, mating, rooting, hoarding, adaptation, attachment and other basic behaviors are regulated mechanisms that are poorly understood. In some Children who are genetically predisposed to TS and OCD these mechanisms may become dysregulated. In our understanding of these manifestations, we hope to clarify how attempts intended to ward off danger surface as disturbing symptoms and whether more effective alternatives are available. With other patients, we try to show them how their symptoms are shaped by their personality or shape their personality and what they mean to them. This helps our patients develop a better sense of themselves and a vocabulary to share with us their experience and to gain some sense of mastery and control over their experience. We try to utilize as many measures as we need, be it psychology, neurophysiology, medication or interpretation in order to help our patients make sense of their chaos and deal with it through a sense of understanding and enhanced mastery.

Dr. David Freedman expressed the belief that there is a

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certain degree of obsessiveness that is universal and physiological in the service of adaptation, unlike the behavior in OCD or TS. In young children these are products of cognitive immaturity which results in false notions attributed to concepts expressed by adults. Sometimes it serves to deal with situations of fear. We would all prefer to have a surgeon or a pilot who is obsessive and will leave nothing to chance. One comment from the floor proposed that in constitutionally predisposed children the involuntary behavior always assumes the meanings associated with the deepest level of the conflict. For example, one young girl thought her head tic was due to blood rushing to her head in situations of anger. Later, she reinterpreted the tic as related to her experience of sexual abuse. She thought it both represented a violent objection, as well as an expression of pleasurable excitement.

Dr. Freedman asserted that only sociopathic and autistic individuals are not obsessive. In his opinion, every child uses obsessiveness as a matter of securing approval and attachment, since object relations are always confusing and conflicted and a source of anxiety.

Responding to a question about the role of genes in OCD, Dr. King noted many studies find preponderance of OCD and TS in families. This supports a genetic contribution. However, what is in fact transmitted may be the family culture. It is suspected that there may be different genetic involvements in different kinds of conditions. For example, OCD in TS is associated with a need for symmetry and completeness. OCD without tics, on the other hand, is in response to anxiety and anticipation of catastrophe. Dr. Donald Cohen felt that excluding the numerous repetitive behaviors of the autistic children from this group would be needlessly narrowing the field by requiring an element of object-relatedness for obsession. Such behavior and psychopathology in general can be arrived at from a multitude of pathways. What we should try to understand is what a particular symptom is doing for a given individual during a particular stage of development.

In response to a question regarding multimodal treatment, Dr. Phyllis Cohen stated that of her five cases, four used medication and three had some behavior therapy either during or before their analytic treatment. Some responded very well to behavior therapy, but their difficulties were rather uncomplicated. Dr. King stressed the importance of various disciplines working in coordination rather than in competition in order to discredit each other. Dr. Guttman commented that when children in analysis receive medication or behavior therapy, they attribute meanings to those aspects of their treatment which also need to be analyzed. Dr. King pointed to common elements in behavior therapy and analysis. They both look for what precedes the symptoms, what affects or accompany them and what alternatives may be used. The couch allows for a certain degree of affective exposure and a kind of practicing in dealing with a situation. Dr. Donald Cohen said both in

analysis and cognitive behavior therapy we help the patient understand their difficulties, to ponder, reframe and consider the consequence of their behavior. Children we see are often receiving many different interventions, e.g., in schools, at home and by other disciplines. Today, we are past the point of thinking that we would contaminate the analysis if other treatments are employed at the same time. Analysis has to look at every aspect of the child's life, the family, the school and other treatments. Analysis is the over-arching framework and the analyst the over-arching clinician. Today, the analysts do better in treating their patients not only because of the progress in our treatment, but also because we work better with other disciplines.

Dr. Donald Cohen also remarked that the long term adaptation of these individuals is much more the function of their sociability, sense of humor, skills in dealing with interpersonal and intrapersonal world than it is the functions of their tics. We have much more to learn about how the early experiences in life interact with biological vulnerability.

In her concluding comments, Dr. Phyllis Cohen referred to the unresolved nature of many of the basic questions we see in our patients, such as those with ADD, OCD, TS, or PDD. Family histories are very illuminating and invariably one finds others in the family with undiagnosed conditions but behavior similar to those we see in our patients. Many children don't receive treatment until in adolescence when their condition creates greater disruption. Other children we see earlier became symptomatic later in their adolescence and will require more intensive measures and medications.

Dr. King referred to the lack of a body of data in our field that we might use as reference in psychoanalytic or psychodynamic treatment of these children. We need to think of ways that we can pool our data about the outcome of psychoanalytic treatment in these children. He encouraged the Association for Child Psychoanalysis to begin to formulate frameworks for pooling our collective experience as analyst in treating these disorders.

No one would expect a man to . . . build a large house in the time it would take to put up a wooden hut; but as soon as it becomes a question of the neuroses . . . even intelligent people forget that a necessary proportion must be observed between time, work and success.

Sigmund Freud, *On beginning the treatment* (1913).
SE 12, pp. 128-129

April 3, 1998 — Annual Meeting of the Association for Child Psychoanalysis — Boston, Massachusetts

Child Analysis and Psychotherapy: A Comparison Based on Clinical Experience

Presenter: Erna Furman

This paper compares child analysis (in the form of four or five times weekly sessions) with psychoanalytic psychotherapy (in the forms of once or twice weekly sessions and of treatment-via-the-parents of under-fives) in regard to five aspects, each summarized below. I trained in child analysis and psychotherapy and have had the opportunity to practice both for fifty years in especially favorable settings' in the West Sussex Child Guidance Clinics in England and in the Hanna Perkins Center in Cleveland, Ohio. In both places the choice of therapy was not burdened by financial and administrative pressures. Families of very varied socio-economic background could be served, with each patient offered the treatment of choice for his or her difficulties, and with the length of treatment depending on the patient's need – mostly for several years, with follow up contact available. Despite my long-term interest in and chance to study and compare the different types of therapeutic intervention, the present attempt is intended to delineate and clarify some aspects and pinpoint questions, rather than to state definite conclusions.

1) Demands on the therapist

The present discussion is based on the premise that the therapist has been trained in child analysis as well as in psychotherapy, has received supervision in each, and has achieved a measure of clinical experience with both forms of treatment.

The reason for this prerequisite is that psychotherapy is technically and intellectually more difficult than analysis. In psychotherapy not even a hint of material should be missed and likewise the interpretive response needs to be prompt to assure that the patient is still in tune with the material. Analysis, by contrast, allows us much more time to "catch on" and to respond to gradually developing material. Our analytic experience often helps us to recognize and gauge the deeper context of briefly communicated "bits" of psychotherapeutic material and is therefore invaluable for our psychotherapeutic work.

2) What kind of psychotherapy

Although many forms of psychotherapy may benefit certain patients in certain situations, for the purposes of this comparison I have considered only the type of psychotherapy which shared with analysis the goals of uncovering unconscious contents which have produced interferences in the child patient's functioning and to assist his/her personality to achieve phase-appropriate integration, with appropriate chances for progressive development. Depending on the age and needs of the child patient, they also share ongoing contact and work with the parents and usually extend over several years.

In this study psychotherapy (once or twice weekly individual sessions with the child) is used for latency aged and adolescent patients and treatment-via-the-parents

(parents' weekly sessions with the child analyst in conjunction with the young child attending the Therapeutic Preschool) is viewed as the equivalent for pre-latency children. This is based on earlier studies showing that individual psychotherapy with under-fives was less effective than treatment-via-the-parents (Furman, R.A. & Katan, A., 1969).

3) Criteria for case selection

Three follow up studies are reported: one from the West Sussex Child Guidance Clinics (Daunton & Furman, E., 1952), two from the Hanna Perkins Center (Furman, R. A. & Katan, A., 1969; Furman, E., 1992). The latter two studies use the diagnostic categories adapted from A. Freud's (1965) metapsychological profile and consist of repeated profile assessments of each child, including assessments of parental functioning. The first study utilized Slavson's (1952) diagnostic system, closely related to that of A. Freud in the relevant areas. The findings tally strikingly:

Psychotherapy and treatment-via-the-parents of under-fives are the treatments of choice for children in diagnostic categories II and III, i.e., those whose pathological formations are phase-appropriate, as well as those whose pathological formations are not phase-appropriate but do not preclude progressive development, if the following factors are in evidence: Adequate and consistent early mothering, phase-appropriate parental functioning, disturbances during the oral and anal levels either absent or related to external experiences rather than pathology in the parent-child relationship, a positive drive balance (libido outweighing aggression) with adequate drive fusion, adequate tolerance of anxiety, and flexible defenses.

With children in these same two diagnostic categories but without evidence of the listed prerequisite factors, benefits of psychotherapy tend to be limited to a greater or lesser extent.

With patients suffering from neuroses or severe early disturbances which have precluded progressive development, psychotherapy is not indicated. This does not mean that these disturbances are always helped by analysis.

4) Three times weekly treatment

Neither my colleagues nor I at the Hanna Perkins Center have experience with this form of treatment. Discussion with other colleagues and review of the literature suggest that three times weekly treatment may be suited well to some patients' needs. Further detailed exploration of the related data would be essential, however, before stating general conclusions.

5) The role of analysis and psychotherapy in psychoanalytic research

In principle, an analyst can learn from every patient

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and how much he or she learns depends above all on him or herself. As mentioned earlier, however, it is easier for us to learn from analyses and, inevitably, we learn most from the patients who encounter difficulty in using their treatment.

Where analysis makes its special contribution, however, is in affording us the best opportunities to learn about the unconscious aspects of id, ego and super-ego and their mutual influences and interaction within the personality. Since this is a cardinal aspect of psychoanalysis, perhaps its sine qua non, the chance to learn more about it is crucial for analytic research as well as for professional growth.

6) Comparison with other studies

This study was completed some time before the publication of Fonagy and Target's (1996) work. They were, in fact, aware of my studies and corresponded with me in regard to the use of the profile as a research tool. Unfortunately, their investigation and results cannot be compared with those described above because their cases were grouped by symptoms for diagnostic and follow up comparison, rather than by metapsychological assessment; also, the reasons for assigning patients with alike symptoms

to different forms of intervention remained unclarified which, in turn, obscures the reasons for benefiting or not benefiting from the different treatments.

References

- Daunton, E. and Furman, E. (1952). Observations on psychotherapy with children in the latency period. Unpublished manuscript.
- Fonagy, P. and Target, M. (1996) Predictors of outcome in child psychoanalysis: A retrospective study of 763 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association*, 44: 1: 27-77.
- Freud, A. (1965). *Normality and Pathology in Childhood*. New York, NY: International Universities Press.
- Furman, E. (1992). *Toddlers and Their Mothers: A Study in Early Personality Development*. Madison, CT: International Universities Press.
- Furman, R.A. and Katan, A., eds. (1969). *The Therapeutic Nursery School: A Follow Up Study*. New York, NY: International Universities Press.
- Slavson, S.R. (1952). *Child Psychotherapy*. New York, NY: Columbia University Press, pp. 274-292.

April 3, 1998 — Annual Meeting of the Association for Child Psychoanalysis — Boston, Massachusetts

Analysis of an Obsessive-Compulsive Preadolescent Girl: Anal Influences on Development

Presenter: Anita G. Schumkler, D.O.

Reporter: Alexandra K. Rolde, M.D.

[Dr. Schumkler's presentation was largely clinical material. Consequently, in the interest of confidentiality, her report will be brief and cover the basic ideas she was trying to demonstrate in the case presentation.]

Dr. Schumkler observed the paucity of material in the analytic literature on the influence of the anal stage in female development. Even recent literature, attempting to study female development from an alternative vantage point, focuses upon female genital anxieties, but fails to examine, in depth, the anal stage. Some reasons for this may include hesitation, perhaps inhibition, among clinicians, to examine anal stage conflicts and defenses in their maternal imagoes.

Influence of the girl's anal phase upon the urethral, oedipal, latency phase, and ultimately on the girl's genital function has taken, so to speak, a "back seat" with respect to research in the field. Some of the "blurring" of that which is anal and that which is vaginal in the girl is accounted for by anatomy (cloaca in fetal development), the fact that simultaneous anal and genital stimulation appears to be more frequent among girls than boys, differences in mothers' and caretakers' attentiveness to cleanliness, particularly perineal cleanliness, in girls, and the fact that anus and vagina are discoverable by digital (or other object)

exploration, rather than visual inspection.

The material presented, in terms of anal conflicts and defenses in female development, was intended to complement the work of Shengold in *Halo in the Sky*, in which the clinical evidence was largely from the perspective of male development.

With illustrations from the seven-year analysis of an eleven-year-old obsessional girl, Dr. Schumkler presented the notion that the psychosexual phases of development, at least beginning with the anal phase, may be less well-delineated in girls than boys. It is Dr. Schumkler's contention that anal influences upon the urethral, oedipal, latency and adolescent stages are prominent in some female patients and tend to be overlooked by clinicians. The patient who was presented viewed girls, at least from puberty, as "leaky", "drippy" and "out of control". Her image of her genitals, and her self-representation, as an extension of her anus, minus the sphincter, emerged lucidly in the clinical presentation. The patient's early sense of helplessness and efforts to force her analyst to organize her had multiple determinants, one of which was the patient's response to her early struggle over particularly harsh bowel training. Her response to her first menstruation was likened to a bout of diarrhea and this image was reflected in the way she

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Case Presentation: Developmental Obsessional Symptoms in an Early Latency Boy Diagnosed as ADHD and Treated by Way of His Parents

Author: Robert Furman, M.D.; Presenter: Denia Barrett, L.I.S.W.

Reporter: Maida Greenberg, Ed.D.

The case presentation, a third paper in Dr. Furman's series on Attention Deficit Hyperactivity, was read by Denia G. Barrett, LISW, in Dr. Furman's absence. It was a clinical report of the successful treatment of a five-year-old youngster diagnosed as having ADHD who was treated by way of his parents with the assistance of two therapist(s) while the child was enrolled at the Hanna Perkins therapeutic psychoanalytically informed pre-school program. For reasons of confidentiality this report will focus only on selective aspects of the case. A developmental history, discussion of the obsessive mechanisms of the child, description of the child's classroom behaviors, the progression of the child's treatment, and a summary of Dr. Furman's thinking about ADHD will be presented.

David was a full term baby born by Caesarian section with some post-natal period transient colic. He was breast fed until 6 months, but due to his mother's hospitalization for pancreatitis, was switched to a bottle, was fully weaned at 18 months. He was cared for by his grandmother and saw his mother daily while she was hospitalized. He slept through the night at 10 weeks, walked at 10 months, had clear speech by 18 months and was toilet trained by three-and-a-half. The salient difficulty for David was the birth of a brother when he was 17 months old. He refused to visit his mother in the hospital and ignored his brother when they came home.

David and his mother attended a "Moms and Tots" group when he was one. At two years of age he was enrolled in a program with ten to fifteen other children for two hours, twice a week. He had two teachers, one that he liked, one that he hated. Unfortunately the "good" teacher left the program after a three month period. David missed her and remained unenthusiastic about the program. His obsessional symptomatology, however, did not develop until he was three-and-a-half when he was enrolled in a half-day Montessori nursery school. He did not develop friendships, did not follow directions, fought with children in the classroom, and was considered to be an "overactive" child. His mother was often asked to take him home early. David's mother found herself becoming increasingly embroiled in intense arguments with him over seemingly small interactions. She enrolled him in a different Montessori school the following fall. David's difficult behaviors escalated both at school and at home. A behavior modification program was initiated, a child psychologist saw him in play therapy, but to no avail. His parents reported that they felt that they were living on the edge all the time. "The smallest interaction, such as getting dressed in the morning, brushing his teeth at night, became a battle." This was juxtaposed with their younger son who was and remained the easy, pleasant, "good" boy.

At the end of the school year, when David was five, their pediatrician recommended the Hanna Perkins School for David and the therapist diagnosed David as ADHD. At that point the parents obtained a full child psychiatric evaluation at a major local hospital. David's "hyperactivity and disorganization in play" suggested the diagnosis of ADHD to the psychiatrist as well. Interestingly, all the professional staff, the psychologist, psychiatrist, school personnel, and pediatrician felt that Hanna Perkins would be beneficial.

The parents accepted the recommendation acknowledging that their participation in the program was important. They were opposed to a trial of medication and seemed to endorse Dr. Furman's position that although David was currently out of control for reasons not understood, the opportunity for a prolonged diagnostic evaluation made sense.

The provision of a therapeutic environment where the child can feel safe to express his feelings is an essential ingredient of the school program. The therapist who works with the parents observes the child in the classroom setting on a regular weekly basis and shares observations of the child both with the teachers and parents. The therapist also assists the parents in treating and understanding their child's behaviors and intrapsychic struggles. It was in this context that the following treatment strategy unfolded.

It was observed that when David entered the classroom he seemed frightened by a few of the out-of-control children in the room. The teacher suggested that when he felt frightened by the children he could come to her to feel extra safe. With this intervention David began to relax. It was observed that David provoked children into losing control as a way to feel a sense of control over them. This too was interpreted to David. His teachers helped him identify this pattern -- When he felt scared or anxious he teased the children and became provocative and silly. When his provocative behavior was pointed out to him, he could stop what he was doing and was able to state why he was frightened. It was hypothesized that he experienced excessive guilt for past and present misbehaviors which caused him to externalize his conscience; that is, provoking others into anger seemed like a better strategy than listening to his own harsh conscience. With the provision of firm assistance and clear expectations, David put his feelings into words, and slowly acknowledged his own harsh conscience. He experienced his fear of failing as he attempted new tasks and recognized how his perfectionistic standards got in his way.

As a result of David's experiences in the classroom and his parents' involvement in the treatment process, a deeper

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Developmental Obsessional Symptoms . . .

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appreciation and understanding of David's conflicts emerged. David began to verbalize his feelings rather than enact them, and his parents in turn could more openly respond to his questions and concerns; in short, a more open communication evolved. David became less provocative. His efforts to be a "better boy" influenced positive parental interactions as well. And with the loosening of his harsh conscience his obsessional symptoms diminished.

In reviewing David's developmental history and the course of his treatment a coherent narrative emerged. In retrospect it was felt that the interrupted breast feeding was the start of David's difficulty regarding his mother's separation and his angry feelings regarding the loss of his mother. The birth of his brother, the second separation from his mother was even more difficult for him to master. The rage at his new sibling who took his place with his mother was displaced onto his school classmates. The "mean" teacher only added to this vulnerability. David's anger which was then externalized colored his oedipal relationship with a sadomasochistic quality. The combined interventions, the participation of the parents in David's treatment, and the provision of a therapeutic classroom which enabled David to rework his issues, led to the resolution of his sadomasochistic conflicts resulting in the mastery of his ego-superego conflict and the emergence of true oedipal feelings and passage into latency.

Dr. Furman's views regarding ADHD were crucial to David's treatment. He writes, "I do not think ADHD is a diagnosis but rather is a collection of symptoms that demarcates a child in distress, a child who, rather than having a diagnosis, is in need of a diagnostic study to obtain a diagnosis or working hypothesis regarding his distress." He adds that "one of the seductive attractions of the ADHD diagnosis is that it can be used with almost anyone who presents with a diagnostic problem. If one did not know how to diagnose the boy, if one would not have known what to prescribe after a well structured preschool and psychotherapy had been in vain, how easy to diagnose him as ADHD and eligible for methylphenidate (Ritalin). In essence, a perfectly normal rambunctious boy could be labeled as chemically defective, or that a child with

problems like David could have his problems ignored with his symptoms lumped together to get the ADHD diagnosis en route to the medication now given to 4.4.% of all American school age children between 5 and 18."

Lastly, in Dr. Furman's view, David was a child who seemed to have "an isolated neurotic conflict that had not yet consolidated into a fully structured neurosis. His conflicts were intermingled with age or phase appropriate ones of such severity that threatened his ability without therapeutic intervention to master his transition through his oedipal period. He was a child who was suitable for exploratory treatment by way of the parents before considering an analysis for him." Another significant factor regarding the success of this treatment plan was "the capacity of the parents to put the needs of their child ahead of their own" and to actively participate in the program.

In summary, this paper highlighted the need for a psychoanalytically informed therapeutic milieu that treats the child and involves the parents in the treatment process. Dr. Furman's paper raised many interesting issues and questions which evoked lively discussion regarding diagnostic considerations, treatment of a child via the parents, and the variety of educative therapeutic models that can be utilized to both assess and treat a child with ADHD symptomatology.

In Confession the sinner tells what he knows; in analysis the neurotic has to tell more.

'What can you possibly mean by "telling more than he knows"?"

Sigmund Freud (1926), "The Question of Lay Analysis."
In *SE*, 20, p. 189

Job Opportunities for Child Psychiatrists

The Division of Child and Adolescent Psychiatry at the University of Alabama has openings for several child and adolescent psychiatrists who are analytically oriented and interest in an analytic approach to treatment and education. Applicants should be board-certified or board eligible. Anyone interested in these positions should contact:

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Obsessive-Compulsive Preadolescent Girl . . .

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experienced her affects, her mode of approaching schoolwork and it clearly affected her object relations.

The discussion that followed the presentation involved questions about the timing of interpretations, issues of confusion, for girls, between anal and genital, links between anal regression and obsessional symptoms, the nature of anal defenses in female development, and the effect upon the Oedipus complex and subsequent stages when these phases of

April 4, 1998 — Annual Meeting of the Association for Child Psychoanalysis — Boston, Massachusetts

Plenary Session

Moderator: Thomas Barrett, Ph.D.

Reporter: John Rosegrant, Ph.D.

Treatment of a Boy with Ego Deviations

Presenter: Wendy Olesker, Ph.D.

Treatment of a Latency Boy with an Obsessional Neurosis

Presenter: Rex McGehee, M.D.

Dr. Barrett began his introduction by stating that now, more than 30 years after obsessional neurosis was the focus of the 24th IPA Congress, it is fitting to reconsider this topic. Many child analysts are concerned that the DSM-IV symptom-oriented diagnostic approach leads to misunderstandings, because by ignoring metapsychological considerations it can inappropriately group together children with very diverse personality structures. Dr. Barrett then summarized Anna Freud's detailed metapsychological picture of obsessional neurosis from the 24th Congress. Miss Freud cautioned that obsessional neuroses proper always involve reaction formation and intellectualization, and that such neuroses differ from more severe or earlier disturbances in which superficially similar obsessional mechanisms are employed to support organization and integration. In this regard, Dr. Barrett reminded us that many child analysts have noted that work with severely disturbed children which promotes structuralization can result in development of a more true obsessional neurosis, as exemplified by the case of Frankie. Dr. Barrett then introduced the session's two case presentations: Dr. Olesker's work with an atypical child with ego deviations, and Dr. McGehee's work with a child with an obsessional neurosis.

Dr. Olesker presented her paper, "Treatment of a Boy with Ego Deviations." Don was three and three-quarters years old when first brought for an evaluation, at the nursery school's request, because Don was unable to relate to other children, and howled and bit himself when frustrated. Dr. Olesker described a history rife with severe developmental challenges: Don was premature, had unusual sensory sensitivities, and had great difficulty establishing a sleep pattern and separating day from night. Don's parents were extremely different, and separated two years into the treatment. Don showed major social problems and had many fears and preoccupations by age two. Don had not been able to develop awareness of the existence of his own mental life or that of others, and so did not comprehend that his parents had separate thoughts and feelings which guided their behavior. He used language not for mutual communication but for expressing his own interests. In DSM-IV terms, Don would be diagnosed with Asperger's Syndrome.

Dr. Olesker then described the first four years of a four-times-weekly treatment. (Don is now twelve, and she is currently treating him twice-weekly.) Don only gradually showed interest in relating to Dr. Olesker. Dr. Olesker described an extended period of careful therapeutic work

focusing on various manifestations of Don's anger, his fear and hurt regarding separation and loss, and his obsessional counting as a defense against these affects. Don gradually became more able to integrate his internal states and to see both himself and others as separate people who remained the same even if they had different feelings. Dr. Olesker continued by describing how she both came to understand more about and to help Don structure his internal life. Initially his inner life seemed to be populated by other-worldly characters to whom disastrous things happened for no reason. With much repetition, it became possible to translate his images into emotions and meanings. By affectively engaging with Don's characters, and questioning their motivations and feelings, Dr. Olesker helped with the emergence of a coherent story which was followed during years of therapy. This helped Don to better understand his family and his inner organization.

Dr. Olesker stated that the primitiveness of Don's ego structures meant that she needed to create psychoanalytically-informed ways of treating him, in addition to standard technique. She helped Don organize his inner life and modulate his affects. A crucial technique was to aid in narrative structuring of his communication and experience, so that they became more coherent and affectively-focused. Dr. Olesker moved back and forth as necessary between these developmental object functions and more standard technique, in which she approached the unconscious and served as a transference object. All of this required preliminary work to enable Don to trust her as his analyst.

With regard to Don's obsessiveness, Dr. Olesker stated that he showed obsessional behaviors but not an organized obsessional neurosis. Classic obsessional pathology is based on regression from Oedipal to anal-sadistic concerns. Don was dealing with more primitive annihilation anxiety, and had not reached the level of psychic structure which is prerequisite for Oedipal dynamics. Don's obsessional symptoms were an attempt to achieve a level of control not yet attained, rather than representing a regression from a higher level of structure.

Dr. McGehee then presented his paper, "Treatment of a Latency Boy with Obsessional Neurosis." Evan was referred for treatment at the age of 10, because of obsessive compulsive symptoms and panic. His anxiety was especially severe at bedtime, and he required his parents to engage with him in rituals taking as long as one and one-half hours before he could fall asleep.

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Plenary Session, Boston . . .

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Evan's developmental history was reported as normal until the age of three and one-half. At that time, he began to be afraid of sleeping alone, and stated that he wanted his father to leave so that he could sleep in his mother's room. He was held back from kindergarten because he was so anxious, and when he did start school, he worried about whether his mother would be there to pick him up. Dr. McGehee's formulation was that Evan had developed obsessive compulsive symptoms and panic attacks in a regression from Oedipal level anxieties. Therapy was begun twice-weekly, and shifted to four times weekly analysis after three months.

Immediately after converting to analysis, Evan became increasingly angry at his analyst, with the anger focusing around appointment times and cheating at games. Evan's rituals began to extend into the analytic sessions. Dr. McGehee carefully and consistently interpreted Evan's enormous anger and need to control him, as well as his need to have Dr. McGehee keep them both safe. Evan's anger and misery continued to escalate, to the point that Dr. McGehee began to worry that he really was making Evan miserable. However, Evan's parents reported that he was doing better and better at home and at school, and that his compulsive rituals had almost disappeared.

Evan continued struggling with intense sadomasochistic ambivalence toward his analyst, and brought in material with castration and anal themes. Dr. McGehee's technique focused on interpretation of defense, genetic material, and the transference. Evan gradually became less competitive and conflicted, more affectionate toward his analyst, and more able to tolerate imperfection in his family. He also began to be able to recognize his defenses in action even before Dr. McGehee pointed them out. Because of Evan's improvement, his parents began to talk about reducing frequency of sessions, which resulted in an upsurge of anxiety in Evan. A termination phase was agreed upon, which lasted four months. Three years later, Dr. McGehee heard from Evan's father that Evan was excelling, and had not experienced any return of his ritualistic behavior.

Group discussion was brief, since afternoon discussion sessions were scheduled. Michael Singer asked Dr. Olesker about her work with Don's parents, since these types of children put so much strain on their parents. Dr. Olesker reported that she initially met regularly with the parents together, but the parents were so extremely at odds with each other that she shifted to separate meetings. The parents continue to turn to Dr. Olesker for help with handling Don. Cal Narcisi asked Dr. McGehee about Evan's relationship with his brother in the transference. Dr. McGehee answered that the brother primarily served as a displacement for feelings from the Oedipal father, and that Evan often found it easier to talk about these feelings toward his brother than toward his father. Jules Glenn asked both presenters to

compare the two cases, who seemed to be so different. Dr. Olesker and Dr. McGehee agreed that the cases were very different, in that Evan was organized at the Oedipal level and had stable self and objet representations, whereas Don had much less coherent ego structure and object relationships, so that his internal world would fall apart under stress. Similarly, Evan's parents had much greater ability to reflect on and tolerate their and their child's inner worlds, and a much stronger relationship, than did Don's parents. A question was raised from the audience about the effects on Don of his prematurity; Dr. Olesker answered that it was unclear if this produced specific effects, or was simply one factor contributing to Don's difficulty with organization. Another audience member commented that premature children need parents who can accommodate to the child's difficulty establishing self-regulatory rhythms, and that Don's parents could not do this.

CHILD ANALYSIS

CLINICAL, THEORETICAL & APPLIED

is an annual journal published by
**The Hanna Perkins Center for Child
 Development**

Editors: Denia Barrett, Elizabeth Daunton & Devra
 Adelstein
 Editorial Advisors: Erna Furman, Robert Furman & Ruth
 Hall

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Cost: \$25.00 (within USA), US\$35.00 (outside USA)

MINUTES of the EXECUTIVE COMMITTEE MEETING

Friday, December 19, 1997 ❖ Beekman Hotel ❖ New York, New York

Theodore J. Jacobs, M.D., President, called the meeting to order at 9: 05 a.m.

Present: Judith Chused, M.D., Secretary; Alan Zients, M. D., Treasurer; Erna Furman, President Elect; Joseph Bierman, M.D., Secretary Elect; Peter Blos, Jr., M.D.; Barbara Deutsch, M.D., Jules Glenn, M.D, Laurie Levinson, Ph.D., Kerry Kelly Novick, Jack Pelaccio, M.D., Lilo Plaschkes, M.S.W., Anita Schmukler, D.O., Martin Silverman, M.D., Stephanie Smith, LICSW, Karen Marschke-Tobier, Alan Gurwitt, M.D., Remigio Gonzalez, M.D., Barrie Richmond, Judy Yanof, M.D. Nancy Hall, Administrator.

Minutes The Minutes of the Executive Meeting held in Cancun Mexico on March 21, 1997 were approved.

REPORT OF THE SECRETARY, Judith Chused, M.D.

ACP MEMBERSHIP STATUS

<u>Regular Members</u>	494
USA	406
International	88
<u>Candidate Members</u>	138
USA	115
International	23
<u>Collegial Members</u>	2
<u>Total Membership</u>	634

Membership Changes Since the Executive Meeting, March 21, 1997, Cancun

Members Deceased

Peter Blos, Ph.D. New York, NY
 Virginia L. Clower, M.D. Irving, Texas
 Naomi Ragins, M.D. Pittsburgh, PA

Members Resigned

Barrie Biven, Ph.D. Cape Town, South Africa
 Jay Alan Davis, M.D. Austin, Texas
 Michael Fishman, M.D. Bethesda, Maryland

A moment of silence was held for deceased members

REPORT OF THE TREASURER, Alan Zients, M.D.

This report reflects our finances through December 1, 1997. A year end report will be presented at the Annual Meeting in April 1998. Our funds are invested with the Vanguard Group.

The Endowment Fund has a balance of \$72,230. This is an increase of \$14,334 from the 1996 year end figure of \$57,896. The Operating Fund has a balance of \$57,618 on 11/30/97 which compares to \$49,269 on 12/31/96. Our total assets as of 11/30/97 were \$129,848 which compares with \$107,165 on 12/31/96. *The checking account had a balance*

of approximately \$18,000 as of 11/30/97.

A decision was made in 1997 to permit dues payment through the use of Visa and MasterCard. Our costs for this services are 2.65% per transaction in addition to \$7.30 per month. An initial expenditure of \$300 for the terminal was necessary. In order to obtain the best rate for Visa and MasterCard, we transferred our banking from the Lakeview Bank in Ramsey, New Jersey to Commerce Bank also in Ramsey, New Jersey. The use of Visa and MasterCard will permit European members to charge their dues and eliminates costly conversion costs to US dollars.

We are thankful to Ros Bidmead and The Anna Freud Centre for the years of assistance they have provided in collecting dues from our European colleagues. Income for 1997 is estimated to be \$73,500 with expenses estimated to be \$74,190. Efforts at reducing costs have continued. Final figures for 1997 will most likely show that we have eliminated deficit spending.

We are making every effort to collect delinquent dues. Members who have not paid their dues for three years will have their membership terminated if there is not a prompt response to our request for payment.

Discussion. Dr. Zients will not be able to continue as Treasurer due to pressing commitments. President Jacobs thanked Dr. Zients for the outstanding job he has done.

Ethics Report, Moisy Shopper, M.D.

Discussion: President Jacobs stated that the issue before is whether to proceed to form a standing Ethics Committee which would take this report, make changes, etc. and put it in a final form of Guidelines. The discussion centered on the role of the ACP in relation to the ethical standing of its members. Points raised concerned the Constitution of the ACP on what is unethical, the cost and procedures of an insurance policy, and the need for an Ethics Committee. The committee will give further consideration of the points raised and bring it back to the Executive Committee for discussion.

ARRANGEMENTS, Jack Pelaccio, M.D.

I. The Hotel - The Boston Back Bay Hilton is located adjacent to the Hynes Convention Center and the new Prudential Plaza. It's close to Newbury Street, Copley Place, Symphony Hall and the Museum of Fine Arts. The hotel is four miles from Logan International Airport and is accessible to all forms of public transportation. We have a 5% group discount for airfare.

The Hilton is a 26 story first class hotel with 330 newly refurbished guest rooms. Fourteen meeting rooms are located on the second and third floors. There is a restaurant and bar located in the hotel, attached covered garage parking, an indoor pool and fitness room. The conference room rate is \$160/single and \$175/double. The meeting space is free if we get 90% of rooms contracted for.

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Stephanie Smith has generously offered to help out members who may have to make alternate arrangements for accommodations.

II. Social Events - On Friday night we will have our first event which will include cocktails and dinner at the Hilton. There will be a charge for the dinner. Early Saturday evening the Boston Psychoanalytic Institute will host a cocktail party at the Harvard Club for members and spouses. The club is located at the intersection of Commonwealth and Massachusetts Avenues in the Back Bay, and can be reached by walking or by a short cab ride. There is no charge for the party. The Boston Institute is covering up to \$1 500 of the cost. The ACP will pick up any costs above that.

III. Boston is a culturally rich city. There are many historical sights, wonderful museums, terrific restaurants, and many entertainment options. Information about things to do will be made available to members. Judy Yanof and Rene Gelman have been very helpful in planning Saturday's event, and I hope they will supply us with some insider tips on things to do in Boston.

IV. Dates: Our 1999 annual meeting will be March 26,27 and 28. There were a number of suggestions at our last meeting. The most interest was in Seattle and Santa Fe. It has been suggested that the time is right for a west coast meeting. East coast airfare this year for dates around the annual meeting are \$528 from NY to Seattle. NY to Santa Fe is \$378 to \$500. Charlie Mangham and Cathy Henderson have offered to help with the local arrangements in Seattle. Seattle is a terrific modern city with good hotels and many interesting things to do. The end of March is not the best time to be there.

COORDINATE ASSISTANCE IN CHILD ANALYSIS IN EASTERN EUROPEAN COUNTRIES , Lilo Plaschkes

(A report on the Eastern European Summer School held in Nida, Lithuania was previously published in the November 1997 issue of the Newsletter) One addition to that report: Lilo Plaschkes presented a paper on "Understanding the Child: The Mind of the Child."

COMMUNICATIONS, Leon Hoffman, M.D.

The major work of this committee for the last several months has included:

1. The development of a "list" for the dissemination of information via e-mail.
2. A web site, with Perry Branson, M.D., webmaster. The page includes the roster, including geographical listings, an introduction to child analytic principles in treatment and a listing of Early Childhood Intervention

Programs conducted by members of the ACP throughout the country. This material was published in the most recent Newsletter. This material has to be updated and will continue to be updated.

3. If you remember, I reported previously that there were no child analysts, other than myself, on the Committee for Public Information of The American Psychoanalytic Association. In our efforts to communicate more directly the importance of child analytic principles in the outreach efforts of The American Psychoanalytic Association, several members of the ACP have been appointed to that Committee: Barbara Deutsch and Stephanie Smith. In addition, Moisy Shopper has been appointed as liaison from the ACP to that Committee.
4. The President is continually informed of important developments on the national scene for possible action by the ACP: legislation of controls on TV, meetings at the Carter Center in Atlanta, etc.

EXTENSION DIVISION, Karen Marschke-Tobier, C.S.W.

NEW YORK

The 12/21/97 meeting is all set with about 35 already registered as of last week. We have a room reserved for 50 so that we can accommodate about 15 or so more attendees. Additional flyers have been placed at the Waldorf with Deborah Edel as of 12/19 to inform those who may still wish to attend. Many thanks are due to Ted Jacobs for his timely suggestions--for the meeting and for the liaison distribution through the APA. Deborah Edel has been most helpful.

BOSTON

An extension program for Boston is being discussed. If accommodations for about 50 people from 1-3:30 can be arranged at the hotel, Allan Palmer and Stevie Smith have asked that we find someone who would speak to the use of play in long and short term treatment with children and/or how to work with traumatized children and their parents. They also asked that we try to find someone outside the Boston area. Any suggestions for possible speakers are welcome. Perhaps someone has presented locally on the topic/s suggested and would like the opportunity to represent in Boston with the same or different discussant We have about a month to work out the details before the announcement goes to press. We should consider whether we want to try to do another add-on Extension Program next APA mid-winter meeting. Their mailing goes out in early September so we need to plan ahead if we want to go forward for next December. The committee is interested in feedback. Lastly, the committee would benefit from suggestions for additional members who are located outside of the NY area.

LIAISON, CHAIR, Barbara Deutsch, M.D.

We have focused our attention on our relationship to the Academy of Child and Adolescent Psychiatry. Drs. Moisy Shopper and Nat Donson are our liaisons. For the first time, the Academy, in response to our efforts has

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appointed a liaison to the ACP. Dr. Jon Shaw, ACP member and also on the editorial board of the Academy Journal, will serve in this capacity. We hope to make our presence felt by encouraging our members to participate actively in the Academy program. To this end we feel that the panel on eating disorders, organized by Dr. Howard Rudominer and originally planned for the American Psychiatric Association, would be more suitable for the American Academy of Child and Adolescent Psychiatry meeting in October 1998.

Currently, Child Psychiatric Fellowship programs contain little or no training in dynamic psychiatry. An Academy committee has been organized under the leadership of Rachel Ritvo to study this and other related issues. The ACP has sent two representatives to this new committee, Drs. Moisy Shopper and Harold Benensohn.

Dr. Shopper, who attended Dr. Ritvo's committee meeting in Toronto, reported that the Academy is currently working on Practice Guidelines for children and adolescents. (Similar to the Guidelines published on a variety of disorders in adults by the APA). He was invited to review the Guidelines on Depressive Disorders in Children which he felt were very poorly done.

Dr. Shopper has suggested that the ACP find a way to encourage and support child fellows with a program similar to the American's fellowship program. We might provide ACP mentors and facilitate attendance at ACP meetings or interim workshops.

The ACP liaison committee has been unable to find someone willing to serve as liaison for the American Psychiatric Association.

LIAISON, ACAPAP Stephanie Smith, L.C.S.W.

The program plans for Stockholm, July, 1998 are well under way. Dr. Tom Barrett has the tentative title; "The Other Child: Therapeutic Efforts on Behalf of Siblings of Children with Severe and Disabling Congenital Anomalies". The program will consist of two analytic case presentations and discussants. The cases are a late adolescent girl and a child in transition from preschool to latency. In a letter to Dr. Donald Cohen, Dr. Barrett stated that the "Salient factors in the work involved the degree to which the parental attitude toward the well child was affected by their feelings of being parents of children with severe deformities. The analytic work also focused on types of defense mechanisms and "sense of self" difficulties engendered in the children in treatment in consequence of their observations of and feelings about their impaired sibling."

I will provide full details in April. My role has been to facilitate communication between Dr. Rydelius and Dr. Barrett, make certain that we were invited participants rather than having to submit a proposal, and thinking with Dr. Barrett about appropriate topics and the general mechanics of putting together a panel for IACAPAP. We are also appealing to Dr. Donald Cohen because we would like to

have a larger block of time than we were offered. Dr. Barrett's efforts are impressive and I am confident that he and the ACP will ensure a child analytic presence and provide a significant contribution to the Stockholm Program.

LIAISON, IPA, Peter Blos Jr., M.D.

Discussion: The Executive Committee felt it is important that ACP represent our agenda in an official way on the North American Committee of the IPA by the appointment of a representative. This would give ACP an official position on the committee. Dr. Peter Blos, Jr.'s representation on the Program Committee of the IPA is by appointment from the President of the IPA. Lilo Plaschkes and Peter Blos, Jr., representatives on the Eastern European Committee, are appointed by the ACP. It was agreed that Jack Novick be the official appointment of ACP as a representative to the North American Committee. Dr. Blos made a request for a \$1,000 grant to the Eastern European Committee of the European Psychoanalytic Federation, which administers the summer school and the week-end seminars. (*Excerpts from his letter requesting training grant of \$1,000*) The ACP has hosted a reception at the IPA Congress each year. Dr. Blos asked for approval to do so again in Santiago. The Executive Committee strongly supports this endeavor and the work done by Dr. Blos.

MEMBERSHIP, Kerry Kelly Novick

1. There are currently 27 sponsorships of candidate members being processed, and 4 for regular membership. This excellent rate of inclusion is helping the Association grow. The Membership Committee congratulates members for actively involving candidates. Regular Membership is also proceeding well, with renewed interest from Europe.
2. There is some improvement on the part of members in using the format of the Guidelines for Sponsors to save themselves and the Committee work. It has been helpful to have them published regularly in the Newsletter. In an attempt to clarify them further, the Membership Committee is drafting a short additional paragraph that explains the rationale for the standards for sponsored individuals. We will report on this effort in April.

NEWSLETTER, Paul Brinich, Ph.D.

The following is a brief report on the *Newsletter* for review by the ACP executive committee.

Over the past year we have published three issues of

Dates:	6/1995	10/1995	3/1996	6/1996	10/1996	3/1997
Pages	36	12	16	28	24	12
Copies	1200	1200	1200	1250	1250	1040
Printing cost	\$1,224.30	\$527.88	\$585.12	\$1,232.57	\$1,011.35	\$489.03
Mailing cost	\$1,159.00	\$813.90	\$869.39	\$1,489.87	\$949.43	\$693.00
Total cost	\$2,383.30	\$1,341.78	\$1,454.51	\$2,722.44	\$1,960.78	\$1,182.03
Printing/page	\$0.028	\$0.037	\$0.030	\$0.035	\$0.034	\$0.039
Mailing/page	\$0.027	\$0.057	\$0.045	\$0.043	\$0.032	\$0.056
Cost/page	\$0.055	\$0.093	\$0.076	\$0.078	\$0.065	\$0.095
Mailing/copy	\$0.97	\$0.68	\$0.72	\$1.19	\$0.76	\$0.67
Cost/copy	\$1.99	\$1.12	\$1.21	\$2.18	\$1.57	\$1.14

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the *Newsletter*; some data appear below

To the above production costs we need to add the cost of some supplies (e.g., printer toner), software upgrades, the replacement of our "486" computer with a newer machine, and the purchase of a scanner for inputting materials sent in hard copy form. The total for these expenses was about \$2200.00 (after subtracting the amount we gained from the sale of the old computer).

The "abstracts" issue of the *Newsletter* was the largest issue of the year, in terms of content. Our reporters are getting quicker in their response time and we were able to get the Abstracts of the Cancun meeting to ACP members in June. The November issue was, like the June issue, 36 pages; this was because the "minutes" of the Cancun executive committee meeting and of the annual business meeting were included in the November rather than the June issue. [While this was not planned, it worked out for the best as our printer runs into some extra problems when he has to bind more than 9 sheets of paper (i.e., 36 pages) in a publication like ours.]

As agreed at the Cancun meeting, we will be reducing the **frequency** of publication of the *Newsletter* to two issues each year (the Abstracts issue in May or June and another in November or December). (Since mailing costs are a large portion of the expenses, this alone will cut our costs by about \$700 per year. See the chart above for the cost of mailing our March issue.)

I would suggest that the Executive Committee consider establishing a regular budget "line" for the *Newsletter*, one that would bring some long-term planning to this project. Specifically, although our switch to "desk-top" printing reduced our printing costs substantially, the equipment needed to do this work does need periodic replacement (as software changes and hardware ages). I would suggest that we budget a certain amount -- perhaps \$1000 per year -- to cover the periodic expenses of the *Newsletter* and its production.

Finally, I have recently been asked to take on the role of "interim" director for the Children's Psychiatric Institute here in North Carolina (effective 1/1/98). This additional responsibility has me looking around for other areas where I can "cut back." I've done the *Newsletter* for 5 years now (2 issues in '93, and 3 issues in '94, '95, '96, and '97) and I think it would be a good idea for the ACP to be looking for a successor -- or at least a collaborator. I've enjoyed many aspects of the job but it does take roughly 2 days of fairly concentrated time to put together each issue. It would be essential that this person be someone who is comfortable with computers and with the Windows 95 environment; I'd be happy to spend some time introducing him or her to how I've organized things and why. If the directorship at CPI turns out to be truly "interim" and I return to my position of head of psychological services within CPI, I may have time to continue with the *Newsletter*. But I think it is at least prudent that we have an understudy available should I be

unable to do the job.

President Jacobs spoke of the excellent job Dr. Brinich has done with the *Newsletter* for the last 5 years. Because he has recently been asked to assume additional responsibilities in his work, Dr. Brinich is seeking assistance with the ACP *Newsletter*.

NOMINATING, Jules Glenn, M.D.

The Nominating Committee presents the following slate for President-Elect and Councilors. Balloting by the Membership will be in January 1998 with instructions to choose a President-Elect and three Councilors.

President-Elect Martin Silverman, M.D.

Antoine Hani, M.D.

Treasurer Julio Morales, M.D.

Councilor Denia Barrett, M.S.W.

Arthur Farley, M.D.

Steve Marans, Ph.D.

Julio Morales, M.D.

Ruth Karush, M.D.

Willem Heuves, M.D.

Question was raised regarding the double nomination of Dr. Morales and the lack of a 2nd nominee for treasurer. The official vote on the Bylaws Addition states two Candidate members will be elected to serve on the Executive Committee in a non-voting capacity. Therefore, this December 1997 report is not complete because the Nominating Committee will now be selecting four Candidate members for this election.

PROGRAM, Laurie Levinson, Ph.D. and Janet Szydlo

Friday April 3, 1998

8:30 – 10:30 am Open Discussion for ACP Members

Sponsored by Executive Committee

12:00 – 3:30 pm Luncheon Meeting of the Executive Committee

8:30 am – 5:00 pm Registration

12:00 – 4:00 pm WORKSHOPS

1. "Clinical Case—Eleven yr. old Boy"
Presenter: Steven Ablon, M.D.
2. "Obsessional Manifestations in Children: (3 cases)
Presenter: Judith Chused, M.D.
3. "Vulnerable Child"
Chair: Theodore Cohen, M.D.
"Therapeutic Psychoanalytic Models for Children with OCD"
Presenter: Phyllis Cohen, Ph.D.
Robert King, M.D.
4. "Child Analysis and Psychotherapy: A Comparison Based on Clinical Experience"
Presenter: Erna Furman
5. "Clinical Case—Eleven-year-old Girl"
Presenter: Anita Schmukler, D.O.
6. Continuation of Topic "Symptom Diagnosis: Treatment of a Five-year-old Boy via the Mother"

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Presenter: Robert Furman, M.D.

Saturday, April 4, 1998

7:30 – 8:30 am Scheduled Committee Meetings
 8:45 – Noon Scientific Meeting Plenary Session

Moderator: Thomas Barrett, Ph.D.

“Treatment of a Boy with Ego Deviations”

Presenter: Wendy Olesker, Ph.D.

Treatment of a Latency Boy with Obsessional
 Neurosis”

Presenter: Rex McGehee, M.D.

12:15 – 2:00 pm Discussion Groups with Lunch
 (Alphabetical assignments)
 Group Leaders (to be announced)

Sunday, April 5, 1999

7:30 – 8:45 am Program Committee Meeting
 9:00 – 10:00 am Annual Business Meeting
 10:00 – 12:00 noon Marianne Kris Memorial Lecture
 Donald Cohen, M.D.
 12:00 noon Adjournment

OLD BUSINESS

There was no old business to come before the meeting.

NEW BUSINESS

Members of the Executive Committee thanked Drs. Jacobs, Chused, and Zients for all their work as officers.

The above Minutes were accepted by the Executive Committee at their Executive Committee Meeting on April 3, 1998. Draft Minutes of the April meetings of the Executive Committee and of the Annual Business Meeting

People often ask whether psychoanalysis makes life easy. Quite naturally they would suspect anything which made such a claim. Psychoanalysis, apart from its being a painful process in itself, does not alter the fact that life is difficult. The best that can happen is that the person who is being analysed gradually comes to feel less and less at the mercy of unknown forces both within and without, and more and more able to deal in his or her own peculiar way with the difficulties inherent in human nature, in personal growth, and in the gradual achievement of a mature and constructive relationship to society.

D. W. Winnicott, “Towards an objective study of human nature” (1945). In R. Shepherd, J. Johns, & H. T. Robinson (Eds.), *D. W. Winnicott: Thinking about children*. Reading, Massachusetts: Addison-Wesley

Roster Update Form for ACP Members

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

Name:	_____	Degree(s):	_____
Home Address:	_____		

City:	_____	State/Prov.:	_____
		Postal Code:	_____
Country:	_____		
Office Address:	_____		

City:	_____	State/Prov.:	_____
		Postal Code:	_____
Country:	_____		
Preferred mailing address for ACP correspondence (circle one):	Home	Office	
Telephone	Home: Country code:_____	Area code_____	Number:_____
	Office: Country code:_____	Area code:_____	Number:_____
FAX	Home: Country code:_____	Area code:_____	Number:_____
	Office: Country code:_____	Area code:_____	Number:_____
E-mail	_____		

Update on ACP Committees: Chairs and Members

Erna Furman, ACP President

ACP Committees, Chairpersons, and Committee Members, confirmed by the Executive Committee:

The names with asterisks * are newly appointed with these considerations in mind:

- 1) competence, conscientiousness, and eagerness to work for the ACP;
- 2) providing continuity of knowledge and experience as all new Chairs of previously existing committees served as members in their respective committees;
- 3) geographical distribution;
- 4) fair proportion of medical and non-medical representation.

The membership invitations for the Long Range Planning Committee and the Committee on Coordinating Assistance to Eastern Europe are still being processed and will be announced in the next Newsletter.

1. Abstracts

Chair: Kent Hart, M.D.

2. Arrangements

Chair: Jack Pelaccio, M.D.

Member: Catherine Henderson, Ph.D.*

3. Communications

Chair: Leon Hoffman, M.D.

Members: Roy Aruffo, M.D., Thomas Barrett, Ph.D., Perry Branson, M.D., Paul Brinich, Ph.D., Cynthia Carlson, Barbara Deutsch, M.D., Nathaniel Donson, M.D., Theodore Jacobs, M.D., Laurie Levinson, Ph.D., Frances Marton, Judith Pitlick, Howard Rudominer, M.D., Anita Schmukler, D.O., Moisy Shopper, M.D., Donald Silver, M.D., Stephanie Smith, LICSW, Barbara Streeter, Andrea Weiss, Ph.D.

4. Coordinating Assistance in Eastern Europe

Chair: Lilo Plaschkes, M.S.W.

Member: Peter Blos, Jr., M.D.

5. Ethical Guidelines

Chair: Peter Blos, Jr., M.D.*

Members: June Greenspan-Margolis, M.D.*, Paul Brinich, Ph.D.*, Barbara Carr, M.A.*

Consultants: Anne Hurry*, Kerry Kelly Novick*, Gustav Amnell, M.D.*

6. Extension

Chair: Karen Marschke-Tobier, C.S.W.

7. Grants

Chair: Charles Mangham, M.D.*

Members: Robert Gillman, M.D., Jill Miller, Ph.D.*, Cynthia Carlson*

8. Liaison

Chair: Barbara Deutsch, M.D.

9. Liaison — IPA Program and European Federation

Chair: Peter Blos, Jr., M.D.

10. Liaison – IACAPAP and Association for Clinical Social Workers*

Chair: Stephanie Smith, LICSW

11. Long Range Planning

Chair: Jack Novick, Ph.D.*

12. Membership

Chair: Kerry Kelly Novick

Members: Ava Bry Penman, Heiman van Dam, M.D., Ruth Hall, Lilo Plaschkes, M.S.W., Janet Shein Szydlo, Jack Novick, Ph.D., Anne Hurry, Colin Pereira Weber, M.S.W.

13. Newsletter

Chair: Paul Brinich, Ph.D. (through 6/30/98)

Co-chairs: Denia Barrett* and Barbara Streeter* (from 7/1/98)

14. Nominating

Chair: Marion Gedney, Ph.D.*

Members: Maurice Apprey, Ph.D.*, Werner Schimmelbusch, M.D.*

15. Program

Co-chairs: Laurie Levinson, Ph.D. and Janet Shein Szydlo

Members: Thomas Barrett, Ph.D., Paul Brinich, Ph.D., Barbara Deutsch, M.D., Kent Hart, M.D., Leon Hoffman, M.D. Theodore Jacobs, M.D., Randi Markowitz, M.Sc., Karen Marschke, C.S.W., Jill Miller, Ph.D., Jack Novick, Ph.D., Kerry Kelly Novick, Eva Landauer, M.S., Wendy Olesker, Ph.D., Ava Bry Penman, Katherine Rees, Ph.D., L. Noah Shaw, M.D., Stephanie Smith, LICSW, Elizabeth Tutters, C.S.W., Catherine Henderson, Ph.D.

16. Register of Cases

Chair: Robert Galatzer-Levy, M.D.

17. Study Groups and Continuing Education

Chair: Stanley Leiken, M.D.*

Member: Barbara Streeter

Please note:

a) Gustav Amnell, M.D. is not a member of the ACP. He is an analyst of adults, member of the Finnish Psychoanalytic Society and the IPA, and a trained experienced child psychotherapist. He has also only just retired as head of the Finnish National Mental Health Service for Children, which plans and administers all therapeutic services. In this capacity and several additional ones he has accumulated a vast experience in ethics regulations and how they work. Dr. Blos and I have worked with him for many years, respect him highly, and wanted him as a consultant for this committee. Consultants are not committee members. Their services are used *ad hoc* at the committee's discretion.

b) The President and President-Elect are *ex-officio* members of all committees, thus enlarging by two the above listed membership counts.

News of the Hanna Perkins Center for Child Development

Robert A. Furman, M.D.

[Erna Furman sends us this excerpt from the Newsletter of the Hanna Perkins Center in Cleveland, Ohio. She writes: In our endeavor to reach out to the community and to engage them in working with child analysts, many ACP members resolved some time ago to share approaches they have tried. This article describes two approaches used by the Hanna Perkins Center in Cleveland which have proved very helpful — the Annual Workshop and the Newsletter.]

This Newsletter, published three times yearly, is a fairly recent venture for our Center. It is designed to keep old friends informed of many activities, to make some new friends, and simply to make ourselves better known so our services can be utilized fully by those who might need them. This issue of our Newsletter focuses on our Annual Workshop, a part of our Extension Service and, as such, was briefly mentioned in the previous overall description of the Hanna Perkins Center's work with preschoolers, with their families and with the professionals engaged in their care.

The Annual Workshop for Preschool Educators, Caregivers and Mental Health Professionals of Northeast Ohio has been a tradition, now celebrating its 30th year. Scheduled in September, it takes place in the Katan Auditorium of the Hanna Perkins Building in University Circle, Cleveland. Two presentations are held: One on a Tuesday evening and one on a Saturday morning, each preceded by an informal meeting time over coffee. By scheduling two presentations we enable participants to fit their attendance around their work responsibilities and we also offer them a choice of structure, as the Tuesday evening presentation calls for floor discussion after the paper with the presenter, whereas the Saturday morning session has small group discussions after the presentation. Moreover, with Auditorium capacity just shy of 100, we need two sessions to accommodate our usual audience of 200 who have to reserve their places in advance.

When our Workshops began we hoped to attract audiences by inviting star guest speakers from the field of early childhood. But despite a great public relations effort we felt we were slowly losing our audience. Some of the teachers and directors on an advisory committee we formed came to our rescue. They said to stop importing speakers with whom the audience had no relationship and instead use only our staff, all known to the audience. In line with this focus on relationships, they urged that we invite all who had ever taken a course with us and ask them to bring a friend who might be interested. The Workshop topics would be selected from the areas of particular interest to the participants, as revealed in those courses and consultation groups, and the Workshop could then also serve to announce our courses for the coming year. This has been our successful format for many years, with each Workshop an opportunity to share with old friends in a milieu that welcomes and readily includes new members. Thanks to the sponsorship of our devoted friend from Akron, Mrs. Gene

Radney, there is no charge for attendance and there is adequate nearby parking which is reimbursed.

The topic of the most recent 1997 Workshop was Surviving in the Early Childhood Profession, given by Kathy Smith, Gann Roberts and Maria Kaiser. All three are veterans of the local early childhood scene and have been closely associated with the Hanna Perkins Center for well over thirty years - first as course participants, later as members of our Advisory Committee and liaison with the community. Instead of attributing their survival in the field to the more ephemeral gratification of seeing children under their care mature and master, a satisfaction they readily acknowledged, their focus was on three basic and practical realities:

The first of these was "surviving with the help of a circle of trusted peers, colleagues and mentors" with whom one could share problems and concerns, profiting from their experiences. An example of such groups are the Hanna Perkins Center's small consultation groups for directors, teachers or caregivers.

The second was "surviving through creativity." Every preschool educator has a special area of creative interest, be it music, art, gardening - the list is endless. When allowed expression in the classroom, its effect is contagious, a source of great interest to the children and of fulfillment for the teacher.

The third and last was the "insights gained through continued learning" which included six areas: 1. Relationships are the only route to learning; 2. Everything and everyone must be safe; 3. If you see a problem, the chances are it is due to separation anxiety; 4. Teachers are not parents; 5. Always relate to the child's developmental level; and last but not least, 6. Respect - everyone needs it. Just listing this outline cannot, of course, do justice to a presentation rich in understanding and experience, in practical examples and gentle humor, but it may convey the flavor of the down to earth, sensible and unromanticized approach to surviving in the stressful early childhood jobs. In its relevance for the audience, and it was deeply appreciated, it was well within the tradition of the past Workshops.

The topics covered over the years have been wide ranging indeed, but they have always represented very practical applications of child psychoanalytic knowledge and insights. Three sessions have focused on racial integration, the management of racial differences in the classroom, from toddler groups through kindergarten. Others have addressed management of anger, discipline, stress, concerns about sexual differences, dealing with the abused child and the abusing parent. Many Workshops focused on developmental aspects - the relationship between

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Hanna Perkins Center . . .

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play and work, speech development, the development of conscience, of self-respect and self-esteem, as well as on relationships - separation difficulties, working with parents, the role of the father, the teacher-pupil relationship. Fundamental classroom techniques were approached, such as the choice and management of field trips, making circle time rewarding, studying the life cycle through gardening, learning to enjoy books. This is not an all inclusive list, but a representative one.

A special aspect of the Workshops is easy to overlook. When we have annual audiences of some 200 professionals dealing with under-fives and each is responsible for from 15 to 150 children, with an average of about 40 children apiece in a conservative estimate, we have the opportunity of influencing the care of many thousands of children each

year. We call this "ripple effect," an important aspect of all our Extension Division activities.

There is another way in which our Annual Workshops reach a wider audience: All presentations have been prepared in pamphlet form which can be purchased from our Center at just \$3.00 each. A full list of the available titles and directions for ordering can be obtained by contacting Mrs. Deborah Gray at (216) 421-7880, or by writing to her at 2084 Cornell Road, Cleveland, OH 44106, FAX 216-421-8880.

Many of the Workshop presentations are also included in two books, *What Nursery School Teachers Ask Us About* (1985) and *Preschoolers: Questions and Answers* (1996), both edited by Erna Furman and published by International Universities Press. Flyers describing these books can also be obtained from Mrs. Gray. They are useful for parents and professionals.

Psychoanalysis in Finland

Erna Furman¹

This past fall the Finnish Psycho-analytical Society celebrated the 30th anniversary of its membership in the IPA, achieved, at the time, with the dedicated participation of D.W. Winnicott and Pearl S. King. This past fall, too, Dr. Robert A. Furman and I paid our sixth teaching-learning visit during the last sixteen years -- a good opportunity to share experiences and think with colleagues, to make good friends, to enjoy the cultural milieu and natural beauty of this unique northern country, and to follow its psychoanalytic developments.

The itineraries and programs of our visits reflect the marked increase in Finnish psychoanalytic endeavors over the years. On our first visit we presented papers to the Society and to its then less than ten-member child analytic group. We also gave lectures and case discussions to two psychotherapy associations, one in Helsinki, specializing in work with adolescents, one in Oulu near the Arctic Circle, focused on work with young and older adults. Both associations operate independently of the Society but were founded and taught by training analysts. Students are mental health professionals, including psychiatrists, child psychiatrists and pediatricians who have to undergo a personal analysis or intensive psychotherapy. The course extended at first over three, later over five years. Already at the time of our first visit, some psychotherapy graduates had enrolled in psychoanalytic training.

During our most recent visit, our lecturing and case consultation programs in Helsinki alone included: A much larger Psycho-analytical Society; its child analysis group numbering over seventy qualified members plus a new child psychotherapy course sponsored by them; the Adolescent Psychotherapy Association with a new branch group in Vasa (a northwestern university town) who joined our seminars; the Adolescent Psychiatry Association, largely

psychoanalytic, which had asked us to contribute papers to their 20th anniversary scientific meetings; and meetings with an excellent day-care consultant. In Oulu, the arctic site of the first psychotherapy course, we met with their now sixty four members and participants in their courses for adolescent and child psychotherapy. They have been active in consulting at the pediatric hospital, carry some treatments-via-the-parent of under-fives, and discussed with us their plans for a therapeutic mother-toddler group, following our Hanna Perkins model. In addition we work with the psychotherapy associations and course participants in the other university towns -- Turku and Tampere (southwest) and Kuopio (northeast). We usually spend two days in each center, presenting papers they have selected from our list or asked us to prepare, and discussing a couple of clinical cases with reports sent to us in advance. Some centers invite local professionals to these meetings, some reserve them for just their members.

The enthusiasm, dedication and sheer stamina of faculty and students are indeed impressive. Most teaching analysts travel hundreds of miles to and from weekend seminars. Many students travel 70 miles and more to their daily analytic sessions. Excellent train and plane service and good roads are a help, but the winter weather is not. Equally impressive are the high level of clinical work, often with difficult cases, and the ability to be in touch with feelings, an aspect much stressed in Finnish analyses. This admirable growth in analytic endeavors has surmounted the serious economic recession in the wake of the collapse of the Soviet Union, a major trading partner. It also appears unhampered by the fact that the university psychiatry departments have seen an increase in biological trends, with only one now headed by a training analyst. This has, however, led to more

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child psychiatrists enrolling in psychotherapy courses to make up for what they don't learn in their departments. Since the Society as well as the psychotherapy associations have always accepted medical and non-medical applicants, this trend is not new, nor is the fact that both forms of training have never been short of applicants and that psychotherapists are among the 10-12 candidates who apply for every available analytic candidacy.

The demand for skilled psychotherapists was prompted by lay and government recognition of the widespread need for and benefits of psychological help and by generous long-term financial support of it through the health service. The benefits to society of treating adolescents and young adults was particularly highlighted when studies showed that the cost of therapy for them is a mere third of the later cost to

society through unemployability, loss of work days and of tax payments, not to mention individual distress and its effect on the adult's family. The treatment of very disturbed adolescents is moreover greatly helped by the availability of excellent in-patient facilities for unlimited periods, allowing for the continuation of out-patient therapy during ongoing or repeated times of special stress and need. Despite cuts during the recession, many patients from all walks of life avail themselves of therapeutic help which is fully paid for for two to three years for twice-weekly sessions and receives some compensation after that.

¹This article has appeared previously in *Psychoanalysis in Cleveland* (The Newsletter of the Cleveland Psychoanalytic Society), Vol. 8, #4, p. 7, February, 1998.

The Cornerstone Therapeutic Nursery Gilbert Kliman, M.D.

1. Bringing a Psychoanalytic Project into a Public School Special Education Class:

A public school has adopted a psychoanalytic method. Gilbert Kliman, M.D., Medical Director of The Children's Psychological Trauma Center, Inc., in San Francisco, reports the Cornerstone Project has operated a therapeutic nursery in collaboration with the San Mateo County Department of Education, Special Education Division since 1995. It is believed this project is the first time that multi-weekly mental health therapy for children has been provided in a public school setting. All patients are special education "seriously emotionally disturbed" pupils, whose parents signed up for the program. During 1995 and 1996, Dr. Kliman provided the treatment himself, five times a week, right in the classroom. A school psychologist, Tish Teaford, is continuing the third year of the project at present, under Dr. Kliman's supervision.

Parent guidance is provided by teachers weekly and therapist monthly. The Cornerstone Method is unique for its provision of treatment right in the classroom. Notably, children's I.Q.s are found to rise an average of 12 points when preschoolers are treated by this method.

2. Bringing a Psychoanalytic Project to Homeless Children:

Beginning in November 1997, the Cornerstone Project began working with a classroom of seven homeless preschoolers, in collaboration with the Salvation Army. In San Francisco, where there are many homeless families, and 5000 homeless children, Dr. Kliman has established a Cornerstone Therapeutic Preschool for homeless preschoolers and parents living in the Gateway Shelter. Families can stay as long as two years, permitting weekly parent guidance and multi-weekly treatment of the

preschoolers right in the already-established preschool and day-care programs.

3. Videodocuments of a Psychoanalytic Project:

Those wishing to study videos of the San Mateo special education or the Salvation Army homeless children's Cornerstone may obtain archive films. Parents have given permission for scientific and educational use of the archives. Three Cornerstone Method training films have been created. A confidentiality agreement is required of the viewer.

4. Preschool Consortium and the Children's Psychological Trauma Center:

The Children's Psychological Trauma Center has given the Houston Psychoanalytic Institute's Steadman West Center a grant of \$5,000 to fund assessment of I.Q. changes and Achenbach Child Behavior Check List changes among preschool patients treated at the Consortium's therapeutic nurseries. A Wright Institute intern, Miquela Diaz, M.A., is also doing a doctoral thesis on the I.Q. rise phenomenon noted in Dr. Kliman's earlier Cornerstone work in New York. She would welcome data from other Centers. The San Mateo school system and a non-analytic therapeutic nursery have accepted potential comparison and control status for such studies of their preschoolers' I.Q. and behavioral check list outcomes.

For more information, write to

GilKliman@justiceforchildren.com

Letter to the ACP Executive and all Committee Chairs and Members

Dear fellow members of the ACP Executive Committee and all Committee Chairs and members,

I very much look forward to working with you and I am therefore sorry if this, my first communication with you, is a bit surprising. I hope you will first read my Newsletter message to the membership at large to understand the context which has prompted me to make some practical changes to facilitate the effective representation and cooperation of our medical and non-medical members within the administrative structure. The particular step towards this goal to be described below concerns our mid-year administrative meeting which, for many years, took place in December in New York City on the Friday of the week of the meetings of the American Psychoanalytic Association. I shall change the time and venue of this meeting and explain why and how.

According to our bylaws there is only one mandatory annual meeting. The President may call any number of additional meetings. During the first few years of our organization there was no mid-year meeting. As mid-year meetings became necessary to transact the increasing administrative load of a growing organization, our presidents and officers, most of them members of the American Psychoanalytic Association, found it convenient to schedule these meetings at the time and place where many of them would be present and where, therefore, they would incur no extra expense to take care of ACP business. It never was convenient for out-of-town non-medical members or for those not active with the American, and many of them have not attended. For them it is a distinct inconvenience to travel to New York at that time of very uncertain weather conditions, of over- congestion, and of pressing pre-holiday family needs at home. The real hardship, though, is the cost.

During the last two years I attended the mid-year meetings as president-elect. Exclusive of meals and of loss of income due to a missed working day, each trip cost me over \$1200. In order to attend the Friday, 7:45 a.m. meeting, I had to arrive Thursday evening and stay the night (single room at \$203—including tax at an especially reduced ACP rate). The airfare was almost \$800 from Cleveland, despite an early purchase rebate. It would have cost much less had I stayed over Saturday night but the extra hotel nights and meals would have cancelled that out, not to mention neglect of home commitments. Ground transportation accounted for the rest of the expenses. Non-medical child analysts do not earn enough to afford such outlays. Perhaps this is even true for the ACP as a whole: the last mid-year meeting cost \$1344.10, already a considerable reduction thanks to Dr. Jacobs's relocation of venue from the Waldorf to the Beekman.

Perhaps mid-year meetings will again become unnecessary at a future time. Right now there is a backlog of important essential items to be processed. We cannot yet do without a meeting but, to best serve the interests of the ACP,

we have to enable all administrators to participate, put the entailed expenses within reach, share them equitably, and assure effective transacting of all business.

In keeping with our bylaws, which state that "the main office of the Association shall be the office of the President then in office" (Article III., 1.), I am therefore planning the following mid-year meeting: It will take place on Saturday, October 17, 1998, 1-4 p.m. in Cleveland, Ohio. This will enable participants to arrive as late as Saturday noon and to take advantage of the Saturday overnight airfare, or to return on Saturday evening, if they prefer, without missing a working weekday. Two bed and breakfast establishments (within walking distance of the meeting place) will accept room reservations for \$117.- or \$125.- double occupancy, and both have very good restaurants either on the premises or next door. I hope, of course, that most of you will come in person, but you will have the option of attending by phone via prearranged conference call, costing you less than \$30.- per hour. Courtesy of Dr. Thomas Barrett, Hanna Perkins Director, the ACP will not be charged for the use of the meeting facilities in the Hanna Perkins building which include a receptionist and phone service, and which made this the best of several local options. The enclosed "Coming to the Mid-year Meeting 1998" page and a map provide the practical details and guidelines as well as suggestions for enjoying your stay this full color fall weekend.

To assure effective committee work, I am sending you, also enclosed, a copy of our bylaws. Please acquaint yourself with all details. Lack of such familiarity has significantly impeded deliberations, process and decisions as well as created needless hard feelings. This we should and can avoid. Note that the Executive Committee consists of the Councillors, President, Secretary, Treasurer, President-elect, Secretary-elect, 14 in all. It is their task to confirm all appointments, to receive, discuss and evaluate all Committees Chairs' reports. Note also that the President and President-elect are ex-officio members of all Committees.

Dr. Joseph S. Bierman, our Secretary, will notify you of the mid-year meeting and its agenda as specified by our bylaws, but I am asking you already now, please, to send your requisite reports to Dr. Bierman one month in advance, i.e., by September 17, 1998, so that he can distribute them to all concerned, allow the Councillors and Officers sufficient time for study and to prepare for discussion. When a number of reports are not handed in at all and others are handed out during the meeting, discussion is unproductive or impossible, with precious time wasted. Please be prompt and help us work well together.

I extend to you a warm personal welcome as well as an offer to answer your questions and to assist you as best I can. There will be "glitches" to iron out and mistakes to learn from, but I hope the new format will be helpful and provide an option future Presidents can adapt to changing locales and needs.

Erna Furman

Memo to ACP Members from the Chair of the Nominating Committee

April 15, 1998

From: Marion Gedney, Ph.D., Chair of the Nominating Committee and Erna Furman, President

Our past Nominating Committee Chair and all his Committee members have worked hard. Both of us were members of that group and have learned a great deal from and with them. We are dedicated to continuing the positives and to addressing some aspects that need improving.

Among the latter, two are our foremost goals:

1) To enlist members from *all* geographical areas and to bring more non-medical members into the administration so that the balance between medical and non-medical participants will be representative of the membership as a whole. One option for achieving this would be to pair two medical or two non-medical nominees so that the individual person's qualifications rather than his or her professional background would be compared by the electorate; for example, there could be two medical or two non-medical nominees for treasurer. Our past experience indicates that when the pairing consists of one medical and one non-medical nominee, the medical one always wins – not because he or she is necessarily the better, but because of a variety of other factors. This has also discouraged non-

medical members from accepting nominations. No organization can long survive with only half its membership being active participants. And this brings us to our second goal:

2) To involve as many members as possible in active participation. To that end we appeal to all members to come forward and let us know what office you are willing to hold and in which time period. We also encourage all members to let us know of colleagues they feel might be able to participate. Not least, we hope all of you will encourage each other to take on responsibilities in the running of this organization – working together for child analysis.

Inevitably, some will be nominated, some not (or not right away), some will win an election and some will lose, but your name on our Committee's list, not to mention your name on the ballot, will tell of your willingness to work for the ACP. Even if you lose, as your President did, it will stand you in good stead for the next time or for another spot on our shared endeavor.

The Nominating Committee members are Marion Gedney, Ph.D., Chair, Maurice Apprey, Ph.D., Werner H. Schimmelbusch, M.D., Martin A. Silverman, M.D., *ex-officio*, Erna Furman, *ex-officio*. We all join in our effort to serve well.

Our nominating report for the next election should be ready by mid-September 1998. Please contact any one of us now, give us your suggestions, work with us. Thank you!

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

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

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

Fees for overseas students are approximately \$17,000 for one year, or \$8,500 per year part-time. Application forms and further details may be obtained from

Dr. Mary Target, MSc Course Organizer,
Subdepartment of Clinical Health Psychology, UCL,
Gower St., London WC1E 6BT, UK.
☎ 011-44-171 380 7899 — fax 011-44-171 916 8502
E-mail mary.target@ucl.ac.uk.

Links Between the Anna Freud Centre and the Genootschap (Holland)

In 1993 Professor Joseph Sandler was instrumental in establishing a link between the Anna Freud Centre and what is now The Nederlands Psychoanalytisch Instituut (NPI) — best translated as the Dutch Psychoanalytic Institute. Traditionally, Holland has had two Institutes; The Nederlands Vereniging voor Psychoanalyse (NVP) in Amsterdam and the Nederlands Psychoanalytisch Genootschap (NPG) in Utrecht. Both Institutes have an important role in assessment and diagnosis, providing psychoanalytic cases for candidates where analysis is indicated and providing support for other mental health professionals through supervision and consultation. A process of amalgamation between the two Institutes was settled between 1993 and 1995.

From 1990-1993, the NPG in Utrecht had run a supervision group led by Dr H.C. Halberstadt-Freud (Member of the IPA and ACP) Following Professor Sandler's visit I was asked to run a series of eight seminars throughout 1994-1995 as a first step in establishing a child training. In 1995 the NPG officially recognised the Genootschap's new Child Psychoanalytic Programme.

The first training group consisted of 9 members: 1 adult psychiatrist, 3 child psychiatrists, 4 clinical psychologists and 1 teacher. Two members are trained as psychoanalytically oriented child psychotherapists, 5 are candidate members of the NPG, 2 are full members of the NPG and one is also a member of the ACP. The challenge was to devise a programme that would meet the needs of this already well qualified group where there was also a wide and varied range of clinical experience in different

settings. Organising the seminars and shaping the curriculum involved a process of discussion with both the Training Committee and the student group so that particular areas of interest could be met. The overall structure of the week end visits was a 5-hour seminar divided into 2 hours discussion of theoretical/clinical papers grouped around a specific topic followed by 3 hours of clinical presentation by members. The course had further input through additional seminars run by Mrs. Irene Westrop. Regular week-end seminars were run by Ms Viviane Green from 1995-1997. From September 1997 the group have been taught regularly by Dr Alex Holder from Germany.

In 1995 several members of the group attended a Study week at the Anna Freud Centre and expressed an interest in both continuing and furthering links with the Centre. In order to supplement the main training programme in Holland two intensive week-end visits were organised for the group at the Anna Freud Centre in London. The first one took place in February 1998 and focused on Under Fives and Latency. The second study week end is due to take place in June and will focus on Adolescence. Over both week-ends the participants have the opportunity to hear about the work of a variety of practicing clinicians associated with the Centre.

Both the Anna Freud Centre and the Genootschap have enjoyed this collaboration and look forward to its continuation.

Viviane Green
(Head of Clinical Training, The Anna Freud Centre)
Dr Willem Heuves
(Course Organiser, The Genootschap)

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

Director: Julia Fabricius

Head of Clinical Training: Viviane Green

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

The Course comprises

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

The Course is designed for trainees to become qualified in the field of child psychoanalysis and psychotherapy and experienced in diagnostic, consultative and applied work with children and adolescents. It leads to the qualification of Child Psychotherapist and is recognized by the Association of Child Psychotherapists for work in the National Health Service in Britain, and by the Association for Child Psychoanalysis, Inc. Plans are under way for the course to lead to a Doctorate.

Enquiries and applications should be made to:

The Head of Clinical Training
Anna Freud Centre
21 Maresfield Gardens
London NW3 5FH UK

[Leon Hoffman, Chair of our Communications Committee, suggested that we publish the following comment by Dr. Robert King regarding the recent "practice parameters" proposed by the American Academy of Child and Adolescent Psychiatry. Dr. King was kind enough to give his permission for us to reprint his message.]

As the only psychoanalyst on the Academy of Child and Adolescent Psychiatry's work group writing the Academy's Practice Parameters for the assessment and treatment of children and adolescents with various disorders, I'd like to comment on some of the recent correspondence on how analysts can influence the shape of these parameters. Although the Academy's process is substantially different than the APA's, some of the issues are recurrent ones.

Maintaining a role for psychoanalysis in the practice guidelines entails two distinct issues.

1) First is the issue of empirical data. The various practice guidelines are often over-weighted in the direction of medication or cognitive-behavioral interventions. This is not merely because of various experts' preference for these modalities (or against analysis), but because there is an extensive body of empirical data. Whatever one may think of the flaws of these studies-- too short term, symptom-oriented, ignoring the developmental context, monochromatic, etc. there are at least studies to be looked at. As analysts, we are at an extreme disadvantage when we have so few empirical studies we can point to assessing outcome. Granted that we are studying much more complex phenomena that are harder to measure, that we are interested in a broader range of outcome criteria, and that we use a method that is harder to "manualize", etc. However, we cannot simply go on citing clinical experience or the fervor of our personal (or even collective) beliefs. When it came to the Academy's guidelines on anxiety disorders in children what made it possible to maintain a role for analysis (despite some strong opposition) was the availability of two empirical studies, methodologically limited though they were: Chris Heinicke's study and the Target & Fonagy studies of outcome of several hundred cases in the Hampstead Clinic archives (the outcomes of which they reanalyzed and studied with consultation from the Yale Child Study Center). Special pleading alone simply earns the retort that we analysts have not learned that data is not the plural of anecdote. As a field we desperately need more methodologically sound outcome studies. Even if these cannot be randomized comparison studies (the "gold standard"), we can be doing more to design collaborative studies using some degree of standardized baseline and outcome measures that collectively move us ahead as a field. This is not only politically essential, but scientifically as well.

2) The second issue is a process one. The time to have an impact on a guideline is when it is being written and the place to exert that influence is from INSIDE the committee writing it. LBJ once said that the reason that he didn't want to fire J. Edgar Hoover was that "It was better to have him inside the tent pissing out, than outside the tent pissing in." We need to be inside the tent.

Having observed this process first hand, I think it is very difficult to have anything but a marginal impact at the point that guidelines get circulated to the general membership for comment. Best of all is to help write the guidelines; it is always better to write the first draft and have someone else be proposing changes than the other way around. This requires that analysts get more involved in such matters, be able cite the broader psychiatric literature and help contextualize the

analytic data within it, and immerse themselves in the endless work of committee meetings and writing that this entails. On an interpersonal level, this also helps us be a respected presence with influence with our non-analytic colleagues on the various committees, who unfortunately have decreasing working professional contact with analysts as academic and clinical peers.

Without involving ourselves on these two levels, our comments and protests will seem increasingly to our non-analytic colleagues who do the hard work of writing the guidelines not as the heroic "voice crying in the wilderness" that we like to think ourselves, but rather the quirky foibles of an eccentric distant relative.

References

- Heinicke, C., Ramsey-Klee D. (1986) Outcome of child psycho-therapy as a function of frequency of session. *Journal of the American Academy of Child Psychiatry*, 25, 247-253.
- Target M., Fonagy P. (1994). Efficacy of psychoanalysis for children with emotional disorders. *Journal of the American Academy of Child Psychiatry*, 33, 361-371.

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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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For Regular Members the sponsors must address the two areas below:

- 1 The sponsors have no knowledge of the individual's ever having contravened the ethical standards of his or her field or profession.
- 2 The sponsors should share their awareness that an individual's training has included:
 - a a personal analysis of adequate duration at a four- or five-times-per-week frequency;
 - b participation in seminars or independent study of three areas:
 - psychoanalytic principles
 - 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.

1. Sponsor's Name 2. Sponsor's Name 3. Name and address of sponsored individual 4. Type of membership	1. _____ 2. _____ 3. _____ 4. _____
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For Candidate Membership

Please address

- 1 ethical standards
- 2 training includes (or will include) all categories of training required for Regular Members (below)
- 3 nature of training program

For Regular Membership

Please address

- 1 ethical standards
- 2 personal analysis: frequency and duration
- 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

Letter to the Editor

[Dr. Jonathan Cohen sent the following commentary following the recent ACP Annual Meeting in Boston.]

On the creation of guidelines for child psychoanalytic clinical write-ups: a need and an opportunity

I was moved by Dr. Donald J. Cohen's Marianne Kris Memorial Lecture at the April, 1998 ACP meetings. Among the many important issues described, was the essential importance for child analysts to develop a set of guidelines that will allow us to collect clinical data for collaborative study. In recent years, many of us have talked and written about how the lack of systemic efforts has seriously hampered the development of our discipline (see Cohen, 1997 for a recent review).

I would like to issue an invitation to members of the Association in general and the leadership of the Association and chairs of child analytic programs in particular: that a work group or a series of work groups be created to develop guidelines for writing up clinical cases to further systematic study.

It is unrealistic to expect that there will be simple agreement about what constitutes the "best" way to do this. It is well known that there are quite divergent points of view with regard to how we can and should define clinical data (Tuckett, 1994). Nonetheless, I suggest that it is necessary and may be possible to create a minimum set of guidelines that could further our ability to discover more about the relationship between theory, goals, clinical process, modes of therapeutic action, methods and outcome.

One of the many ways in which Anna Freud took extraordinary leadership was to initiate the systematic collection of clinical data. This work created the platform for important theory building and clinical insight as well as the retrospective assessments of outcome work that has recently been done at the Anna Freud Centre (Fonagy and Target, 1996). The Profile represents one model that includes extremely detailed guidelines for organizing a case write up. Some practitioners continue to find the Profile extremely useful. My impression is that there are many today who believe that the Profile is so detailed and prescriptive that it is inadvertently cumbersome. In response to this, there has been an attempt to stream-line the Profile and create an even more reliable set of guidelines (Greenspan, Hatleberg & Cullander, 1976).

Today, many psychotherapy researchers believe that we necessarily need audio or even video recordings of the psychoanalytic process to reliably assess process and outcome. Others disagree. I believe that our field does need to collaboratively create additional modes of study to support and compliment case study findings. What is clear is that we will continue to write case reports. Case reports have always provided the foundation for learning, teaching and theory building. And, I think that they always will.

There are a number of collections of child analytic cases which may be used for study and learning: on

adolescent work (Harley, 1974); on child work (Geleerd, 1967); on the termination phase (Schmukler, 1991); on work with learning disabled youth (Rothstein & Glenn, in press); and, on child analysts who returned to analysis in adulthood (Cohen & Cohler, 1998). These kinds of collections can potentially provide a basis for clinical research and potentially enhance our capacity to recognize particular developmental and/or psychotherapeutic patterns, processes and outcomes. To the extent that we have helpful guidelines for case presentations it will enhance our ability to learn from a given case as well as collections of cases.

If it is possible to delineate a series of basic recommendations about how we need to consider writing up cases, this will further our capacity to conduct meaningful clinical research -- empirically and non-empirically -- explore, support or falsify ideas and further the essential psychoanalytic spirit of discovery.

References

- Cohen, J. (1997). Child and Adolescent Psychoanalysis: Research, Practice and Theory. *The International Journal of Psycho-Analysis*, Vol. 78, 3, 865-870.
- Cohen, J. & Cohler, B.J. (Eds.) (1998). *The Psychoanalytic Study of Lives Over Time: Clinical and Research Perspectives on Children Who Return to Treatment as Adults*. (submitted for publication consideration)
- Fonagy, P. & Target, M. (1996). Predictors of outcome in child psychoanalysis: a retrospective study of 763 cases at the Anna Freud Centre. *Journal of the American Psychoanalytic Association*, 44, 1, 27-78.
- Geleerd, E.R. (ed.) (1967). *The child analyst at work*. New York: International University Press.
- Greenspan, S.I., Hatleberg, J.L., & Cullander, C.C. H. (1976). A systematic metapsychological assessment of the personality in childhood. *Journal of the American Psychoanalytic Association*, 24 (4): 875-903.
- Harley, M. (Ed.) (1974). *The analyst and the adolescent at work*. New York: Quadrangle
- Rothstein, A. and Glenn, J. (in press). *Learning disabilities and psychic conflict: a psychoanalytic case book*. Madison, CT.: International University Press.
- Schmukler, A.G. (ed.). (1991). *Saying good-bye: a casebook of termination in child and adolescent analysis and therapy*. Analytic Press.
- Tuckett, D. (1994). The conceptualisation and communication of clinical facts in psychoanalysis. *The International Journal of Psycho-Analysis*, Vol. 75, 3, 499-520.

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Calendar of Events

June 2-6, 1998

First International Conference on Child and Adolescent Mental Health
 The Chinese University of Hong Kong
 Hong Kong, CHINA
For further information contact
 Glenda Giles
 Rydon Farmhouse
 Compton Durville South Petherton
 Somerset TA13 5ER UK
 ☎011-44-1460 242394
 FAX.....011-44-1460 242649
 E-mail.....glenda.giles@dial.pipex.com

June 13-14, 1998

British Psycho-Analytical Society
Technique in Child Psychoanalysis: Clinical Dialogues
 London, UK
For further information contact
 Mrs. Judith Jackson
 Secretary, Child and Adolescent Committee
 British Psycho-Analytic Society
 63 New Cavendish Street
 London W1M 7RD UK
 ☎011-44-171 580 4952
 FAX.....011-44-171 323 5312

June 26-28, 1998

Annual Meeting of The Child and Adolescent Institute
Diagnosis and Analysis of the Sexually Abused Child
 Aspen, Colorado, USA
For further information contact
 Jerome Karasic, M.D.
 400 Medicine Bow Road
 Aspen, Colorado 81611 USA
 ☎ (970) 923-0600
 FAX..... (970) 923-4569
 E-mail.....hldanish@rof.net

July 16-18, 1998

7th International Meeting of the International Association for the History of
 Psychoanalysis
**The Role of Women in the History of Psychoanalysis: Ideas, Practice,
 and Institutions**
 London, UK
For further information contact
 International Association for the History of Psychoanalysis
 8 rue du Commandant Mouchotte
 75014 Paris, FRANCE
 ☎011-33-1 40 47 89 33
 FAX.....011-33-1 40 47 04 49
 E-mail.....mijolla_aih@msn.com

August 2-6, 1998

14th International Congress of the International Association for Child and
 Adolescent Psychiatry and Allied Professions (IACAPAP)
 Stockholm, SWEDEN
For further information contact
 Kari Schleimer, M.D., Ph.D.
 Department of Child and Adolescent Psychiatry
 University of Lund
 S-214 01 Malmö SWEDEN
 ☎011-46-40 331 674
 FAX.....011-46-40 336 253

Autumn, 1998

The Library of Congress

Sigmund Freud: Conflict and culture

For further information contact
 Jill Brett
 ☎ 202 707-2905

October 9-11, 1998

English-Speaking Members of the European Societies
Sexuality and the Neuroses — 100 Years On
 London, UK
For further information contact
 Miss M. Garfield, Conference Secretary
 British Psycho-Analytic Society
 63 New Cavendish Street
 London W1M 7RD UK
 ☎011-44-171 580 4952
 FAX.....011-44-171 323 5312

March 25-28, 1999

European Psychoanalytic Federation
Love, Hate and Violence: Contemporary Challenge to Psychoanalysis
 Berlin, GERMANY

March 26-28, 1999

Annual Meeting of the Association for Child Psychoanalysis
 Seattle, Washington, USA
For further information contact
 Ms. Nancy Hall
 P.O. Box 253
 Ramsey, New Jersey 07446 USA
 ☎/FAX (201) 825-3138
 E-mail.....childanalysis@compuserve.com

July, 1999

41st International Psycho-Analytical Association Congress
Affect and Psychoanalysis
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 International Psychoanalytical Association
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 FAX.....011-44-181 445-4729
 E-mail.....100450.1362@compuserve.com

September 14-18, 1999

European Society for Child and Adolescent Psychiatry
 Hamburg, GERMANY

A Note to ACP Candidate Members

We have recently been chosen as ACP Candidate Councillors. There are currently 140 ACP Candidate Members (118 in the U. S. and 22 in other countries). We would like to represent your viewpoints as clearly as possible in matters concerning the ACP, and also at the bi-annual meetings of the ACP Executive Committee. Please contact either of us with your ideas, concerns, and suggestions.

Sylvia Welsh, Ph.D., 27 West 86th Street, Suite C, New York, NY 10024 ☎ 212 799-4355

Nat Donson, M.D., 185 East Palisade Avenue, Apt. A6, Englewood, NJ 07631 ☎ 201 568-5217

Errata: In Memoriam : Peter Blos, Ph.D.

The obituary for Peter Blos, Ph.D., which we published in the November, 1997 issue of the *ACP Newsletter* contained several errors which our readers have called to our attention.

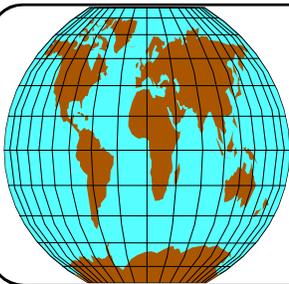
Peter Blos, Jr., M.D., wrote to thank the *Newsletter* for publishing an obituary about his father but noted that there were a number of factual errors in what we published. In order of appearance they were:

1. He wrote five books on adolescence: *The Adolescent Personality* (1941), *On Adolescence* (1962), *Young Adolescent* (1970), *The Adolescent Passage* (1979), and *Son and Father* (1985).
2. His paper, "The Second Individual Process of Adolescence," did not first appear in *The Adolescent Passage* (1979) as implied. The paper was included in this book which was a selection of previously published papers (19) which my father considered to be his best and to which he added reflective comment. The paper first appeared in 1967 in the *Psychoanalytic Study of the Child*, 22, 162-186.
3. His first wife, Merta Gröne, died in 1978 (not 1979).
4. His surviving wife is Betsy Thomas Blos, Ph.D., not Bessy
5. From the content of the obituary it would appear that much of it was taken from the *New York Times* obituary page of June 19, 1997, and it should be so acknowledged.

John Munder Ross, Ph.D., asked that we clarify some of

the remarks which were attributed to him regarding Dr. Blos' views on the relationships between fathers and sons. Regarding Dr. Blos' involvement with a major foundation-backed study of adolescence, Dr. Ross wrote:

It was this work along with his previous experience that helped form the basis for his ideas on the subject. Many of these ideas, written in papers spanning a period of 30 years, were published in *The Adolescent Passage* (1979). Dr. Blos in his last book, *Son and Father* (1985) focused on the importance of pre-oedipal, dyadic son-father attachment and its resolution as part of normative development in adolescence. Like the ideas from his earlier work, those in *Son and Father* rang true, said Dr. John Munder Ross, an author and training analyst at Columbia. "The failure to relinquish the profound, pre-oedipal primal tie to the father during its reactivation in adolescence is a critical factor in the genesis of adult personality disorder in men in their 20's," he added, "and those who are foundering have never given up their illusion of father as omnipotent rescuer."



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