



## FROM YOUR DIRECTOR

PHYLLIS COHEN, PH.D.

*Dear Friends and Colleagues,*

*I want to take this opportunity to thank each and every one of you for your support of NYIPT. This past year has been wonderfully successful, and we expect that 2007 will be even better!*

I would like to tell you about the new and exciting projects on our agenda, which we are proud to be offering:

During this past year we partnered with The Opportunity Charter School in Harlem, and have already started training its social workers who provide mental health services to troubled children. These professionals play a critical role in helping the students address their mental health problems and encouraging them to stay in school and continue learning. Many of these children are in foster care and some are even homeless. As a result of our training, the social workers at the Opportunity Charter School will improve their skills, and thanks to your contributions we will be able to continue our mission.

In addition, this year we started a project to provide training to mental health workers and interns at the Administration for Children's Services. These are people who work with New York City's most seriously abused and abandoned children and with runaway teens (See articles on our collaboration with ACS). In this newsletter we have excerpts from talks presented by **Gloria Malter** and **Tracy Simon** to help ACS workers better relate to the traumatized children that they see on a daily basis.

In the five years since receiving our charter, NYIPT's faculty has supervised candidates who have provided over 18,000 hours of psychotherapy services for needy children and their parents. NYIPT's graduates have continued to work as administrators in programs that are helping children. Most of our graduates have gone on to train and supervise other mental health professionals, thus helping more and more children

each year. NYIPT is proud that our program has created a chain effect of training mental health workers to be the best professionals they can be! We are happy to be continuing our original mission: to provide training for therapists who work in New York City Public Schools and Community Mental Health Agencies, people who are providing mental health services to hundreds of children each year.

In this newsletter, you will read about our work with  
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# THE NEW YORK INSTITUTE FOR PSYCHOTHERAPY TRAINING

*IN INFANCY, CHILDHOOD AND ADOLESCENCE*

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The New York Institute for Psychotherapy Training (N.Y.I.P.T., Inc.) for Infants, Children and Adolescents, is dedicated to improving the quality of mental health services for children in need of all ages and their families who live in the New York City area. We realize our mission by providing psychotherapy training for qualified mental health professionals.

Our three-year program has a psychoanalytic orientation that integrates contemporary neuro-psycho-social theory and research with clinical technique. We are committed to providing this training at a nominal cost to professionals who are interested in working with infants, children and adolescents, or are already working with this population

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## FROM THE EDITOR KAREN CADWALADER, L.C.S.W.

*This is the fifth edition of NYIPT TODAY and marks the sixth anniversary of the program. This edition reflects the diversity of interest of our community and also marks the commitment that each of us feels toward the NYIPT mission of providing psychotherapy training that improves the quality of mental health services for children and their families.*

We hope that this edition will encourage more and more faculty, candidates and graduates to contribute and share their experiences in the next publication. If you are interested in participating, please contact Karen Cadwalader at (607) 547-1951 or [kcadwalader@stny.rr.com](mailto:kcadwalader@stny.rr.com).

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*Please keep us informed of your personal and professional happenings. If you are presenting at a workshop or conference, please send us the specifics to include in our newsletter, emails and web site.*

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## FROM YOUR DIRECTOR

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needy children. First, our Clinical Coordinator **Carole Grand** describes her work with a troubled boy and her interventions with his parents, which seemed to change the trajectory of his life in a profound way. Next, **Hannah Hahn** describes the importance of the therapeutic relationship as illustrated by her treatment of a five-year-old boy. We can all learn from the experience of our esteemed and well-seasoned matriarch, **Jeanette Levitt**, as she takes a historical look at the field of child therapy from the 1930s to the present. She suggests that we have come full circle in terms of what we need to do to respond to the needs of children in therapy today. We have another opportunity to rethink history as **Teri Schwartz** presents us with a noted scholar's talk on the first child therapy case treated by the father of psychoanalysis, Sigmund Freud.

Many of us at NYIPT have been influenced by another major thinker, Dr. Michael Eigen. He has made a major impact in the world of psychoanalysis. We are happy to publish excerpts from an interview that **Regina Monti** conducted with him. Other articles include: **Jane Buckwalter** looking into the lyrics of hip-hop artist Eminem as she gives us some ideas about the meaning of his music; **Martha Herman** giving us her insight on Asperger's Syndrome with suggestions for therapists, teachers and parents on ways to connect with these children; a look at the development of a professional from our graduate **Susan Caputo**; and some comments from our graduates.

We are all proud to be part of the NYIPT program and of the contributors to this Newsletter. I hope you will enjoy reading it.

My best wishes for a healthy new year,

*Phyllis*

## NYIPT WELCOMES GAIL GARTENSTEIN TO THE BOARD OF DIRECTORS

*NYIPT is proud to welcome Gail Gartenstein as the newest member of our Board of Directors. Gail helped make our fundraiser the great success that it was, not only in securing in-kind and food donations, but also in preparing the beautifully displayed raffle baskets, and in bringing in many interested people who supported our cause.*

## NYIPT PARTNERS WITH A CHARTER SCHOOL IN HARLEM

In the spring of 2006 NYIPT Director Phyllis Cohen and Board Member Robin Ashman met with Mr. Lenny Goldberg, principal of the Opportunity Charter School in Harlem, to talk about ways that we might work together to mutually benefit both organizations and ultimately help the children at the school. At that meeting, NYIPT agreed to provide training to the school's social workers who provide mental health services to the school's troubled children. In September 2006, our collaboration began with future plans of expanding our training to help teachers and parents better relate to the students and guide them in their education.

## NYIPT INVITED TO PRESENT WORKSHOPS FOR ACS PROJECT STAY

In 2006, we developed a working relationship with the Administration for Children's Services (ACS). We agreed to provide training for ACS workers who interact with New York City's most deprived and abused children on a daily basis. Following our first training workshop at ACS, NYIPT was asked by Project Stay Coordinator Olatunde Olusesi to conduct a series of training workshops for the staff workers and interns at ACS Project Stay. Project Stay targets runaway foster youth, and many of the staff assigned to help these children lack the training that they need to make a difference. NYIPT was awarded a small grant for this training by the foundation of New Yorkers for Children.

Under the leadership of Tracy Simon, workshops were designed to help the staff understand the issues related to abandonment by birth parents, adjustment to adoptive parents and foster parents, and facilitation of a better fit for these kids in their foster homes. Some of the workshop topics included: who are the teen runaways and what are their needs?; how to work with teen symptoms of trauma including regression, aggression and avoidance; and how to gain support from larger systems in the community, agencies, schools and extended families. NYIPT faculty members Winslow Carrington, Bill Salton and Tracy Simon are leading these workshops and the feedback has been very positive. We are looking forward to continuing our work with ACS.

## THE STORY OF MICHAEL CAROLE GRAND, PH.D.

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*In the following case vignette, our Clinical Coordinator, Dr. Carole Grand, talks about how her work with a 9-year-old boy and her interventions with his parents enabled him to develop new options for himself.*

*Michael was a very boyish, appealing nine-year-old with a slender but athletic build. His parents expressed concern about his development because he avoided playing with boys in school and his good friends were all girls. His dad was a six-foot, pleasant looking High School teacher with a gentle manner. His mom was a math teacher, very competent and somewhat masculine in appearance.*

In the beginning of therapy Michael spoke freely about his feelings, his friends, his after-school sports activities and his hobbies. He sat in my chair with one leg over the arm of it, and I listened, sitting on the couch. Although he said he preferred playing games with me, he usually talked so long that we had little time left for games.

Early on it became clear that Michael's gender identification was very confused. One day he brought his knitting to the sessions telling me proudly that his grandmother had taught him to knit. With his parents' approval, he also brought his knitting to school. In one session, Michael told me that he thought it was better to be a boy because "boys could stand up when they pee although girls could wear pretty dresses. Also, girls have to give birth to babies and that is very painful." In other sessions, Michael spoke about not liking to play with the boys in the schoolyard "because they fight too much."

During one pivotal parent session, about four months into Michael's therapy, his dad described, somewhat guiltily, the rages he would fly into when he lost his temper. He felt that Michael must be afraid of his angry outbursts since he was a big man and was usually soft-spoken in his interaction with his son. In that same session, when Michael's mom began to describe her relationship with her father, her eyes began to redden. With great difficulty, she tried to hold back tears and keep control of her voice. When I drew attention to the intensity of her reaction, she was able to acknowledge the fear she has had since Michael was born. She was always afraid that her son might turn out like her father, who was an angry, aggressive man who hit his children and terrified her throughout her childhood.

Michael's mom and dad had no trouble seeing the

links between their issues and their son's fear of his own aggressive feelings and resulting problems identifying with the masculine world. In subsequent sessions with Michael, I raised the topic of his dad's anger and how scary that can be to children. Michael described the things he did to avoid his dad getting into one of "his tempers," and he confirmed that he was afraid of his dad at those times. The insight gained by the mom had allowed her to modify her reactions to Michael's aggressiveness and, when necessary, she was able to accept his getting angry at something she did.

Gradually, Michael became more comfortable expressing his angry feelings at home and he began to be more aggressive with his peers. It did not take long before Michael lost interest in his knitting and he began to talk about a boy in school who had become his friend. He was now able to spend time in the schoolyard joining in the rough and tumble play with the other boys. In his therapy Michael re-connected with the masculine part of his personality, a part that had been so conflicted for him. When Michael terminated treatment a few months later, he had become a boy with dirty knees from soccer who was becoming popular in the schoolyard!

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## NYIPT CELEBRATES IT'S 5<sup>TH</sup> ANNIVERSARY

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To show our appreciation of the support we have received, and to celebrate the completion of five years as NYIPT, we hosted a wonderful party on June 25, 2006 at the Wyckoff-Bennett Homestead in Brooklyn, New York. Owned by Board Member Annette Mont and her husband Stu, this Dutch colonial farmhouse was built prior to 1766 and is filled with antiques. Annette invited us to "step back in time for a rare opportunity to spend a memorable evening in a historic landmark." Annette and Stu were our gracious hosts, and NYIPT supervisor Jane Buckwalter provided us with wonderful classical music performed by a flute trio of gifted musicians including Jane herself.

## A SAFE PLACE TO STAND: THE HOLDING ENVIRONMENT WITH CHILD PATIENTS AND THEIR PARENTS HANNAH HAHN, PH.D.

*NYIPT faculty Hannah Hahn has written and presented an interesting paper on how child therapists create and provide a therapeutic environment for their patients. She gives us a wonderful case example of her work with a child who was being pulled apart by his warring parents. The paper in its entirety is on our web site but we have included some excerpts below.*

*Much of what we do in child psychotherapy, both with the patient and with the patient's parents, involves "holding." The metaphor of the holding environment was first used by Donald Winnicott. It refers to how the therapist attends to, listens to, understands, and, accepts what the patient brings, however difficult or disturbing, without retaliating. The holding environment can be thought of as providing both safety and attunement.*

Because with child patients we rely more on the noninterpretive, nonverbal aspects of the therapeutic endeavor, with children "holding" constitutes an important avenue for therapeutic change. The holding environment can also be a useful therapeutic stance in working with parents.

***Working with child patients and their parents requires that in some way we split our allegiances. In order to work effectively and empathically with a child patient, we must temporarily identify with him or her. Moreover, in order to form a working alliance with the child's parents, we must be able to put ourselves in their shoes.***

In psychotherapy sessions with young children, we are affirming, accepting, attending to, and understanding at the same time that we are processing the meaning of their play. Doing so enables us to know how to understand them, and to respond to them in a therapeutic manner.

Working with child patients and their parents requires that in some way we split our allegiances. In order to work effectively and empathically with a child patient, we must temporarily identify with him or her. Moreover, in order to form a working alliance with the child's parents, we must be able to put ourselves in their shoes. Because of this, we are very likely to have countertransference feelings about the parents. The use of the metaphor of the holding environment can be

applied with difficult or hostile parents. It is a way to help parents who at some level feel themselves to be in a painful emotional predicament to feel safe.

### CASE PRESENTATION

In the case of Fritz, a five-and-one-half year old whose separated parents treated him like "Solomon's baby," liable to be cut in half, "holding" proved a helpful approach not only in working with this disturbed child, but also in working with his difficult, estranged parents. Fritz's separated parents had opposite styles as individuals and as parents, and could agree on nothing for the good of their child. Fritz experienced immense rage and acted out physically due to the intolerable bind in which he found himself, a bind which was the result of parents pulling him in different directions. When he began treatment, Fritz spent several days with each parent every week (he had to switch homes at least twice a week).

Fritz's father, Morris, was controlling with everyone. His mother, Hetty, was rebellious, had low self-esteem, and a "laissez faire" attitude. Fritz's parents could not talk at all and even though they had been separated for over two years, they had still not been able to agree on the terms of a divorce. Because Fritz's mother was a student, his father paid for the entire treatment, as well as for many of his former wife's expenses.

In their interactions around Fritz, Morris would say, "it's this way" or, "I won't pay for it." Hetty would then strike back, refusing to give in to Morris' demands or giving ultimatums of her own. Morris behaved provocatively toward Hetty and ~~she~~, in reaction, she became more and more irrational. Much of Fritz's anger arose from being caught between his parents' opposite ways of doing things:— ~~if~~, for example, his father were to say, "change your clothes," his mother inevitably told him not to do so.

Before seeing Fritz, his father requested that I meet with his parents together, because, without

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## A SAFE PLACE TO STAND: THE HOLDING ENVIRONMENT WITH CHILD PATIENTS AND THEIR PARENTS

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mediation, they could not talk at all. As the child's Therapist. I understood this request as a bid for "holding." The initial sessions were distinguished by bitter arguments. My response was to tell Fritz's parents that I would recognize each of them; I added, however, that their fighting with each other would stop Fritz from getting the help that he needed.

When I met Fritz, he was intelligent, mischievous, energetic, and angry. He immediately played a noisy game of war. He blew things up, simulating explosions, rockets bursting into the air, and multiple killings, portraying a war of everyone against everyone; this seemed to mirror the war in which his parents were constantly engaged. His fierce aggression seemed somehow gleeful. Fritz dumped all my crayons and markers at the end of the first session.

During the early months of the treatment, Fritz's energetic wars continued. He repeatedly said, "I'm tough," reflecting his fierce attitude. He soon began to order me around, telling me how to set up his games. Sometimes he ran around the clinic.

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*My countertransference during my initial sessions with Fritz included worries about my ability to handle him. Did I have enough energy for him? Responding to the aspect of sadism in his aggression, I wondered whether he would attack me.*

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In sessions Fritz began to describe himself to me as "tricky," as well as "tough." During one session he made "powerful" balls from Play-doh, announcing that they were so powerful that they could "do anything." He then threw them very hard against the wall. Next he emptied a whole can of yellow Play-doh, flattened it, stepped on it, and threw it. During many sessions, he cheated at games, a pattern that continued throughout the treatment. In one session he stated, "I'm special. I'm fast at games. I win most of the time."

My countertransference during my initial sessions with Fritz included worries about my ability to handle him. Did I have enough energy for him? Responding to the aspect of sadism in his aggression, I wondered whether he would attack me. I knew my job was to live with and process these worries so that I could provide a safe and secure holding environment for Fritz. By doing so, I allowed him to expose the feelings and conflicts generated by living with his parents' war. My

attempt was to provide a safe space in which Fritz could order me around and in which his wildness would be accepted and contained. This was, however, very hard work; it was at times overwhelming. I sometimes felt angry at Fritz, as I absorbed his sadistic aggression. It was a challenge to process both Fritz's rage and my angry reactions so that I could continue to "hold" him.

Fritz tried to find ways to behave powerfully in sessions. During one session, we played basketball (the waste paper basket was our basket); when it was my turn with the ball, he turned "tricky" and moved the basket; later he moved the basket by putting it on his head and dodging whenever I threw the ball.

As our work progressed, Fritz and I began to have some therapeutic verbal interaction, much of it in connection with the "Talking, Feeling, Doing Game." He told me that he did not like his father yelling at him. Later, in response to a game prompt about a child hearing fighting, I said, "a child's mother and father are fighting about what days they'll have him, and the child feels bad." Fritz agreed that his parents argued about that.

Throughout the treatment, Hetty and Morris acted-out. For example, in working on a custody agreement, Hetty refused Morris joint custody—which she actually wanted—because he would not pay for a summer program for Fritz which she had chosen (he preferred a different program). This type of disagreement was, in fact, routine between Morris and Hetty.

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*Because of Morris' frightening degree of anger, "holding" with him meant using a great deal of discipline to exclude my subjectivity. Yet, at the same time, "holding" with Morris dictated that I provide a space in which he could expose his hate and his rage.*

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As I worked with Fritz, I also met with his parents individually. At times the sessions were peaceful. During such sessions, I actually felt sympathetic toward each of them.

In one difficult session with Morris, he demanded that Fritz spend an additional day per week with him, rather than with Hetty. He felt that it was absolutely crucial that he enroll Fritz in an after-school

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A SAFE PLACE TO STAND: THE HOLDING ENVIRONMENT WITH CHILD PATIENTS AND THEIR PARENTS

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enrichment program on that extra day and that Hetty would refuse this program on her day. He angrily stated, "I'll take it all the way to the Supreme Court." I tried to point out that Fritz was being torn apart by such battles. I felt furious at Morris at that moment, but did my best not to respond angrily to him. Because of Morris' frightening degree of anger, "holding" with him meant using a great deal of self-discipline to exclude my subjectivity. Yet, at the same time, "holding" with Morris dictated that I provide a space in which he could expose his hate and his rage.

During one session, Hetty told me that she felt criticized for not being firm enough with Fritz, countering, "But I am firm:" At this point I needed to hear her feelings on this issue, rather than to help her provide more structure for Fritz. In order to work with Hetty, I needed to walk a fine line between excluding my subjectivity and offering much-needed reasonable parenting advice.

*providing a "holding" environment—rather than offering interpretation—is important to the therapeutic action.*

During the first year of the treatment, Fritz did better both at home and at school. This did not continue, however. Hetty threatened to move to an unsafe neighborhood in order to lower her rent. This was an attempt to loosen the financial strings which kept her tied to Morris, and the process began which would further pull Fritz apart and prove disastrous for the family. Morris was determined that Hetty not move to this unsafe neighborhood.

When Hetty indeed went forward with her move, Morris became increasingly anxious, controlling, and angry. The situation between the two of them worsened and Fritz began to deteriorate. In the last few months of the two-year treatment Fritz was generally more out of control both in sessions and outside. When the situation between Hetty and Morris had reached a crisis (Morris was threatening to end the treatment because he felt all Fritz's problems had to do with Hetty's move), I decided to meet with the two together one more time. Although the two were able to cooperate somewhat on a plan to reward Fritz for good behavior at school, the session did little good.

Finally, because he could not force Hetty to leave

Morris ended the treatment by refusing to pay for it. In our last session, Fritz and I had a good interchange. While playing the Talking, Feeling, Doing Game, I said, "This girl is crying because her parents fight all the time." "Like me," he responded.

**CONCLUSIONS**

It is my hypothesis that in child treatment, providing a "holding" environment—rather than offering interpretation—is important to the therapeutic action. In child psychotherapy, "holding" functions both as a mode of receiving what it is that the child is trying to communicate and, in addition, as a mode of responding therapeutically to the child.

The use of the "holding environment" is also crucial with difficult or hostile parents of child psychotherapy patients. "Holding" with a parent aims to protect the treatment relationship with the child, rather than provide individual therapy for the parent.

What distinguished the case of Fritz from other child psychotherapy cases was the level of anger that Fritz, Morris, and Hetty all experienced toward one another and in the treatment room. I have found pervasive anger in child patients to be relatively common. However, the degree of anger that these parents experienced toward one another—which both caused them to treat Fritz like "Solomon's baby" and contributed to Fritz's own intense anger—was unique.

As a therapist I tried to provide a safe space in which Fritz could expose his rage, his powerlessness, and his fantasies. Of note is that, in holding Fritz's intense emotions, I had to at times hold my own intense reactions to them. That I accepted, understood, and validated Fritz's rage, rather than punishing it, was important. That I could "experience his anger with him" and communicate to him that I understood its source in his life with his parents, I hope helped him to feel supported. What helped therapeutically with Fritz? I believe that the holding environment played a role in three interrelated functions that led to therapeutic change: the experience of a new object (the therapist); attunement, and the feeling of safety.

REFERENCES AND FOOTNOTES

Available on our web site [www.nyipt.org](http://www.nyipt.org) in the original article.

## A "NEW" DIMENSION IN CHILD THERAPY

### JEANETTE LEVITT, M.A.

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*In light of the serious problems facing children today, and from the historical perspective of a well-seasoned analytic thinker, Jeanette's article discusses how the work of a child therapist, informed by the writers of the 1930's, has gone full circle – from a social work/case work approach in the 1950's to a more psychoanalytic approach in the 1970's, and back to the original approach of the 1950's in contemporary society.*

*Thirty-three years later, the present NYIPT child therapy program is the thriving grandchild of the program I organized in 1973 at the New Hope Guild Center using psychoanalytic principles to treat emotionally disturbed children.*

The wonderful background of theory and practice in child therapy afforded to us by the great contributors of the 1930's has remained the solid rock upon which we have been able to continue our work today.

The use of Freudian psychoanalysis for adults was expanded to more specifically treat the problems of the child by Melanie Klein, Anna Freud, Donald Winnicott, Margaret Mahler, Fred Pine and Anni Bergman, among others. It is through their work that we can now apply such theoretical concepts as the primary and secondary process, the early oceanic feeling, the paranoid schizoid and depressive positions, the ego and mechanisms of defense, transitional objects, symbiosis and individuation, and so on. We now work with transference and countertransference and we have come to know the developmental lines to understand special problems from infancy to adolescence. In addition, we have been able to gain the cooperative ego of parents who are seen in monthly collateral visits to supplement the child's weekly sessions.

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*We are now in a position to re-evaluate all the old accepted notions of the relative balance between the psyche and the soma, between the influences of each in these cases and to choose the right road to travel.*

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Today we are faced with difficult problems, such as physical and sexual child abuse, drug addiction and mental disturbances in both birth and foster parents, and severely unstable home environments. We can no longer be principally concerned with the child's psychic stress. In these extreme cases, the reality-unreality balance has tipped toward the soma-psychic response to physical abuse. Projective identification with an internalized persecutory object may still operate in the

psyche, but grounds for persecutory feelings in abuse cases have a reality base. The post traumatic stress syndrome has a history which cannot be dealt with by a purely psychoanalytic approach.

We are now in a position to re-evaluate the old accepted notions of the relative balance between the psyche and the soma, between the influences of each in these cases and to choose the right road to travel. What are these accepted notions?

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*Freud's hope for a curative therapy for all mankind was "to fuse the copper of suggestion with the gold of psychoanalysis."*

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It has astonished me to find so many paradoxes involved. For example: there is no dichotomy between mind and body. Post Freudians have found the opposite to be true. The "Existential Paradox" tells us that the mind is symbolic and functions with a psychic awareness of self, whereas the body is creature-like and finite. But before we get to "finite" we have the whole story beginning with Freud's discovery that in "conversion hysteria" unresolved fantasies could produce a body symptom with no anatomical defect. Other symptoms involved with reality-unreality problems were classified as psychosomatic, and when they appeared in children they were successfully treated by Melitta Sperling. Winnicott believed that the tolerance of illusion is necessary for the formation of a transitional object and for a true self to develop. On the other hand, Melanie Klein used only psychoanalytic theory to treat two very young brothers who were sexually acting-out with each other and they were treated by interpreting the sadism and masochism involved.

Further development in areas specifically related to child therapy brings us to an appreciation of Mike Eigen and his understanding of Wilfred Bion whose ideas opened the psychoanalytic door to the unconscious communication between mother and child called "content and container."

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## A "NEW" DIMENSION IN CHILD THERAPY

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The gist of these paradoxes highlights the reality-unreality problem as a psychoanalytic conundrum and one for psychoanalysts to resolve as it relates to neuroses and psychoses. But what is the relevance for the physically abused child?

The opportunity afforded me as a supervisor of therapists working with today's abused children, gives me direct access to their history as a presenting problem and how the needs of these patients deviate from the formerly accepted "psychoanalytic treatment" model. How can we use a "band aid" for bruises sustained in abuse cases?

Freud's hope for a curative therapy for all mankind was "to fuse the copper of suggestion with the gold of psychoanalysis." But he lived in a world of "Civilization and its Discontents" where all people were considered as living in the civilized mold. We are now living in another world – that of globalization and its terrors. We recognize child abuse as one of its manifestations. It seems important that we look back now so we can see the huge disparity between "the then and the now," and its relevance for the new picture of child therapy today.

In the world of the 1970's the psychoanalytically based treatment of children was carried out in the expectable environment of a cooperatively oriented parental involvement. It was within this setting that the parent and child therapist could work together so advantageously for the child. A scrutiny of today's cases reveals that these favorable conditions can no longer prevail. In their place, we have chaos, both in terms of living conditions and parenting.

In many of these cases, the child's parents were born and raised outside of the United States. They talk about their early years as troublesome and how they had to cope with life in places like Puerto Rico, Jamaica, Trinidad and Mexico. Many have struggled with overwhelming trauma, and psychoanalytic language and concepts are new to them. Disaster, in one form or another has led to their present turmoil. In one recent sexual abuse case, the father is a vagrant living in the street and found to have criminal intentions. The foster mother in another case takes in children as a money-making proposition. It is not uncommon in today's cases to find parents who are homicidal, suicidal, and/or addicted to alcohol and drugs. Many parents are unavailable for monthly collateral sessions with the child therapists.

On the other hand, the child coming for treatment

is very much like the 70's child – transferentially interacting and psychoanalytically available. The result is a need for a two-pronged approach; on the one hand, to "fix" the needs of the parents and on the other, to attend to the needs of the child. We have to agree with Freud that a "suggestion" technique might be a fitting adjunct to psychoanalysis in these instances.

Our past experience with psychoanalytic techniques still serves us well where we can effectively use them, but something else has to be introduced to deal with cases where the environment is so chaotic.

What to do can only be worked out with a better understanding of what we are "supposed to be" doing by the parents who bring the children in the first place. Their attitude sometimes suggests that we're in business here to correct the "naughty child." We get paid for it – sometimes by them or mostly by the government. It's purely a business where they're doing their part by bringing the child, and they say, "now go ahead and do yours."

Where any indication of an opening into a better self-adjustment in the parent exists, we can hope to work more psychoanalytically with them as we have in the past.

But to deal with damaged bonds experienced by the abused growing child, I have found Mike Eigen's reference to be helpful in his book on "Damaged Bonds." It is not possible to remove the damage to self by removing the "damage" object (e.g. residues of a depressed or psychotic or abusive parent); the damage is done. The only resource that remains for us is a preventive one; to prevent further damage by improving some of the environmental chaos in the here-and-now.

Traditional social work case-intervention certainly would seem to hold promise as our elusive "band aid." We need the expertise of our traditional case workers to come to grips with deplorable living conditions, with family counseling with any of the home corrections where needed - even in the preservation of life itself where criminal intent is openly displayed and in need of legal mandates .

In view of the foregoing, social work/case work where needed would seem to be a viable new dimension in child therapy today on an equal footing with psychoanalytic technique for those cases where extreme abuse occurs.

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## AGGRESSION AS AN OUTCOME OF TRAUMA NYIPT WORKSHOP AT ACS GLORIA MALTER, L.C.S.W. AND TRACY SIMON, PSY.D.

*On July 12, 2006 NYIPT conducted a training workshop with mental health workers at the Administration for Children's Services (ACS). These workers see children who have been taken from their homes and are awaiting foster care placement.*

*Donna Smith, Director at ACS and NYIPT Candidate, oriented us to the activities, needs and problems at the agency. She explained that many of the children seen at ACS have been victims of trauma and appear to be very angry or aggressive. Our workshop on how to understand and manage children's aggression was greatly needed.*

*As part of the training we broke into small groups and some of our candidates, graduates and faculty served as facilitators, helping the workers speak about their own personal worries, angers and concerns so that they could better relate to the children on the job. We even added an exercise on stress management at the end of the session to help the workers take care of themselves!*

*In reaction to the small groups NYIPT Graduate Nneka Njedeka said:*

*"Initially I expected the staff to speak at length about the children they worked with on a daily basis and the various traumas they have been exposed to. However the ACS group I volunteered with spoke in detail about the traumas they experienced during their childhood and it turned into a support group for ACS staff. During the group I realized the extreme importance for ACS staff to have ongoing support and therapeutic training."*

*The following two articles are excerpts from talks by Gloria Malter and Tracy Simon that were presented at ACS. The original talks are on our web site at [www.nyipt.org](http://www.nyipt.org). These adaptations are not for publication or copy.*

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EXCERPTS FROM  
AGGRESSION AS AN OUTCOME OF TRAUMA:  
**CLINICAL INTERVENTIONS**  
GLORIA MALTER, L.C.S.W.

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*All of you at ACS live with trauma on a daily basis through your contact with traumatized children. Trauma can be a sudden event or it can occur over time. Some of the children we see have been hit, burned, starved, misused, abandoned, or may have watched their mother being beaten, which, in effect, means they have also been beaten.*

Many of the children you see have been subjected to intense emotional stress during critical periods of early brain development and personality formation. The experience of trauma causes structural change and injury to the brain and it causes emotional disturbances which are prolonged for some time.

Aggression is one possible outcome of trauma, and I understand the most troubling, if not overwhelming, consequence you are faced with at ACS. Repeatedly traumatized children often experience PTSD and when feeling anxious may automatically freeze. Those of us who are interacting with these children can easily view them as oppositional or defiant when they do not

answer or respond to our requests or they may actually be physically volatile and aggressive toward themselves and/or others. When dealing with traumatized children we must protect ourselves in this stressful environment before we can help them.

Ms. Smith told me of a 15-year-old girl who recently became so wild and out of control with rage and hate that it took several police officers to restrain her and tie her down. While this particular situation may have been unavoidable, sometimes it may be possible to short-circuit or avoid the explosive event by being tuned-in to cues from the child that may indicate that his or her rage may be building. For example, if you notice signs of agitation in the child, such as leg-shaking or other compulsive discharging of energy, you might say to the client, "Maybe I'm talking too much. I'll stop talking for a while. Is that alright?" This offers the child an opportunity to cool down in his or her own time. After allowing "sufficient" time, you might then ask, "Are you okay to continue our conversation now or do you need to wait a little longer?"

We would not be so presumptuous as to come here and say, "Here, this will solve your problem tonight." What we can hope to accomplish in this workshop is to present a mind-set that can be productive in searching for ways to manage and help these difficult children:

*continued on pg. 11*

EXCERPTS FROM  
AGGRESSION AS AN OUTCOME OF TRAUMA:

**CLINICAL INTERVENTIONS**

*continued from pg. 10*

1. *We must offer them complete protection from traumatic handling by any personnel associated with the facility. This must be guaranteed. No one in the facility can afford to duplicate traumatic handling that has occurred in previous life situations, handling that has contributed to the creation of the child's disturbance pattern.*

2. *We must provide age-appropriate activities in a caring manner. In addition, all offerings must be absolutely divorced from any consideration as to whether the child deserves them or not from the point of view of his behavior.*

3. *We must develop tolerance for the child's symptoms and give leeway for regression. This must be an intrinsic part of the environment. Techniques must be developed for purposes of protective interference on the part of the staff in moments when the overflow of excitement and stimulation involved in some behavior will force the child into overwhelming guilt, anxiety, fear, depression, or rage.*

(Adapted from *Children Who Hate* by Redl and Wineman)

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EXCERPTS FROM  
AGGRESSION AS AN OUTCOME OF TRAUMA:  
**DISCUSSION OF MALTER'S PAPER**  
**TRACY SIMON, PSY.D.**

*As Ms. Malter illustrated in her wonderful paper entitled, Aggression as an Outcome of Trauma, children removed from the home due to parental neglect or abuse experience trauma at multiple levels and often transmit their trauma onto others. These children, harmed by those who are supposed to protect them, come to ACS with fear, anger, uncertainty, self blame, and isolation. Aggression is one response to trauma that often creates anger and frustration in others, thus repelling caregivers and repeating the trauma of feeling unloved.*

Ms. Malter described and our small group discussions highlighted, that children's trauma is often transmitted to care providers. As providers, we can

both identify with these children based on our own experience of trauma or through the child transmitting their feelings onto us. As service providers, it is our job to receive, hold onto, and name these feelings for the child.

Traumatized children often use projection and, as child care providers, we are constantly the receptacle for children's projections and intolerable emotions. We can come to know and empathize with a child's experience by becoming aware of our own thoughts and feelings while sitting with a child. Via countertransference reactions, we become aware of the child's experience, which most often includes feeling sad, hopeless, scared, hated, abandoned, alone or unloved.

As Ms. Malter discussed, when a child is feeling vulnerable, threatened or pushed by you in the interview, we can assume they have been pushed before, whether physically or emotionally, and it is your job to slow it down, name the feeling, and adjust the pace, tone and questioning of the interview accordingly. In therapy we have the privilege of getting to know the patient over time, but at ACS, service providers have only a few hours in the middle of a crisis, so there will be heightened emotions for everyone. However, it is our job as the adults and the safe providers to hold onto the feelings the child cannot, without attacking back or repeating the abuse the child already experienced.

Some useful clinical techniques for interviewing traumatized children include talking about events in a factual, open and honest, but structured way. Find out what the child thinks and feels. Many children have distorted information and make false assumptions, such as self blame for being removed from the home. Take the child's lead; let the child ask questions, which may need to be repeated many times in different contexts without without feeling as if you must know all answers to all questions.

Caregivers of these children should continually reassure them about their safety and decrease traumatic stimuli by attempting to create a calm, soothing environment. Anticipate increased emotional and behavioral problems, including regression and aggression, which often resolve with reassurance, patience, and nurturing. Additionally, caregiver's reactions influence the child and children respond to the emotional intensity around them. Therefore, it is important to monitor your own hate, rage, and frustration. Finally, it is important for care providers to recognize their own mental health and physical needs and to address these appropriately.

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**“LITTLE HANS,” CHILD ANALYSIS, AND A CONTEMPORARY OVERVIEW,  
FROM THE HEROIC AGE TO THE PRESENT  
BY HAROLD BLUM, M.D.**

**TERI J. SCHWARTZ, PH.D., REVIEWER**

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*NYIPT Supervisor Teri Schwartz reports on a paper that sheds new light on the first child therapy case, treated by Dr. Sigmund Freud. This was the case of Little Hans, a 5-year-old boy with a phobia about horses who lived in a time when horse drawn carriages were the only means of transportation! For decades, therapists have marveled at how Hans received therapy from Freud through his father, but many of the details of his life were left out as we now learn.*

*Dr. Blum presented this paper on November 10, 2006, as part of the NPAP Scientific Meetings in Honor of Sigmund Freud's 150<sup>th</sup> birthday. Having read Freud's case study of "Little Hans" many times and having given much thought to his phobia of horses, I was thrilled to have the opportunity to hear so noted a psychoanalyst as Dr. Blum present his views. I had hoped that Dr. Blum would discuss the obvious flaws in this first child analysis, such as the traumas that "Little Hans" experienced (e.g., actual threats of castration by his mother for masturbating, and Hans' observing the bloodiness of childbirth when his mother gave birth to his sister) that might have contributed to the development of his phobia.*

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*Perhaps the most poignant theme in this presentation, was that generations of analysts and analysts-in-training have missed (in their reading of the case study) the obvious child abuse that occurred in this family.*

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Dr. Blum went beyond the case study itself to include historical information culled from archival material (e.g., Freud's letters), and from a 1952 interview with "Little Hans" (Herbert Graff) and his father (Max Graff). Moreover, in his re-analysis, Dr. Blum incorporated advances in psychoanalytic theory to include the role of parental discord, child abuse and maltreatment, and parental pathology, in the development of "Little Hans's" symptoms, and he discussed the concept of resiliency in Hans' recovery.

Throughout his presentation, Dr. Blum reminded the audience that this analysis is nearly 100 years old and that it took place in a particular time, place and culture. At the turn of the century, Viennese culture included an intolerance of masturbation, little understanding of child development, and psychoanalysis

was in its infancy. Perhaps the most poignant theme in this presentation, was that generations of analysts and analysts-in-training have missed (in their reading of the case study) the obvious child abuse that occurred in this family. "Little Hans's" mother (Olga) beat his sister Hanna when she was between six and 18 months while "Little Hans" played within earshot of his sister's cries.

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*As a writer, Freud was unique in that he later returned to his older writings, adding footnotes reflective of newer developments in his theorizing; but one wonders why he did not return to this case study to amend it.*

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Olga had been one of Freud's patients in 1897 before her marriage to Max Graff. Her father died when she was 10 months old. Two of her brothers committed suicide. She was viewed as compulsive, anxious and hostile. During "Little Hans's" analysis, Freud maintained contact with the Graff family. Max (the father) had joined Freud's Wednesday evening seminar and became part of the growing circle of Freud's admirers interested in psychoanalysis. Freud had encouraged the members of his seminar to observe their children and present their observations to the group.

When "Little Hans" became symptomatic, Max was directed, under Freud's supervision, to conduct the analysis utilizing Freud's current view of neurosis as stemming from the Oedipal Complex. The need for boundaries and confidentiality had not yet been established in treatment. Moreover, in Freud's attempt to protect his former patient Olga, and perhaps, preserve the family's image, he did not include important information about "Little Hans's" mother in the case study. Olga had never wanted any children, and although she did develop

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**“LITTLE HANS,” CHILD ANALYSIS, AND A  
CONTEMPORARY OVERVIEW**

*continued from pg. 12*

a close relationship with her son, she did not want another child. Olga suffered what we would call a post-partum depression after the birth of her daughter. We might call her a neglectful mother. She would leave “Little Hans” on the balcony for hours watching other children play. Olga was a difficult woman who had a hard time getting along with others. She was socially avoidant and in many ways her son’s phobia was a blessing in disguise. It allowed her to remain close to home and not venture out where she might have to interact with others.

As a writer, Freud was unique in that he later returned to his older writings, adding footnotes reflective of newer developments in his theorizing; but one wonders why he did not return to this case study to amend it. At the time he wrote the case of “Little Hans,” he had only posited a positive Oedipal situation and had not developed his tripartite theory and he, therefore, had limited understanding of ego development and the mechanisms of defense. Throughout his life, Freud reworked his understanding of anxiety, its etiology and purpose, yet he did not go back to include his newer views in relationship to “Little Hans’s” phobia. Perhaps this case study served its purpose for Freud: It launched child analysis and he was able to “protect” his patient, “Little Hans’s” mother.

In closing, Dr. Blum pondered whether “Little Hans’s” life would have been different had he not been analyzed. He raised the concept of resiliency. In the case study of “Little Hans,” one can observe how the child worked at coming to terms with such issues as anatomical differences, the difference between thought and action, and his annoyance at his parents’ inability to provide him with the whole truth about birth. However, we have to wonder whether an important outcome of this analysis was to bring “Little Hans” and his father closer so that the Oedipal Complex could be resolved. Prior to the phobia, Max Graff seemed to be a somewhat absent father. Identification with the father is an important part of resolving an Oedipal Conflict and in this case, both Max and Herbert (“Little Hans”) Graff were noted musicologists. I cannot help but believe that those few intense months when the father and son had grappled with “Little Hans’s” phobia, that the treatment helped forge the future development of Herbert, including identification of the son with his father.

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**CLINICAL DILEMMAS IN CHILD ABUSE &  
NEGLECT REPORTING: FOCUS ON HEALING**

**WORKSHOP PRESENTED BY  
NYIPT DIRECTOR DR. PHYLLIS COHEN**

**DEBRA J. HARRIS, L.M.S.W., J.D.**

*Graduating candidate Debra Harris reports on a workshop on child abuse reporting held at Park Slope Center for Mental Health*

*The clinicians at the Park Slope Center for Mental Health, together with other NYIPT candidates, were transfixed during Dr. Phyllis Cohen’s unique presentation entitled “Dilemmas Related to Abuse and Neglect: Focus on Healing” on the evening of September 18<sup>th</sup>, 2006. Unlike the typical presentation on mandatory reporting, Dr. Cohen transcended the basics of when clinicians must report and focused on the ramifications of reporting on the therapeutic relationship. Dr. Cohen addressed the central question in the minds of so many clinicians faced with the need to report: will I be able to continue to work with this family?*

Dr. Cohen’s answer was a resounding yes - if the report is made in partnership with the parent(s) rather than as an adversarial act. While this is no simple feat, Dr. Cohen suggests that, when possible, the clinician discuss with the family not only her obligation to report under the law, but also her role of keeping the family safe from harm, and her desire to support them through this difficult process. Ideally the parent(s) will participate in making the report, reducing its adversarial nature and increasing the likelihood of a continuing therapeutic alliance.

Dr. Cohen emphasized that child neglect is often symptomatic of larger environmental and societal problems, including poverty and differing cultural views of appropriate discipline. In the end, the workshop’s message was that our goal as clinicians can be to maintain our therapeutic relationship with the family despite the need to report and to work with them on repair and healing.

Early in 2007, Dr. Cohen will return to the Park Slope Center to help bring her ideas to life through a series of role plays. No doubt the second part of this workshop will offer those attending new and creative solutions to maintaining the therapeutic alliance in the face of the need to report.

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## EXCERPTS FROM INTERVIEW WITH DR. MICHAEL EIGEN REGINA MONTI, PSY.D.

The following article contains excerpts from an exclusive interview that NYIPT supervisor Dr. Regina Monti had with Dr. Mike Eigen. Mike's influence in the field of psychoanalysis and psychotherapy has been far-reaching and this interview attests to the incredible mind and gifts that Mike has shared with us.

The entire interview including all references is available on our website at [www.nyipt.org](http://www.nyipt.org).

Dr. Michael Eigen was interviewed in September of 2006 by NYIPT faculty and supervisor, Dr. Regina Monti. Dr. Eigen is a renowned psychoanalyst and prolific writer. Dr. Eigen has a relationship with NYIPT going back to the 1970's when he was a teacher and supervisor at the New Hope Guild. His supervisees at that time included current NYIPT faculty, including Dr. Phyllis Cohen, Director of NYIPT. Reflecting upon Eigen's impact in the field of psychotherapy and psychoanalysis, Dr. Cohen stated, "Mike Eigen has helped influence our thinking and how it has been imparted to our students and faculty over the years, and ultimately how we have been able to help children."

**RM:** Throughout your writings, there is a thematic grounding of faith. In *The Sensitive Self* (2004), you describe the infant's agony and hunger for the mother leading the infant into a "numbness, stupor, oblivion"... You go on to say that "something of this pattern remains as an organizing sequence . informing emotional life". .. Is this the arena of faith?

Along with faith, you write often about destructiveness with references to the Bible (a book of faith). Where does the therapist's faith originate? In sitting and witnessing with the patient his/her trauma, destruction and shattering?

*A lot of therapy is about the slow recovery of faith in which caring has a real place, a caring about one's destructiveness.*

**ME:** I'd like to start by taking these first two questions together. The problem of faith and destructiveness is basic to the human condition. Many sessions I write about are felt to be crises of faith, faith in the face of destructiveness. Can faith survive destruction? In what way? How?

As you know, a person sours in the face of injury. Disillusionment can lead to cynicism, an embittered personality, an embittered soul. A baby faith devastated. Often one never recovers from devastation, not fully.

We get a thrill from acts of obliteration. The biblical

God is a model of our psyche on this score. What's his response to feeling hurt by how badly his human creation turns out? He wants to wipe the human race out with a flood. Destruction wiping out destruction. This primal response shows how prone we are to respond to difficulty and injury by trying to blot it out. Because we feel wiped out by it.

A lot of therapy is about the slow recovery of faith in which caring has a real place, a caring about one's destructiveness. To care enough to struggle with it.

In my twin books, *Toxic Nourishment* and *Damaged Bonds*, I describe how people are poisoned by what nourishes them, damaged by bonds that give them life. I describe in *The Sensitive Self*, a basic rhythm. Therapy supports or tries to jumpstart a rhythm of coming through injury, defeat, megalomania, a rhythm one goes through over and over, a rhythm of faith.

**RM:** You have written that the post-Freudian interest and deeper exploration of psychotic process has allowed psychoanalysis to "come out of the closet". Please explain. What is the closet? Who and or what is in there?

**ME:** Although Freud ostensibly developed a theory and clinical approach to neurosis, I point out in *The Psychotic Core*, that his concepts are heavily steeped in a phenomenology of psychosis. I brought out how psychotic states informed the background and construction of Freud's structural concepts, and that psychosis was crucial to his theory and practice from the outset.

As psychoanalysis unfolded, attention gravitated to psychotic states: Melanie Klein, Harry Stack Sullivan, Searles, Winnicott, Fairbairn, Bion. In 1975 Andre Green formalized this seismic shift in psychoanalysis in his statement that where once neurosis was a defense against perverse tendencies, now both were seen as ways of warding off and organizing psychotic anxieties. Henry Elkin, steeped in Jung and the British school, used to lecture: "Behind every neurosis is a hidden psychosis".

**RM:** In your work, you refer to "states of

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## INTERVIEW WITH DR. MICHAEL EIGEN

*continued from pg. 14*

consciousness." For example, you write, "We are challenged to work with cosmic and practical I-feelings." I love this statement. Would you explain further?

**ME:** In many of my books I write about the challenge of being in multiple worlds at once. Pluralistic dimensions of experience. For example, when immersed in taste, touch, vision, hearing - worlds open in each that the others can't offer.

With this in mind, one appreciates the implicit humor in Bion's references to "common sense". How to coordinate the senses is no small wonder. In autism, for example, attention is pulled first by something preeminent in one sense, then another.

*Part of therapy involves a certain double (multiple) directionality. The rhythm of opening-closing, expanding- narrowing is part of basic rhythms that need to evolve.*

And yet each sense gives us inexhaustible worlds, gives us ourselves differently. There is no end to the nuances of self-feeling, the self-sensations that our senses modulate.

How much more so is the challenge, the invitation, to get to know, to taste, to smell different worlds along the cosmic-personal dimension. In *The Psychotic Core* I showed intricacies of being both anonymous and personal beings. We are made up of many anonymous capacities that work by themselves. Yet we have personal self-feeling, I, me, you, we.

Part of therapy involves a certain double (multiple) directionality. The rhythm of opening-closing, expanding-narrowing is part of basic rhythms that need to evolve. Therapy tries to support evolution of capacities to nourish each other.

How to confess we are at a loss what to do with ourselves, with all we are and have been given, with all we can do? We are like babies who have not yet developed frames of reference. I am glad you love the sentence you ask me about. It shows a love of the mystery we are part of.

**RM:** I am confused by the discussion in your book *Damaged Bonds* regarding the idea that with traumatized or what Bion refers to as "shattered" patients, the analyst needs to "dream the patient". "Dream" in the sense of imagine? Or literally dream as in during sleep? Or both?

in during sleep? Or both?

**ME:** Bion remarks in *Cogitations* (1992), "I am his other self and it is a dream." Let this resonate, let it seep in. Sometimes I play with a resonant statement like this: I am his other. I am his other. I am his dream. I am his other dream. We are indeed each other's selves, each other's dreams.

In *Cogitations*, Bion develops the notion that dreaming is part of our psychic digestive system. In *Damaged Bonds* and other places, I somewhat rework this and put it this way: Dreams, in part, help initiate digestion of catastrophic impacts. They help feed trauma globs into the stream of experience and try to begin the processing of injury. There is always more than we can ever possibly digest. But we try to bite off some bit of trauma glob and chew on it, dream it, rework it, develop expressive symbols and gestures. In some form or other, through dance, music, painting, poetry, hopefully psychotherapy, we slowly develop, over thousands of years, an emotional language, a digestive language.

That is why in *Psychic Deadness*, in a chapter called "Primary Process and Shock", I call the analyst an auxiliary dream processor, rather than auxiliary ego. And this support partly comes by profound self-to-self interweaving, unconscious permeability, in which we taste each other's self-substance, a kind of mutual steeping.

**RM:** You (like Winnicott, Bion, and Lacan) have found a personal language, a unique voice in personal with the historical-theoretical. Your work is at psychoanalysis and methodology. Your idiosyncratic use of language, the experience-near aspect of reading your work manifests, I feel, from the ability to blend the deeply times unabashedly autobiographical, experiential, and self-revealing. In light of the issue of self-disclosure in psychoanalytic work, please comment on the evolution and use of your personal experience in your analytic work.

You often cluster your thoughts, observations, case studies around specific human emotions/feelings: e.g. *Lust, Rage, Ecstasy*. Why these particular emotions, and how has this methodology served to express your professional experiences/observations?

**ME:** Thanks, Regina, for these thoughts. Let me try putting these two questions together. When I wrote

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## UNDERSTANDING THE LYRICS OF EMINEM

JANE BUCKWALTER, L.C.S.W.

*A few years ago, I had reason to research the early history of the popular rap artist Eminem, when I was asked to write, from a therapist's point of view, about his lyrics for XXL Magazine, which was doing a special edition about him. Eminem might be of interest to the readers of this Newsletter partly as a study of childhood pathology in relation to modern music. Ultimately this article was not published as the publisher feared a lawsuit. Here is the article, slightly updated. Jane B*

*With in-your-face language, five of Eminem's early poems describe the impulses that stem from a childhood of neglect, violence and over-stimulation. These intense, vehement, and yet quite witty lyrics portray the effects of such a childhood on an adult mind in a way in which the listener can relate, if he/she is not repelled by the explicit language. The poems are from these five songs: "Stir Crazy" from The Madd Rapper's Tell 'Em Why U Madd, "Busta Rhyme" from Missy Elliott's Da Real World, "I'm Shady" from Eminem's The Slim Shady LP, "If I get Locked Up Tonight" from Funkmaster Flex's The Tunnel, and "I Am" from Marshall Mathers LP.*

Eminem's feelings are not based on current causes, as we see in "Stir Crazy:"

*I got a beautiful wife, kids and  
a gorgeous home...  
I'm still mad at the world, even if it  
apologized to me*

Without knowing anything about the growing-up years of Eminem, it would not be possible to understand the thoughts of this talented, popular and very successful young man. His suicidal thoughts repeatedly break-through his images, shocking the listener as a small child can be shocked by the sudden intrusion of something terrifying:

*What would make me jump in the tub  
with a cordless phone?*

In "I'm Shady," the commonplace is again followed by a shock and we get a glimpse at some old thoughts that plague him:

*I like happy things,  
I'm really calm and peaceful ...  
I like funny things  
that make me happy and gleeful...  
Like when my teacher sucked my wee-wee  
in preschool (Woo!)  
The ill type, I stab myself with a steel spike  
While I blow my brain out...*

In this song, the listener is invited to experience the confusing over-stimulation of a small child, followed by the self-directed aggression of the grown man who

carries the burden of blame and his self-directed aggression appears in suicidal thoughts as well.

In "Busta Rhyme," we find Eminem to be:

*suicidal with no friend...  
Jumped out of the 93<sup>rd</sup> floor of a building.*

The writer's loneliness and vulnerability is buried by thoughts of violence both toward himself and others. Eminem was the victim of inconsistent parenting and erratic responsiveness and his feeling abused leads to the wish to be the abuser, a defense we call "identification with the aggressor." We can see this in "If I Get Locked up Tonight:"

*Hell yea I punch my bitch  
and beat my kids in public.*

To the outside world of music critics or parents of teenaged Eminem fans, what appears as security or arrogance does not quiet Em's inner, crazy-making rage. From "If I get Locked up Tonight:"

*I hate the straight jacket  
it aint latching, and can't lock it  
So they stapled my hand to my pants  
The cell's padded and battered.*

In the midst of his inner turmoil, Eminem casts about for someone to blame. Typically, the troubled young man's pain and rage remain mixed with images of those he loves, so those are the ones he imagines killing. Often this means women, because it was his mother who was at least around to raise him, however inadequately. Eminem displays this tendency in "Stir Crazy:"

*I'm straight vicious.  
I hit you with plates and dishes  
Leave you eight stitches...  
Slut don't be nice to me,  
I've had it with girls...  
You're hearing the last words of a man  
about to blow his fuckin' brains out  
Fall back with a blood stained blouse  
on top of his spouse  
Spread out on a blood stained couch.*

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## UNDERSTANDING THE LYRICS OF EMINEM

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In America's ghettos and trailer parks, or wherever women wield most of the domestic power, men often become emasculated in the eyes of young boys, whose own powerlessness leaves their gender identity in question. We can see this issue expressed in "Stir Crazy:"

*I'm sicker than Boy George  
picturin' Michael Jackson  
In little boys' drawers shoppin' at toys  
stores.*

Or, in "If I get Locked Up Tonight:"

*You faggots ain't tough...*

For Eminem, all of this psychic stress leads him to seek drugs as his only relief. From "I'm Shady:"

*I got mushrooms, I got acid,  
I got tabs and aspirin tablets.*

Or, from "If I get Locked Up Tonight:"

*I'm dedicated to medication  
But this med is taking too long  
to bring me this sedation*

After Eminem achieved stunning international popularity, he was puzzled by this response. Yet as he rapped of violence, he became ever more popular and he even became a role model.

He says in "If I Get Locked Up Tonight.:"

*Became a role model after Colorado  
Now all they do is follow me around  
and holla Bravo!*

Yet his confusion is reflected in "I'm Shady:"

*I try to keep it positive and play it cool  
Shoot up the playground and tell the kids  
to stay in school (Stay in school)  
Cause I'm the one they can relate to  
and look up to better  
Tonight I think I'll write my biggest fan  
a fuck you letter.*

One would wonder why he would need to spoil the good feelings that his fans have toward him, yet knowing that he has had little experience of positive relationships helps us understand something of what might make him tick.

While these first four poems portray Eminem as a man on the edge, "about to blow his fucking brains out" (Stir Crazy), he hasn't done it yet. Instead, he chooses to shout to the world about his pain. Marshall Mathers, the writer, clearly understands the inner life of Eminem, his alter ego. It seems reasonable to guess that

Mathers has experienced the feelings expressed in Em's lyrics, but his rapping is what has saved him from acting on them, by creating distance between him and those disturbing feelings. In therapy, kids play out violent themes and this is a way of preventing them from acting them out in real life. By pouring his pain into his lyrics, using them to express and contain his pain, Mathers is making art, not war. Whether this art is sufficient to keep his rage from erupting into action remains to be seen over time. And why it attracts 12-year-old girls is another important question.

The fifth poem under discussion, which comes from Eminem's most recent album, is less explicitly violent, but opens us up to his inner soul. In "I Am," Em says:

*I'm so sick and tired of being admired.*

Generally, a boy's first "audience" is his mother, and burden of blame and his self-directed aggression appears in suicidal thoughts as well. One of her jobs is to recognize and give words to the boy's feelings. When that process is derailed, for example, by the child needing to enliven and entertain a depressed mother, the child's sense of who he is becomes distorted. Perhaps, for Em, it does not feel like admiration for who he is but for an image that he feels was created by and for others: fans, producers, even commentators such as this one. He obviously failed to get the feedback of admiration that he greatly needed and he feels enslaved by the continued expectation:

*To tap what 'my name is*

Although he expresses the wish to

*Get fired and dropped from my label,*

it is because he feels misunderstood,

*pigeoned holed by cocky caucasians*

*who think I'm some wigger*

*who just tries to be black cause*

*I talk with an accent and grab on my balls.*

But ultimately Eminem needs his audience, just as the small child needs his parent, no matter what the cost. Em seems to surrender and he gives up his true self or soul when he says

*I am whatever you say.*

"I Am" has come to mean "I no longer am."

In the end we can only hope that although this is Em speaking, that the young artist has found a way to achieve an even keel in his private life despite living in the glare of hip-hop stardom.

\* \* \* \* \*

## ASPERGER CHILDREN: EDUCATION AND THERAPY

MARTHA HERMAN, PH.D.

*Dr. Martha Herman is on the NYIPT faculty and is a psychologist who has worked for many years with young children on the autistic spectrum. Here she reports on a program that has been recently implemented to address the specific needs of these children, and she gives us some insights for therapists to help these children as well.*

*Child therapists and parents in New York City should be aware that a ground-breaking program for children with "Asperger Syndrome" (or, wording it in another way, "high-functioning autism") is expanding throughout the city. The program is called the "ASD Nest Program," and it provides children with "Autism Spectrum Disorders" (ASD) who can handle grade-level academic work with a small special-education "nest" group as well as inclusion in larger mainstream classes. The program began in 2003 at PS 32 in District 15 (Region 8) in Brooklyn. This year it will be offered in six regions, including one middle school, and by 2007 there will be programs in all ten regions of the city.*

The motto of the program is: "If children cannot learn the way we teach, then we have to teach them the way they learn." Although Asperger children may be very bright cognitively and may use language on a high level, there are major areas of functioning where they cannot operate as "normal" children do (or "neurotypical" children, to use a word from the Asperger literature that expresses their different perspective). Oliver Sacks in his book about Temple Grandin, a very accomplished autistic woman, described her like "an anthropologist on Mars."

Asperger children do not automatically and intuitively acquire ordinary social understanding or attain age-expected social and behavioral skills on their own. They need to be explicitly taught how to understand social reality and the perspective of others. For example, they need direct instruction on how to engage in a conversation, how to perceive emotions of others and themselves, how to place themselves physically in relation to others, and how to sustain a friendship. They often have atypical sensory responses and specific obsessive interests that they must learn to moderate, especially in social situations. Although generally bright (by definition, Asperger children have normal intelligence or higher, and some have areas of genius), they may also exhibit scattered skills, showing significant discrepancies between areas of strengths and weaknesses, that require specific remediation.

Also, although their formal language level may be age-appropriate, often their pragmatic use of language is atypical, with inappropriate statements or odd qualities in the sound of their speech, in the tone, volume, or rhythm of their language.

Therapists working individually with Asperger children should be aware that their behavior problems are deficits caused by a neurological disorder. These should not be misinterpreted psychologically as conflicts or defenses arising from disturbed experiences in their families or otherwise in their lives. These children need a more active psychoeducational approach in therapy, to help them understand their experiences, to explain the reactions of others, and to guide them in planning their behavior. It is also critical to help the children and their parents choose the right environment (the right class or job or social activity) that best fits the individual child. There may be limits to the extent of change that is realistically possible for these children, and their quality of life will be crucially dependent on providing the best fit with a supportive environment. Depression is also an issue for some Asperger children, especially adolescents, who want to be accepted by peers and who suffer from their social failures and rejections. Also, in addition to their neurological deficits, Asperger children may experience stresses and traumas that can befall any child (such as divorce, illness, abuse, foster care). In this, the child therapist may have a unique role, not touched by the formal educational program, in helping the child understand and cope with disturbing life events.

Working with Asperger children can be very gratifying to a therapist who becomes aware of a new way of thinking and responding to the world that is fascinating and at times amazing. Although these children are often said to have limited attachments to others, it is my experience that they can be highly connected to a therapeutic adult, as they are to their parents. They are attached but may be differently so.

*For further information about the program, please call 718-935-3946 in Brooklyn.*

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## TRANSITIONS: TRAINING AND BEYOND

### SUSAN CAPUTO, L.C.S.W.

*We at NYIPT are proud of the impact our training has had on the careers of our graduates, and ultimately how this umbrella has reached out to help countless numbers of children and families. In this article by NYIPT graduate Susan Caputo, these effects are obvious.*

*Four years ago I entered the NYIPT program, embarking on a journey to learn and develop skills providing play and individual therapy for children and adolescents. I was happy to be able to learn from child clinicians who have had years of training and experience. This experience has changed my life in ways that I could not even begin to imagine. The teachers, supervisors and candidates of NYIPT all shared my passion, and the people in the program began to feel like an extended family.*

At the time I had developed a strong connection with Dr. Rita Seiden, the Executive Director at the Park Slope Center for Mental Health (PSCMH). In August 2002, Rita and I met with Dr. Phyllis Cohen, and formed an affiliation with NYIPT that merged our goals. It is hard to imagine that my need to develop and learn to be a child therapist, would lead to some major changes in an agency that I loved.

In my first year of training, it became apparent that the need for child clinicians and services for children and families was astronomical. Three of my classmates also began their clinical work at the Park Slope agency and over that first year the child caseload of 5 children grew to approximately 50 children. PSCMH was an agency that had previously served the mental health needs of adults and the elderly! I began to realize that being a child clinician would not be enough. My vision to help children had become a large-scale goal.

Dr. Seiden had confidence in me and encouraged me to expand the PSCMH Child Program. She enabled me to build the program by supervising the child therapists and adhering to the government regulatory requirements for working with children. Her faith in me began my 2<sup>nd</sup> transition from training into development. At times I wondered if I could fulfill my dream but I was not unique. My dream was inspired by the dedication of Dr. Cohen and the faculty of NYIPT. My own dedication and awareness of the need for mental health services for children and families, was also facilitated and encouraged by my NYIPT supervisor, Karen Cadwalader.

When I started my second year of the training program, a new group of candidates began their clinical work at the agency. I have been fortunate to work with

the entire graduating class of 2006 (Debra Harris, Marilyn Ippolito, Susan Stark and Royanne Weiss), and to have seen their growth and development. Each of these candidates also has this "passion" inside and the vision to help children. Every year since, the candidates who have come to do their clinical work at PSCMH have shared the same goals.

While developing my clinical skills, I learned how important supervision and personal therapy were in developing and growing as a therapist and supervisor. Prior to completing the program, I made the transition into a small private practice where I now work with adults and children. The training I received at NYIPT helped me feel confident and prepared to take this step. Learning and being supervised by child therapists who are also in private practice as well as maintaining roots with clinics and other agencies has helped me realize that I could also have both. My first child client in private practice was four-years-old. I realized how far I had come by my confidence and willingness to work with a child so young. I no longer felt terrified or unsure of how to help.

When I finished the NYIPT program in 2005, the Park Slope Center for Mental Health was providing mental health services to over 150 children. The transition from completion of training to the present has been amazing, overwhelming and unimaginable. In August 2005, the Board of Directors at Park Slope Center promoted me to Acting Director of the PSCMH. Taking on the overall responsibility of the agency has been a scary transition for me, but the support I have continued to receive from my therapy and supervision, and my connection with NYIPT has helped ground me. I have been given an opportunity to nurture and develop my vision to branch out further and help a larger number of children and families.

In the short time that I had worked with adults, I came to understand that many of their issues related to childhood trauma, abuse, neglect, financial hardship, broken families and more. I began to wonder how different their lives would have been had they received the kind of help that the clinicians and supervisors at

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## TRANSITIONS: TRAINING AND BEYOND

*continued from pg. 19*

NYIPT provide. Children can benefit from therapy, and when indicated, the earlier they receive it, the better. Children can be nurtured, listened to, helped to express their feelings, heal their "wounds," and ultimately build better lives for themselves.

As Acting Director one of my first projects was a "quality assurance" program being developed by the Department of Health and Mental Hygiene to improve services for children and families. We are currently exploring and developing interventions to improve the initial screening and ongoing therapy appointments for children and their caretakers. I remember how in my first class at NYIPT, Dr. Cohen addressed the importance of engaging the child's parent/caregiver in the therapeutic process and the "quality assurance" project is also addressing this need. I am hopeful that one day my vision to help children will be enhanced by the cooperation of the clinicians, the agency, the training program, the families and the regulatory agencies such as the Office of Mental Health all working together for the benefit of the children.

Taking on the overall responsibility of the agency led to another difficult transition for me because it was no longer possible for me to continue to head the Child Program. My transition was made easier by the knowledge, that another candidate, Debra Harris, had the same passion and love for working with children that I did. Debra's ability to help children continues to be nurtured by her NYIPT supervisors, teachers and personal therapy, and passing on the responsibility of the child program to a "new" graduate of NYIPT has brought the agency and NYIPT full circle.

Today at PSCMH we are embarking on many new projects. In October, seven clinicians began a one-year training program in Cognitive Behavioral Therapy that was offered by the Office of Mental Health to work with depressed and traumatized children. Also in the fall of 2006, PSCMH answered a call from the Office of Mental Health to submit proposals for a program to identify the mental health needs of children and adolescents in the public school system. We have applied to do ongoing assessments, and make referrals for therapy when indicated. This project is a huge preventive measure to help identify children in need, and to provide services at earlier stages. And finally, we are in the process of building a family therapy program at PSCMH to address the needs of families. We have

identified as one of our missions to help families stay together. Through play, individual and family therapy we, hope to rebuild healthier families. We now have clinicians attending the Minuchin Family Training Institute, and we hope all these measures will help us to meet the increased needs of the children and families that are referred to PSCMH every day.

The more we work with children, the more I believe that the children we help today, are the adults we will see leading productive and healthy lives in the future. We cannot let these children be unrecognized or their needs go unnoticed. My transition has gone from social work student, to adult therapist, to candidate in training, to child therapist, to Agency Director, and my continuing to tread in the vision to help children has been one of the most fulfilling and challenging experiences of my life.

In Erikson's last stage of development, a person looks back and reviews their life. Knowing that I have played a role in helping children, will allow me to look back with a sense of meaning and fulfillment.

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## NYIPT GRADUATE SOCIETY WORKSHOPS

*The NYIPT Graduate Society is pleased to announce the initiation of a series of workshops for our alumni (present candidates also welcome) to continue and enhance the training mission of the Institute.*

Our first workshop will be

### **"A COLLABORATIVE TREATMENT USING VIDEOTAPE FEEDBACK WITH A DEPRESSED MOTHER AND HER INFANT"**

**Sunday, February 4, 2006,**

**10:30 am – 1 pm**

with our esteemed director,

**PHYLLIS COHEN, PH.D.**

At the lovely and historic **Montauk Club** in Park Slope, Brooklyn only 1/2 a block from the #2 and 3 subway stop at Grand Army Plaza.

For more info call Geri Ness at 718-789-6739

## NYIPT FUNDRAISER: "A NIGHT OF PLAY" AT NYC'S MARQUEE

*On October 18, 2006 NYIPT hosted a very successful fundraiser at the New York City hotspot, Marquee. Our Host Committee, Board of Directors and many other volunteers all joined together by donating their time and resources to make this event a huge success! We are happy to announce that the event attracted nearly 200 people, we had more than ten VIP sponsors, and that nearly all of the food and drink was donated. As a result, we were able to raise enough money to support our budget and goals for the upcoming year. NYIPT thanks you for all of your contributions and we hope to see you at our event next year. For a list of all corporate sponsors and contributors, please visit our web site at [www.nyipt.org](http://www.nyipt.org).*

In order to explain "what child therapists do" to our guests, NYIPT graduate and faculty Lorenzo Munroe spoke about his work with a six-year-old boy;

*John's mother brought him to therapy because he had witnessed a violent relationship between his parents and she was worried about its effect on her son. John's parents were divorced but his father still exhibited ongoing aggression and violence toward his mother in front of John, whenever the father came to pick him up at his mother's house.*

*John came to the first session and almost every session thereafter with a toy airplane – sometimes it was made out of Legos, other times of paper, and sometimes of materials that were not easily definable. When his plane was unrecognizable, he wondered why I didn't know that this was, in fact, an airplane. As a therapist, I quickly realized that I needed to understand the meaning of this recurring airplane play theme.*

*After meeting with the mother for several regularly scheduled collateral sessions, and after meeting the father once when he brought the child to his session and had a tense interchange with his son, I began to understand what this plane symbolized.*

*In the next session with John, I said, "It must be really hard for you going between both homes, and especially seeing Daddy get so angry with Mommy and with you." John looked at me as if to say "It took you long enough to get it," and he nodded his head "yes." After that I was able to use the airplane as a metaphor for John and his feelings about moving between 2 different "airports" were able to be verbalized. Soon John stopped bringing airplanes to his therapy sessions and his anxiety and behavior at home began to improve.*

After hearing this vignette, all the non-therapists in the room began to understand the significance of our "Night of Play" – that children communicate through their play. Whatever they play out has a meaning and it is up to us to try to decipher the code!

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## INTERVIEW WITH DR. MICHAEL EIGEN

*continued from pg. 13*

*Ecstasy* my intent was to give expression to something that made my life worthwhile, something at the very heart of my experience. An ecstatic core at the heart of life. Yet when I got into it and tried to let come out what wanted to speak, I found myself gravitating more and more to destructive ecstasies.

The second book in this series, *Rage*, caught a ruling feeling of the time. Everyday news reports spoke of one kind of rage or another, race rage, terrorist rage, road rage, computer rage, alcoholic-addictive rage, you name it. Rage appeared to be a core affect in our nation and I tried to put some tracers on it. I tried to turn the experience of rage around, something like a kaleidoscope, and touch it in many contexts from many angles through art, literature, religion, clinical sessions, politics.

The last book in this series, *Lust*, just came out this year. My own experiences of lust, ecstasy, rage play an important role in these works. But lust, too, took me deeper into the body politic and the lust for power. It straddles individual and group activities.

My latest book, *Feeling Matters*, should be out any month, any day. It builds on these themes and pleads for the importance of feeling in personal life and in public life. It shows how insensitivity spirals, wreaking havoc on a national and global scale. While this new book is concerned with fits between personal and group trauma, it also opens domains beyond trauma.

This work explores ways that faith meets catastrophic impacts and helps support beginnings of processing them, ways of working with them. An affirmation of life in the midst of horror. We have much work to do.

**RM:** Mike. Thank you for addressing these questions so comprehensively and inspirationally.

**ME:** Thank you, Regina, for your questions, your care, and your exuberant sensitivity.

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## PRESENTING...THE GRADUATING CLASS OF 2006

*continued from back cover*

### MARILYN IPPOLITO, L.C.S.W.

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candidate I often felt overwhelmed, yet over time the many ideas, theories, and understandings that I gained were combined with my increasing confidence in my abilities. And all of this must have been creeping in on "cats' paws!" There were times that I felt I was not "getting it" (or maybe even "losing it"), but I can now proudly say that I feel like I have become the child therapist I dreamed of being, and, though the work is still hard, it is as exciting and fulfilling as I hoped it would be.

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### SUSAN STARK, L.C.S.W.

*NYIPT enabled me to return to my clinical roots and add a new dimension to my professional work by specializing in the treatment of children and adolescents and their parents.*

My recent experience with a child patient exemplifies my growth as a child therapist over the last 3 years - growth I attribute directly to NYIPT. As a candidate in the program, I recently met with a female adolescent, "T," with whom I had worked for 3 years at the Park Slope Center for Mental Health. T is physically disabled, has learning disabilities, and had anger management problems at home and school. She also protected herself by making up fantastic stories that made her seem powerful.

Through our work together T had less of a need to invent stories and she became more able to identify her feelings, control her behavior, and express positive goals. Over time, T's mother began to understand her daughter's need to acknowledge her vulnerabilities and express her pain in order to minimize her negative behaviors.

When I was terminating therapy with T, her mother had been unable to bring T in for a final session to say goodbye. The end result was some desperate phone calls from T's mother that T was acting out again and threatening to hurt herself. I arranged to meet with T, and in our last session I was impressed with T's ability to articulate her need for a non-family member to talk to about her worries and other feelings. She also had the

courage to tell her mother how much she needed her to take her therapy seriously and bring her consistently. Despite her stress level and her shame about her daughter's disability, in that session T's mother was able to hear her daughter, perhaps for the first time, and I was able to facilitate having her quickly reassigned to a new therapist.

In retrospect, I was struck by the power of our therapeutic relationship and of play therapy as a therapeutic milieu. I attribute my ability to work effectively with this child and her mother to all I had learned in my three years in the program, my experience at the Park Slope Center for Mental Health, and my three years of excellent supervision with Gloria Malter, Ruth Price, and Marilyn Rifkin.

Although my supervisors were all very different, each had something unique to offer and helped me apply the theory of child therapy to my professional practice. I am grateful to all my teachers and to Dr. Phyllis Cohen for her dedication to making this program a reality and always inspiring me to keep growing and helping children in need.

I want to thank my husband Scott for his emotional support and willingness to take on additional responsibility for our wonderful children, Ethan and Mattea while I was pursuing my training. Ethan and Mattea constantly remind me that children are our most precious resource and that working with children is incredibly important work.

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### ROYANNE WEISS, L.C.S.W.

*When I started the NYIPT program I had been working as an Early Childhood Social Worker in the New York City Department of Education where I had the opportunity to work closely with young children and their families. I was assigned to several schools where I had a large case load and I found myself often frustrated because I was not able to engage in the kind of one-to-one therapeutic treatment I knew was crucial to the healthy and successful development of so many of these troubled children. As a result, I was forced to refer them and their families to agencies or private therapists.*

I heard about NYIPT's Postgraduate Training

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**PRESENTING...THE GRADUATING CLASS OF 2006**

**ROYANNE WEISS, L.C.S.W.**

*continued from pg. 22*

Program from colleagues and therapists to whom I referred, and I decided to go to an Open House. Although I was concerned about how I would be able to handle my full-time job as an Early Childhood Social Worker, my family obligations, and the demands of the NYIPT program, I decided to give it a try.

Balancing the rigors of the weekly seminars, the in-depth readings, and my caseload of clients at the Park Slope Center for Mental Health was often challenging, but mostly very rewarding. I was able to build a consistent and trusting relationship with the children at Park Slope and this enabled me to learn not only how to identify underlying problems, but also to reach short and long-term goals and effect positive change.

I am presently still working at Park Slope, where I provide my clients with a consistent and reliable relationship, one they may not have in their families. It is my hope that I can continue to help them develop the tools necessary for leading healthier and more productive lives. The experiences I have had working with these needy children have been invaluable. Knowing that I have been able to provide psychotherapy services to children who might not otherwise have been able to receive them makes me feel like I am giving back and not just simply receiving from this wonderful program.

During my three-years in the NYIPT program, I was truly fortunate to have had excellent supervisors who helped me synthesize a wide range of theories and integrate them into my work with children in the therapy room. The weekly professional seminars and workshops at NYIPT led by extremely knowledgeable mental health professionals, combined with the readings, all helped to enhance my understanding of different psychoanalytical theories and research. All of this has helped me gain a better understanding of clinical techniques and how to apply them to my work with children, not just at Park Slope, but also in my private practice and in my job as an Early Childhood Social Worker in the public school system.

When I began this program I had anxiety and high hopes, but mostly excitement about the challenges ahead. As I complete the program I feel a great sense of accomplishment in that I have been able to develop the skills and the confidence necessary to continue my work helping children and families.

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**KUDOS TO JEANETTE LEVITT**

UPON THE PUBLICATION OF HER NEW BOOK:

**HOW TO LOOK AT OLD AGE**

[XILBRIS PUBLISHERS, 2004].

*At the age of 95 Jeanette Geismar Levitt has once again shared her insights with us in her newly published book How To Look At Old Age.*

The book has been reviewed by NYIPT faculty and supervisor, Dr. Simone Sternberg and was published by N.P.A.P. in the Journal, Psychoanalytic Review, Vol. 93 (5), October, 2006, pages 845-849. Dr. Sternberg writes: "In this informative, inspiring, and heartwarming book, Levitt explores the dilemmas, dark sides and joys of old age, from the privileged perspective of her 95 years." The review in its entirety can be found on our web site at [www.nyipt.org](http://www.nyipt.org).

Jeanette Levitt trained as a psychologist in mid-life and began working for the New Hope Guild Center in 1958. In 1970 she founded and directed the New Hope Guild Child and Adolescent Training Program, where she was Simone Sternberg's first supervisor. Editor-in-chief of the Psychoanalytic Review, Dr. Michael Eigen, wrote in his preface to the review:

"Jeanette Levitt was one of my first supervisors forty years ago. On the surface, we were an unlikely couple, she firmly rooted in classical psychoanalysis while I found nurturance in Ferenczi and Winnicott. Yet a substantial core connection developed. Ms. Levitt's unwavering sense of the integrity of the psychoanalytic process, her sense of unconscious work, her analysis of transference-countertransference dynamics coupled with resistance - all cohered, amplified, and invigorated my love of this work.

One thing I could not have known then: She would never stop growing in radical ways... When she returns to Freud near the book's end, it is a Freud informed, enriched by a whole life's journey, a journey in process. A journey in which I have the good luck to be included." p. 845.

Congratulations to Jeanette Levitt for helping to shape the careers of so many of us and for ultimately enabling us to help countless numbers of children. Her web has been far-reaching and with this new book, many more will benefit from her wonderful insights.

In writing about the end of life, when the curtain must fall, Dr. Sternberg quoted Levitt: "Old age has fulfilled its part and it is left to us still here to applaud its performance."

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## PRESENTING...THE GRADUATING CLASS OF 2006

### DEBRA J. HARRIS, L.M.S.W., J.D.

*It truly has been a long and winding road to my new profession as a therapist - a dream made possible by NYIPT. I am so grateful to Dr. Phyllis Cohen for helping me to achieve this dream. She has been my director, my mentor, my colleague, and one of my inspirations. Cliché as it is to say, words cannot express my gratitude to and love for such an incredible human being.*

Although I began my social work career intending to be a therapist, my focus quickly turned to other endeavors. Over the course of 25 years I worked as a community organizer, graduated law school, worked for the federal courts, worked at a high powered law firm, taught at 3 major New York Law Schools, and worked for a university-based interdisciplinary center for family and child advocacy. Through all of these job changes I continued to ask myself, "what do I want to be when I grow up?"

The most life-altering event of all occurred in 1992 with the adoption of my son, Benjamin. This amazing boy transformed my life in the best ways and in some of the most painful ways. I learned, and continue to learn, what it means to be a parent. Having Ben in my life constantly enhances my ability to work with children and parents.

In 2003, overwhelmed by the conflict between working full-time and giving my son the attention he needed, I left my job, not knowing what the future would hold. It seemed like fate when Dr. Cohen showed me the NYIPT brochure. I applied to the program and the rest is history!

I no longer ask what I want to be when I grow up - I have found fulfillment in my new profession. All of my life experiences have enhanced the wonderful learning experience provided by NYIPT. I am now an adult and child therapist, Associate Director of Children's Services at the Park Slope Center for Mental Health, and a private practitioner. None of this would have been possible without NYIPT.

I have so many people affiliated with NYIPT to thank: first, my wonderful supervisors: in the first-year, Betty Eigen, for her incredible empathy, insight, and support during a difficult personal and professional year; in the second-year, Ruth Price, for her extraordinary insight, support, and generosity in sharing her knowledge with

me; and in the third-year, Regina Monti, for helping me understand more about the meaning of symbolic play and the art of interpretation; second, the many wonderful teachers on the NYIPT faculty; and third, my supervisor, colleague, and friend, Susan Caputo, Acting Director of the Park Slope Center for Mental Health and NYIPT graduate, who encouraged me to work with adults and helped me believe in my ability to do so. Dr. Cohen's words now really ring true - learning to be a child therapist teaches you also to work with adults and the children who live inside of them.

Last but not least, I thank my family, Mark and Benjamin Lasky, for their belief in my ability to achieve this dream.

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### MARILYN IPPOLITO, L.C.S.W.

*My son's first-grade teacher asked the class to write their reasons for loving their mommies for Mothers' Day. Aside from personal statements about his daily experiences with me such as, "She tucks me in at night," he wrote, "I love my mommy because of her job helping children." I found his response to my work quite touching and it made me realize on how many levels my work was meaningful and important and how proud I was of what I did.*

My early experiences as a child influenced my interest in helping children. I became a social worker almost 30 years ago but I have worked specifically with children for the last 21. However, until I joined the training program at NYIPT, I had not felt that the nature of the skills I had enabled me to intervene in ways that were most helpful to my clients. I realize I was being helpful, but only in relatively superficial ways. What I really wanted was to have the skills to form deeper, more trusting, long-term relationships with children and their families. I wanted to have the opportunity to understand and influence positive development in these children and to offer their families help in healthy, hopeful and productive ways of being.

My involvement with NYIPT has given me the opportunity to develop my knowledge and skills in helping children. My experience in the program has broadened me in so many ways, both emotionally and intellectually. During the three year process, as a

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