The New York Institute for Psychotherapy Training

NYIPT Today

Fall 2004 Volume 3, Number 1

The growth of the NYIPT program and it's plans for the future.

From Your Director

Phyllis Cohen, Ph.D.

I am proud to announce that the NYIPT Program has completed its fourth year of training therapists to work with needy children and their families, and that we have just received word from the IRS that we have officially been awarded our "non-profit/public charity status" retroactive to 2002! We began our program with hard work and a dream, and now we have been officially recognized as a training institute by the New York State Board of Regents, as well as by the Federal Government! Since the beginning, our candidates have helped over 400 children cope with their difficult life circumstances and develop confidence in themselves, with a hope for their future.

Becoming a competent child therapist is a process that takes place over time. It requires a candidate to be able to integrate theory and practice from many modalities ...

Our program provides low-cost training to mental health professionals. Some of our candidates have been working with children, but lacked formal knowledge of the field, while others have never worked with children and sought our training to prepare them for this work.

Becoming a competent child therapist is a process that takes place over time. It requires a candidate to be able to integrate theory and practice from many modalities including seminars, workshops and conferences (see articles by our Clinical Coordinator, Carole Grand on p.6, by NYIPT candidate Allison Goldstein, p. 7).

At our recent all-candidates meeting, many of our students shared their feelings about their training experience at NYIPT. Our first year candidates spoke of feeling overwhelmed beginning clinical work with children and parents, at the same time that they have to become familiar with clinic personnel, procedures, and learn a specialized vocabulary and theoretical perspective. Second year candidates spoke about gaining confidence in what they were doing, and feeling as if they were beginning to integrate some theory into their practice of child psychotherapy. But what was most gratifying was to hear our third year candidates talk about owning their identity as child clinicians. One student spoke about how the "seminars seem to be getting better" as she progresses through the program, even though she knows that she's continually learning more because of

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THE NEW YORK INSTITIUTE FOR PSYCHOTHERAPY TRAINING

IN INFANCY, CHILDHOOD AND ADOLESCENCE

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MISSION:

The New York Institute for Psychotherapy Training (N.Y.I.P.T., Inc.) for Infants, Children and Adolescents is a not-for-profit organization dedicated to improving the quality of mental health services for needy children of all ages with their families who live in the New York 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, LCSW

This is the third edition of the NYIPT Newsletter and the fourth year of NYIPT. In the last year we have been accredited by the New York State Department of Education and received a retroactive tax-exempt status from the federal government. With these difficult to achieve accomplishments we move forward with strength.

As many of you know our Director, Phyllis Cohen has been largely responsible for these achievements. It is to her that I would like to dedicate this year's Newsletter as a tribute to her efforts.

As has become our tradition this Newsletter is made up from articles from many of our community members and reflects our commitment to clinical excellence. Any member of our community is welcome to participate in any way in this annual endeavor.

Karen

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.

Our annual fund-raiser honored the Founder and first Director of the New Hope Child and Adolescent Therapy Training Program. At the age of 94, Jeanette Levitt is not only a supervisor in our program, but she continues to be a wonderful role model for all of us. We are thrilled to honor Jeanette for her vision and her leadership and encouragement in starting the NYIPT program. Here are Jeanette's inspiring words from the event:

NYIPT HONORS JEANETTE LEVITT

JUNE 13, 2004

I am deeply moved by this great tribute to me. Whatever I have done, I have surely not done it alone. We all did it there in our common background, which was the New Hope Guild Community Mental Health Center. It was there we grew up together, giving and taking in the world of psychotherapy.

At that time in the early 1970's, the psychoanalysis of adults was the thing to do. The psychoanalytic treatment of children was still a "cause celebre," but there was an obvious need for this in a child guidance clinic. To fill the gap, our Psychiatric Director at the New Hope Center, Dr. Sherman Schachter, suggested I take on the job.

So, working along with Sherman, I organized and provided for therapists a three-year Child Therapy Training Program, which progressed so successfully. The Program grew from the training of psychoanalytic treatment of just children to include adolescents and eventually to a Continuing Education Program in Adult Therapy.

The Directorship of our program has had three long-term lives. It passed from me to Dr. Norma Simon, and from her to Dr. Phyllis Cohen. Both of them worked wonders in expanding the curriculum and achieving top credit-ratings.

When our relationship to New Hope terminated about four years ago with Phyllis Cohen as director, we were faced with the decision to go it alone. This entailed forming our own Institute for teaching child therapy and the determination to make it work.

Offers to join with well established Institutes were considered by us as unacceptable as they involved losing our independence as a group, so we pulled in our belts and kept functioning alone.

So here we are celebrating tonight thanks to the heroic volunteer efforts of our administrative team: Phyllis Cohen, Carole Grand, Karen Cadwalader, Mary Tirolo, Gloria Malter, and our whole group of seminar leaders and supervisors who hung together and supported them.

Guest of honor, Jeanette Levitt at the fund raiser, 6/13/04

The leadership of Phyllis Cohen has been the constant driving force behind the success of our Institute as a comprehensive thriving and accredited program. So thanks again for this wonderful tribute to me, but I would like to pass the buck tonight to our most deserving Director and Institute founder, Phyllis Cohen.

Phyllis, you have inspired all of us to share together in this combination of a dream and the reality of the need for worldly goods to support it, to accept this paradox in the service of giving and receiving in all that life has to offer.

There is something like greatness attached in the involvement of self and other - in the relationship of the therapist to the needy in the community.

Our Institute is an example of this kind of spiritually motivated endeavor. It is due, in and of itself, for a rewarding tribute - Tonight is truly an ensemble celebration. Phyllis, this memorable evening was unquestionably the high point in my life. Thank you for making it all happen.

Jeanette

NYIPT faculty, member, Tina Lupi, attended a conference on helping refugee and immigrant children who have suffered trauma in a distant place, and who may be referred to us for treatment. The NYIPT Program is dedicated to working with children from all backgrounds and to training therapists to work with all children. Toward that end, we have encouraged our faculty and candidates to raise their consciousness to issues related to cultural diversity.

HELPING CHILDREN OF REFUGEES AND IMMIGRANTS

TINA LUPI, LCSW

On Dec. 4, 2004 the William Alanson White Institute's division of services to immigrants and refugees hosted a conference. Dr. Martha Bragin, LCSW, a therapist and consultant to government and private organizations that deal with the problems of refugees and the effects of war and violence, presented on the topic "Can Anyone Know Who I Am? Reflections On Working With Refugee and Immigrant Children and Families."

Although refugee and immigrant children and adolescents are usually very resilient, many of them experience a great deal of stress and confusion when they arrive here. Dr. Bragin reminds us that these children have traveled great distances and have been through many strange and unpredicted experiences. Their lives have taken a turn that has often brought unwanted change and disrupted their cultural stability.

Dr, Bragin believes that both parents and children need an opportunity to tell their stories, even when they contain unthinkable physical and mental pain, otherwise they will continue to live in an ongoing, silent nightmare

The central focus of Dr. Bragin's articulate and moving presentation was a clinical emphasis on helping refugee children by constructing a coherent narrative, facilitating symbolization and reflectiveness, and finding oneself and feeling "knowable." She gave many examples of families who immigrated after either war or extreme political situations that were marked by fear and poverty. They have frequently witnessed deprivation, violence and abuse. These families often try to "forget" the past and do not want to recall what they have lived through. This tendency towards denial frequently leads to learning difficulties and acting-out by the children, who are unable to articulate their experience. Dr, Bragin believes that both parents and children need an opportunity to tell their stories, even when they contain unthinkable physical and mental pain, otherwise they will continue to live in an ongoing, silent nightmare.

Dr. Bragin began by acknowledging the contributions made by Harry Stack Sullivan and Eric Fromm, both role models for persistent concern about societal matters and mental life, especially in the aftermath of war. She pointed out that as far back as Virgil's Aeneid, those who passed on the history of peoples wrote of how seekers of asylum have a need to tell their stories.

The traditional rituals and ceremonies that are provided within cultures to deal with psychologically difficult events are not always available after immigration. Adults frequently feel they should reject and deny the old ways of cleansing, leaving themselves unable to process their experiences, and leaving their children with no connection to their cultural past. Identity formation is interfered with as parents and children lose both the shared past and the models for their future.

She pointed out that as far back as Virgil's Aeneid, those who passed on the history of peoples wrote of how seekers of asylum have a need to tell their stories.

There is a common tendency for immigrants and refugees to remain psychologically in a kind of dissociation from the past, devoid of the rituals of mourning loss, including death, and all that was left behind. No matter which side of war a person was on, there is shame and guilt to contend with, as well as a need to honor those lost. The impact of a terrible reality must be processed alongside the fantasy and meaning that develops around such events.

For those who become refugees there is conflict between their tremendous isolation/alienation and strong wishes to assimilate. Parents are burdened with the need to establish a new life and know little of their children's new surroundings. Even seeking help can seem to be a betrayal of the past. "Others/outsiders" who are called "helping professionals" are often not seen as neutral. As therapists, we have to prove that

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HELPING CHILDREN OF IMMIGRANTS AND REFUGEES

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we can endure hearing the immigrants' stories without judgment or flinching from them.

By fostering an accepting atmosphere our patients can construct narratives about their experiences, we can help these children begin their healing journey. Slowly, patiently, and gently, we may co-create substitutes for the unavailable cultural ceremonies. Therapists can learn from parents about the rules of behavior back home. Stories need not be linear nor adhere to historical truth in the working-through process. We can help restore meaning and put events in the past by helping people articulate, rather than reenact, their experiences. All of this must be accomplished while helping children continue along their paths of developing identities and achieving other developmental tasks.

Those of us who work in areas with large immigrant populations know that there are as many versions of a scenario as there are cultures present in the community. Not all are violent, but all are distressing and often shameful in some way. We need to take the time to know each one. What was it like there and why did they leave? In facilitating this process we help people symbolize traumatic reality.

Our "knowing" can also be helpful to others who deal with immigrant children, most importantly in their schools. Parents want their children to do well, but often teachers don't understand them. We can help facilitate a positive relationship between teachers and children by encouraging the teachers to be interested and present with the children. Children may seek comfort and may be helped to recall the good and happy memories that have been "lost" along with their painful memories. Children need to mourn much that they will never see again. They need the freedom to be angry at parents who could not protect them, while respecting their parents for their sacrifices. As therapists, we must be able to tolerate the children's shame, their guilt and their rage without prematurely washing it away with our concern or our wish to rescue them from sadness and pain, affects they must connect to. We need to go through the shifting landscape alongside them as they repair their lost selves.

Many of those in attendance at the conference represented organizations that work with refugees in varied capacities. Dr. Bragin critiqued the utility of "Trauma Theory" and reminded the participants to be aware of the potential for multiplicity of selves in the refugee/immigrant experience and problems in memory and language in multilingual children. The participants were eager to conceptualize the complex and emotionally challenging tasks they encounter and were appreciative of Dr. Martha Bragin's sensitive, practical, and humanistic approach.

* * * * *

NYIPT WELCOMES NEW FACULTY MEMBERS

As our program continues to grow, NYIPT has added four new faculty members to its wonderful group of teachers and supervisors. This year we welcome:

DR. HANNAH HAHN is a graduate of Columbia University and the Institute for Contemporary Psychotherapy, where she participates in Child and Adolescent Treatment Services. Her special interests include infancy, object relations theory, and creative processes. In her private practice, she sees children, adolescents, and adults;

* * *

DR. ABRAHAM RING is a Fellow and Training Analyst at IPTAR. In addition to a private practice, Dr. Ring has been a Clinical Supervisor at the Bensonhurst Child Guidance Center; Supervisor at the Thomas Askin Treatment Center for Teenagers (JBFCS). Currently, he is a Clinical Supervisor at the Interborough Developmental Consultation Center (IDCC).

* * *

DR. TRACY SIMON is a practicing clinical psychologist and the Director of "The September 11th Program, Surviving the Aftermath" at the Karen Horney Clinic, where she provides individual and group psychotherapy and lectures on treatment issues with World Trade Center survivors;

* * *

LORENZO MUNROE is a graduate of the New Hope Child Therapy Training Program, and President of the NYIPT/New Hope Graduate Society. He served as the Director of The Den For Grieving Kids Programs, a bereavement resource center offered by Family Centers serving children, families and communities in Fairfield and Westchester Counties. Lorenzo established support group programs for children and their caregivers who lost family members in the September 11, 2001 terrorist attacks. At present, he works with children and adolescents at "high risk" in Stamford and Greenwich, Connecticut.

* * * * *

Dr. Edward Tronick, a prominent analyst and infant researcher, spoke at an IPTAR conference entitled "Rupture and Repair," held on March 27-28, 2004.

THE ANALYST'S USE OF THEORY IN AN ANALYTIC SESSION: THE DYADIC EXPANSION OF CONSCIOUSNESS MODEL (DECM) OF THERAPEUTIC ACTION"

DR. CAROLE GRAND

Dr. Edward Tronick presented his paper "The Analyst's Use of Theory in an Analytic Session: The Dyadic Expansion of the Consciousness Model of Therapeutic Action." Dr. Tronick is Chief of the Child Development Unit of Children's Hospital in Boston and Associate Professor of Pediatrics and Psychiatry at Harvard Medical School. He is engaged in research on social-emotional development and self-regulatory processes in normal and compromised infants and young children. He is a member and teaches at the Boston Psychoanalytic Society and Institute.

Dr. Tronick described the infant as implicitly or explicitly knowing the world and engaged from the beginning in making meaning out of his psycho-bodily experiences and states. Tronick is interested in the developmental phenomenon of the expansion of consciousness and how the infant deals with the complexities of change. His work is based on underlying assumptions that are supported by the research that he and his colleagues are engaged in.

When meaning-making fails, he tells us, there is a "loud thud" within the infant of not being understood by the other, possibly leading to an extreme feeling of annihilation and panic

His basic hypothesis is that the infant arrives at new meanings within a dyadic relationship between a mother and a child, which he refers to as the "Dyadic Expansion of Consciousness" (DEC), and that self- organizing states of consciousness are designed to function best in dyadic relationships. Dyadic relationships, he maintains, are *essential* to the regulation of early bodily states as well as to the infants' making meaning of themselves and their world. Since this process is first a bodily process, it can be interfered with by bodily states.

Dr. Tronick is interested in how the process of meaning-making, as well as the regulation of arousal and affect, is affected by the dyadic relationship of the child and mother. He points out that, just as unconscious conflict affects states of consciousness in neural, chemical, biological and psychological systems, so do states of consciousness, in turn, affect these systems.

When meaning-making fails, he tells us, there is a "loud thud" within the infant of not being understood by the other, possibly leading to an extreme feeling of annihilation and panic. This experience has a profound effect on the developing brain and body of the infant. Analysts are familiar with the "loud thud" when they make an interpretation that is either off the mark, insensitively worded or just poorly timed.

"Why do infants, indeed, all people, so strongly seek states of connectedness and why does the failure to achieve connectedness wreak such damage on their mental and physical health?"

Which brings us to Dr. Tronick's main point. Just as in analysis we have to expect periods of confusion, non-coherence and "messiness" before understanding and insight, we see in child development coherence and meaning occurring out of messiness. He made the point that there can be no coherence without messiness, and that new meanings (understanding and insight in the analytic setting) are made in the dyadic relationship between a parent and a child. He refers to this model as the "Dyadic Expansion of Consciousness Model" or DECM.

Dr. Tronick opened his talk with the question, "Why do infants, indeed, all people, so strongly seek states of connectedness and why does the failure to achieve connectedness wreak such damage on their mental and physical health?" In attempting to answer this question, Dr. Tronick has developed a number of research designs that dramatically illustrate that breakdown in an infant's or older child's State of Consciousness (SOC) when there is a failure of connectedness with the primary caretaker, usually the mother. One of his experiments, "the Still Face," in which a mother is told to stop responding to her infant or child and "freeze" for two minutes. The reaction of the child is videotaped. Young

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NYIPT encourages its candidates to attend as many professional conferences as possible, to augment their formal training provided by the program. Toward this end, 3rd year candidate, Allison Goldstein, wrote about a conference that she attended that dealt with how to understand and help kids who set fires.

JUVENILE FIRESETTING

ALLISON GOLDSTEIN, LMSW

On April 15 and 16, 2004, the Westchester County Department of Community Mental Health hosted a conference entitled, "Juvenile Firesetting: Interviewing, Treatment & Building Community Awareness." The presenters were Brent Ewell, CSW, David Frenzel, CSW, Fred Rion, MSW, and Paul Schartzman, MA, D.A.P.A. This conference provided information that was helpful to many professionals including clinicians, educators, probation officers, police officers, and fire safety professionals.

Juvenile firesetting and fire play is a nationwide problem. There are over 65,000 fires started annually by children. Over 50% of children have been involved with some sort of fire play by the time they reach adolescence (Cole, Golnick, Schwartzman, 1999).

Parents should be encouraged to model appropriate behaviors…

Fire setting was examined at developmental levels. At the preoperational stage (ages 2-7), firesetting behavior is typically a product of curiosity, accounting for 67% of all incidents involving children and adolescents. At this early stage of development, children do not understand the power of fire. To prevent firesetting behaviors in this age, strict supervision in the home is essential. Parents should be encouraged to model appropriate behaviors, limit access to ignition materials, and respect fire within the home.

In the concrete stage of development (ages 7-11), firesetting behavior might also be a result of curiosity. However, in more serious situations, it can be a reaction to being teased, bullied, abused, or a symptom of emotional problems.

In the formal stage of development (ages 12 though adulthood), children are able to think abstractly and in a logical manner. Although firesetting in this stage of development can be precipitated by curiosity, it is more likely due to emotional problems, reactions to stressful situations, peer pressure and/or delinquent activities, possibly gang related.

There are many reasons that children in different stages of development engage in this type of dangerous behavior. They might set fires in order to call attention to a family event that they find disturbing or as a reaction to another stressor. It is important to note that children of all ages often do not understand the intensity of fire, extent of the risk, and/or the severity of possible consequences and damage.

It is essential to distinguish between children who have accidentally set fires and those children who have intentionally done so

Therapists who work with firesetters are encouraged to work with parents to implement a safety and education plan. A comprehensive assessment including a detailed review of the incident(s) is essential when working with children who set fires. These children are often diagnosed with disorders such as post-traumatic stress disorder, conduct disorder, attention-deficit/hyperactivity disorder, depression, and adjustment disorders. It is essential to distinguish between children who have accidentally set fires and those children who have intentionally done so. Once, this is established, a proper intervention can be chosen. Children who also have underlying pathology must be treated immediately. Treatment options include parent education, problem-solving interventions, social skill building including communication skills, family therapy, behavioral therapy, and traditional outpatient therapy with support services.

Resources:

Cole, R., Grolnick, W. & Schwartzman, P. (1999). Firesetting. In Ammerman, R., Hersen, M. & Last, C. (Eds). Prescriptive Treatment for Children and Adolescents (pp. 293-307). Boston: Allyn and Bacon.

www.usfa.fema.gov US Fire Administration; includes statistics for local communities and publications.

www.kidsandfire.com Massachusetts State Coalition for juvenile firesetter programs.

www.sfm.state.or.us Oregon State juvenile firesetter programs including newsletter.

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Many NYIPT faculty and supervisors have been involved in community-based projects, especially since 9/11. The description of the World Trade Center Project that follows is one of them.

THE WORLD TRADE CENTER PROJECT
A MODEL FOR A PROGRAM OF PRIMARY PREVENTION AND INTERVENTION

PHYLLIS COHEN, PH.D., CO-DIRECTOR WITH DR. BEATRICE BEEBE, DIRECTOR

Following the catastrophic events of 9/11, Dr. Beatrice Beebe and I decided to offer pro bono help to mothers and infants who were affected by the trauma. We had previously worked together with a number of depressed mothers and infants using videotape feedback methods as an intervention (Cohen & Beebe, 2003). Our objective was to reach the women who were pregnant on 9/11 when their husbands were lost in the World Trade Center disaster. We wanted to help them mourn their loss during their pregnancy, as well as facilitate bonding in the new mother/baby relationship in order to ensure optimal outcomes for their babies. Under the impact of traumatic loss, even highly competent parents are likely to suffer symptoms of anxiety, depression, dissociation or unresolved mourning. Research has shown that mothers who experience difficulty in mourning are more likely to form insecure-disorganized mother-infant attachments. Thus, infants born under these circumstances might be at risk for a type of insecure attachment that predicts later childhood psychopathology.

We joined together with mother-infant clinicians, Drs. Anni Bergman and Sally Moskowitz, with the goal of helping the mothers once they gave birth, specifically to facilitate bonding in the dyadic mother/baby relationship. This goal was predicated on the idea that mother-infant early intervention can be effective in preventing difficulties later in childhood.

It became necessary to shift gears when we learned that most of the mothers did not live in the New York City area. In order to reach the affected women, we decided to offer them help in areas close to their homes. We began to recruit therapists in those geographically dispersed areas so that they would be able to meet with the women individually and in groups of mothers and infants. As we became aware of the multiple needs in their entire family systems, we began to offer the mothers help with all of their children (not only their infants), since everyone in their families were in need of support. We began making referrals for many types of services, such as individual therapy, parent counseling, child therapy, speech evaluations, movement therapy, medication consultation and massage therapy, keeping in mind that the mother-child relationship itself would be most important in promoting optimal child development.

Mother-infant early intervention can be effective in preventing difficulties later in childhood.

There were many obstacles that impeded the early progress of our project. It took many months to locate the mothers. Once we found them, it was often difficult to encourage them to participate in our program.

The events of 9/11 were unlike any in U.S. history in the number of people affected, the media exposure, and the public nature of the event. Our population of grieving women often did not seek help even though they greatly needed it. They were all in a traumatized state. By the time we contacted them, many felt they had been exploited by numerous voyeuristic outsiders. Even when the mothers felt that a photo shoot or a magazine article would not be exploitative, many reported that they had to say things, look or pose in ways that made them feel uncomfortable in order to "get" something that was being offered "for free." Although we were offering help, we were still "outsiders" who were not to be trusted.

Despite our best intentions, in essence, we were still telling them that WE were offering THEM something that WE thought THEY SHOULD WANT.

After we located the mothers, we tried to reach them, but our telephone calls and e-mails often went unanswered. We continued to call, attempting to reach them in person, though many times only a baby-sitter, mother, sister or neighbor would be able to speak with us. Soon we realized that we needed to change our approach and utilize larger systems for out-reach. Since the women were clearly overwhelmed, we decided to

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THE WORLD TRADE CENTER PROJECT
A MODEL FOR A PROGRAM OF PRIMARY PREVENTION AND INTERVENTION

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make our services more convenient for them by arranging to meet with them in home visits, church groups, hospital outpatient centers, community centers, and through firms where many of their deceased husbands had worked.

In retrospect, many of the women described feeling "numb and out-of-it" during that first year. They were overwhelmed with a myriad of things to take care of.

Going to bereavement groups gave us an opportunity to introduce ourselves and work towards instilling trust while communicating our concern for the well-being of the mothers and children. Despite our best intentions, in essence, we were still telling them that WE were offering THEM something that WE thought THEY SHOULD WANT. They did not want to be identified solely as "needy 9/11 widows," and thus they did not want to need help for being in a position that they did not create. They felt that they were not a group who would have sought our services had this event not occurred. Many felt a stigma in having any need for services at all.

In retrospect, many of the women described feeling "numb and out-of-it" during that first year. They were overwhelmed with a myriad of things to take care of. The paper work (for the government, insurance companies, lawyers, etc.) was overwhelming. Basic self-care responsibilities for themselves, their babies and other children were also extremely difficult to manage. Now, two years later, after becoming familiar to many of the families, we find them to be more receptive to the services we offer.

Although we began the project on a pro-bono basis, over time it became clear that much more time and effort was needed than we anticipated. The process of applying for funding was daunting (including needing to fit our ideas for intervention into diverse agency's funding criteria). Eventually, we received funding from Project Liberty (September 2002 - August 2003), and then from the Robin Hood Foundation (September 2003 - December 2005).

Our project team consists of a wonderful group of analytically trained mother-infant therapists, child therapists, and adult grief and trauma experts who meet every-other- week in a mutually supportive 2-hour peer-supervision group to discuss the process of the work.

There are two separate components to the project: 1) weekly support groups offer a safe environment for the mothers, babies and older children, with a therapist available for each subgroup; and 2) videotape bonding consultations help mothers read each of their children's nonverbal language.

The 2-hour filming session in which the mother and a "stranger"(usually myself or Dr. Mark Sossin) are filmed playing with each child in a face-to-face split screen video, takes place in the Department of Communication Sciences of Dr. Joseph Jaffe and Dr. Beebe at the New York State Psychiatric Institute at Columbia University Medical Center (Beebe, 2003). While in the lab, we also conduct an Ainsworth Strange Situation Attachment Test to assess security of attachment of the child and mother. In a subsequent video feedback consultation session with Dr. Beebe, myself and other support group therapists in Dr. Beebe's private office, the mothers become observers of their children as they watch the videotape and relate what is happening on the tape to their personal histories with their own mothers. This provides a supportive space that facilitates the mothers' reflection and mentalization to help them deal with their trauma and loss. Although these sessions are very emotional and often painful, the overall feedback is that the mothers and children greatly benefit from the intervention.

To date, we are one of the few projects dealing with victims of the World Trade Center disaster that is still ongoing after two-and-a-half years (since April 2002). We have had contact with over 50 families (with more than 90 children) in one or more components of the project. Although our project began with a focus on mothers and their unborn infants, their children have now grown from lap babies to toddlers and many are now pre-schoolers. As the babies and their siblings have gotten older and as they enter new stages of development, they continue to need support.

We have learned that traditional approaches are not sufficient when reaching out to a population that has experienced a traumatic loss because the process of building trust is an important part of the process and

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THE ANALYST'S USE OF THEORY IN AN ANALYTIC SESSION:

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children respond to the maternal "still face" with heightened negative affect and expressions of confusion and demands for change. The toddlers ask, "Why won't you talk to me?" or command, "Talk to me!" while soliciting the mother's interactive behavior (e.g., pointing at her eyes, tapping or almost hitting the mother, making repeatedly louder and louder requests), and then, finally, distancing themselves from her. Infants respond by losing postural control, looking sad, turning away or engaging in self-comforting motions with hands and mouth.

The "still face" was described as "an example of a failure to create a Dyadic State of Consciousness (DSC) and dissipation of the individual's State of Consciousness (SOC). The "still faced" mother precludes the formation of a Dyadic State of Consciousness (DSC) because there is no exchange or creation of meaning. Without the development of DSC's, the age-appropriate capacities for pretend play, cognition, language mentalization, and complex affect are severely compromised.

> *disorganization is a necessary part of development. Disorganization is not an error, but rather, can be the "well-spring of change."*

An extreme example is, of course, the failure to form DSCs in the orphanages described by Spitz in which there was chronic deprivation of infants. "This deprivation of meaning led not only to the failure to maintain and expand their SOC's, but it also led to the disorganization of many of the lower level psychobiological states, such as metabolic systems and immune system" and many of these children actually failed to thrive. Dr. Tronick pointed out, "in a sense, these infants', viewed as systems, lost much of their capacity to generate the most human characteristics."

Dr. Tronick related his work on the distortion of DSCs to the effects of parental affective disorders on infants and children. He maintains that with regard to children of depressed mothers, "connection can only be made in sadness and their self-organizing capacities for creating DSC's aim to create or re-instate this kind of DSC with others." Dr. Tronick concluded by returning to the topic of the conference, "Rupture and Repair." He told us that the clinician works with regulatory systems to prevent derailment but that disorganization is a necessary part of development. Disorganization is not an error, but rather, can be the "well-spring of change." Out of messiness, newness develops which can lead to new States of Consciousness. Reparation, when successful, establishes a positive affective core or mood. The anger of the child in the "still face" experiment is carried over to "reunion play," and when play is resumed, the child asks questions that attempt to make coherent sense of what happened (e.g., Why didn't you talk to me?)

Dr. Tronick's final remarks brought the audience back to the consulting room as he pointed out that in adult analysis, being repetitive reduces the anxiety of change. "What makes for powerful meaning comes about when two private meanings come together." He stated that, "Another example of an intense and forceful DSC is a psychodynamic interpretation." These bring powerful feelings of connection to the therapist. Tronick said, "Connection is the regulation and co-creation of the age-possible meanings individuals make of their world and their place in it. Even more important is to recognize that no connection between individuals ever is perfect but out of all this imperfection, unique meanings and connections emerge."

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THE WORLD TRADE CENTER PROJECT

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programs must be flexible in order to meet the changing needs of families in mourning. In this project we have been expanding our analytic models by working with teams of multiple therapists with different specialties and areas of expertise. We utilize family systems as well as dyadic systems theories to define our approach, allowing us to offer non-traditional services to a traumatized group of mothers and children.

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Countertransference is a concept that therapists often work on, both in supervision and in their own personal therapies. In this article, third year candidate, Susan Caputo, expresses how her personal experience working with a child triggered many countertransference reactions, highlighting the importance for a therapist to keep personal feelings in check.

HEAD ON COLLISION WITH COUNTERTRANSFERENCE

SUSAN CAPUTO, LMSW

During my last year in Social Work School at NYU, I had a class with Judith Mishne on Child Therapy. While taking the class I did not have the opportunity to work with any children, and in many ways some of what I was learning seemed abstract. There was, something related to countertransference that Dr. Mishne said that has stuck with me ever since. She told the class that she had promised herself that she would never work with a terminally ill child because she felt it was one thing that she could not personally handle. I wondered at the time, how any therapist could manage this most difficult situation? Anna Freud (1963) believed that there are unusual pressures and stresses in work with children, and that these pressures produce strong internal reactions within the therapist. Morton Chethik (2000) wrote that the child therapist often feels a gamut of emotions, from negative affect, including feelings of bewilderment, anger and helplessness, to positive affects such as the desire to protect a child, and sometimes to even have "rescue fantasies."

As I learned her story from her oldest sister and mother, I began to realize that this case was going to stir up a lot of personal memories that I would have to deal with.

When I learned this theory I, like Mishne, wondered whether I would ever be able to work with a terminally ill child or one whose prognosis is unclear? How could a nurturing mother/therapist help a child who evokes such feelings of helplessness? In the past year, I have asked myself this question many times, while was in a position to see such a child in therapy. Would I be able to put my feelings aside in order to help?

A year into the program, I was reminded of what Judith Mishne had said, when I "chose" to work with a 13 year old girl who had a brain tumor. N comes from a large family of Mexican descent, and from the moment I took this case, I knew the countertransference issues would be right there, in and out of the sessions. When I met N, the connections were astounding. She was diagnosed with a brain tumor the day before 9/11, and had her first surgery the day after. Before the surgery, she had lost her vision in one eye. Like N, I have no vision in one eye. When I first started working with her she had already had two surgeries. The 2nd surgery was in March of 2002, and after many complications she was in the hospital for four months.

As I learned her story from her oldest sister and mother, I began to realize that this case was going to stir up a lot of personal memories that I would have to deal with. I, too, had had numerous complications and surgeries when I lost my vision. I then understood why the NYIPT training program requires candidates to be in their own therapy. I knew that this was going to be a balancing act between supervision to help N, and therapy to make sure that I could manage my countertransference, while putting N's needs first.

Discussing the case in supervision . . . helped me to realize that it was important that I not assume to know how N felt.

In a very small section of the world, a little girl was faced with a serious life threatening illness, in the midst of the world crisis surrounding 9/11. As I heard N's family describe the events, I couldn't help remembering that many years earlier, in a small section of Europe, my mother was torn from her family and taken to a concentration camp. Another world crisis, another 13-year-old girl experiencing trauma. At the time of N's intake, my thoughts were racing. So many people had died, not only in the Holocaust, but also in 9/11. I remember thinking, if my mother could survive, N could survive. If I could make it through all my surgeries, so could N.

N was friendly, had a beautiful smile, and exuded strength as a result of her family support, and through her own faith. From the moment I met her, we felt connected to each other. My first reaction was, "I want

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HEAD ON COLLISION WITH COUNTERTRANSFERENCE

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to work with her." Then I remembered what Judith Mishne had said, and I thought, "What if she dies?" I remember asking myself, "Are you crazy? Aren't there enough internal feelings that get stirred up by the very act of working with children?"

I was very drawn to this case, and as I thought about all the complications for me, I began to realize there might be complications for N. What if she didn't' want to work with a therapist who only had vision in one eye? What if sitting with me, led to her feeling she had to be strong all the time? Discussing the case in supervision with Karen Cadwalader helped me to realize that it was important that I not assume to know how N felt. The feelings she stirred up inside of me did not have to be the same feelings she was experiencing. I may have understood my own fear, but I could not know how she felt about her illness. I finally spoke with N and her family, in order to understand how they felt about my working with N and her family.

There were times when I would listen to her, and I couldn't help wondering if her defenses needed to stay intact. As long as she had her defenses she would not fall apart.

When N started coming for therapy, she already knew that her tumor was regrowing after her last surgery. Her family was terrified, and N would come into the room each week, hoping that no one would know that she, too, was scared. There were times when I would listen to her, and I couldn't help wondering if her defenses needed to stay intact. As long as she had her defenses she would not fall apart. In the first few months that we worked together, I learned of her embarrassment and shame because she could not always control her bladder. She described to me how during her last surgery, her pituitary gland was cut, and without medication she could not control her bladder. When she felt this way, she became depressed and angry. I would listen, and I helped her verbalize some of these feelings, although sometimes it was very difficult.

While I was listening to her, I would sometimes think of empathizing with her feelings, and check myself. I had to make sure that they were her feelings, and not feelings she stirred up in me. There were times when it felt like there was more than one helper in the room. Sometimes I believed that she was helping me too. One of the struggles she has had, is with her growth and development. I remember thinking one day after a session how difficult it must be to feel disconnected. Her mind was growing, and in many ways she was forced to mature emotionally, but her physical body was lagging behind. I thought to myself, this wonderful, strong young girl was just like my mother. At the same age as N, my mother was starved, unable to grow and develop, but had a myriad of defenses to keep her alive. Sometimes I realized that I wanted to rescue N because I couldn't rescue my mother. Feeling helpless felt unbearable.

After many months of working with N, it was time for her to have another surgery at the Boston Children's Hospital. It was at this time that I felt the most helpless. My countertransference feelings were so strong. I was so grateful that N had such a wonderful and supportive family to help her. I started to notice that as the time approached, I felt scared, yet I had to find a way to hold on to her fear. When I think back on this time, I realize that the key to helping her was my having the opportunity to talk about my own feelings in supervision and therapy. After all, this was about N and her challenges. Her road was unique and individual.

N had her surgery in February 2004, and then had 6 weeks of radiation therapy, 5 days per week. Her latest MRI has shown that the tumor has not grown, and she is now beginning to plan her future. I'm not sure what would have happened to either of us if she had not had a successful surgery. As I continue to see her each week, I feel so grateful to have been challenged by this courageous young woman. In the year-and-a-half that I have seen her, I truly believe that she has helped me grow as a therapist. Without her, I believe that the concept of countertransference might still be a bit foreign - you know that it is there, but you don't necessarily face it head on.

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FROM YOUR DIRECTOR

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the knowledge and experience she's gained over the course of three years in the program (see pp11 and 15 for comments from candidates).

During the past year we've moved onto the computer and we've launched our website at www.nyipt.org. Now anyone with a computer can log on and find out about our faculty and curriculum. Potential candidates can even download an application!

We have run classes and workshops on all aspects of working psychodynamically with children including a workshop at the Training Institute on helping professionals understand the particular needs of children who have suffered loss and experienced trauma. We have addressed the impact of the ongoing war in Iraq on the children with whom we work. Finally, while we continue to provide individual supervision for our candidates, we also ran group supervision at the Park Slope Center for Mental Health (see next column about our affiliation with PSCMH).

In the coming year the faculty of NYIPT will begin to focus on issues pertaining to cultural diversity. The children we see come from a wide range of racial and ethnic backgrounds, and we are dedicated to increase our awareness of the importance of cultural and social influences on the mental health needs of these children. A faculty committee will be addressing ways that our faculty, supervisors and therapists can become more culturally competent. Toward this end we have encouraged everyone to attend conferences (please see Tina Lupi's article on p. 4).

I would like to thank all the faculty and supervisors of NYIPT who have worked hard to make NYIPT the excellent training program that it is. I am proud to say that our staff has many interests and areas of competence (see our new faculty members on p. 5), and many have been expanding the models of therapy into the community and reaching out to those who need help (my article about the World Trade Center on p. 8 is only one example).

I want to express my sincere appreciation to all those who have contributed financially to our program (see description of our tribute to Jeanette Levitt at our fund raiser on p. 3. All of our input is needed for our program to thrive and grow. I hope everyone has a wonderful holiday season and I wish you all a successful and healthy New Year in 2005!

Phyllis

NYIPT AND PARK SLOPE CENTER: WORKING TOGETHER WITH COMMON GOALS

From left to right: Dr. Rita Seiden, Dr. Phyllis Cohen, Gloria Malter, Dr. Carole Grand, Karen Cadwalader, and Mary Tirolo.

On March 2, 2004 the Executive Board of NYIPT, including Phyllis Cohen, Carole Grand, Karen Cadwalader, Mary Tirolo and Gloria Malter, met with Dr. Rita Seiden, Executive Director of the Park Slope Center for Mental Health at the clinic to discuss ways that an affiliation could work to benefit both organizations. Since Park Slope is regulated by the Office of Mental Health, should we move to a more fomal relationship, we will need OMH approval.

Many of the candidates in all three years at NYIPT are doing their clinical work at the Park Slope facility. The meeting marked a beginning step for both entities to contribute toward the common goal of enhancing child therapy in the Park Slope community.

At the meeting it was decided that Karen Cadwalader would serve as the NYIPT Program liason with the clinic, while Susan Caputo will continue as the candidate liason in addition to her role as Director of Children's Services at the clinic. We have discussed holding some classes and workshops at the Park Slope Center and hope to continue to expand programs that will be offered to all the therapists who work at the facility

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The Executive Director of the Park Slope Center for Mental Health writes a letter to our candidates:

EVERYTHING YOU NEED TO KNOW ABOUT YOUR PLACEMENT IN A MENTAL HEALTH CLINIC

RITA SEIDEN, LCSW, PH.D.

Dear NYIPT Candidates:

Here you are, working your heads off, holding down your day jobs, attending evening classes and supervision, and seeing patients in the evening. And now, I'm here to tell you about your obligations to your clinic placement !!

1. Following the rules. Whatever the expectations are from NYIPT, you still have to follow the clinic's rules. The clinic cannot escape its obligations to the Office of Mental Health or whoever else licenses it or pays for services.

2. Maintaining the written record. From the regulators' and insurers' point of view, the only evidence of treatment is the written record (the chart). No notes? No treatment plan? No treatment plan = No treatment. (No matter how well the patient is doing !) The clinic is dependent on its regulators and insurers to continue in business. Therefore maintenance of charts becomes a major and inescapable housekeeping task. When you are paid to provide a clinical service, you are also being paid to complete the paper work.

3. Treating the patient. Who is responsible? – The clinic! When you provide psychotherapy inside a clinic, the clinic is responsible for the care of all patients. You will be asked to meet the standards of care set by the clinic. These standards may or may not be the same as NYIPT's. NYIPT is there to teach the ideal. The clinic represents the actual. Sometimes the clinic will hold you to a lower standard than you think appropriate. But ultimately the clinic must prevail because the clinic is responsible for all patients.

4. Treating the patient. The supervision. As candidates, you have NYIPT supervisors, and as employees of a clinic, you have clinic supervisors. At times they may not agree. The bottom line is that your NYIPT supervisor cannot unilaterally decide how to proceed with a clinic patient. Because of the responsibility issue, the clinic must make the final Decision, if there is a question. As a candidate, you may decide not to be the psychotherapist of a particular patient, but you may not admit, treat or discharge any patient without the clinic's consent.

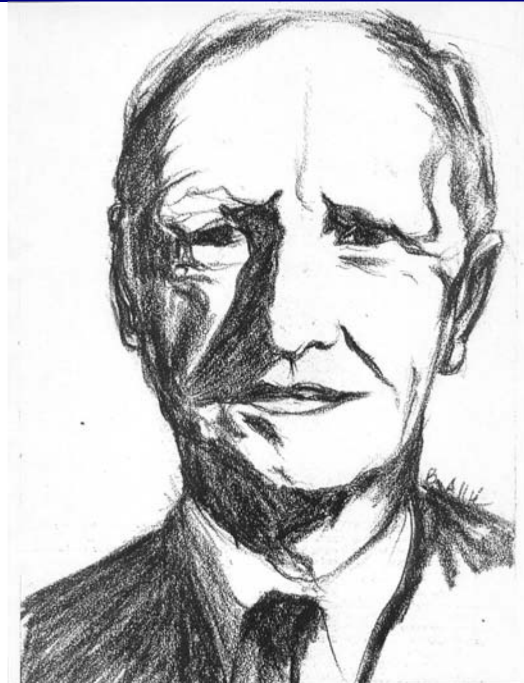
This may sound a bit harsh. But as a clinic director, I also want to tell you that here at PSCMH we are delighted to have you – with your ideals, with your intensive training, and with your dedication. We want you to have a good experience with us. We want you to stay on and increase your caseload, and contribute to our growing reputation as an excellent place to bring children and their families. Thank you for your wonderful service.

Rita

NYIPT faculty member and supervisor, Bonnie Allie, is not only a teacher and clinician, but also an artist! She has generously donated a charcoal drawing of D.W.Winnicott. to be auctioned at our next fund-raiser.

D.W. WINNICOTT, A TRIBUTE IN CHARCOAL

BONNIE ALLIE, MPS, ATR



"I return to my affection for D.W. Winnicott in this portrait of him as an old man. Through my years of knowing children and their caregivers I have revisited his writings seeking inspiration and solace. I rediscover his presence and draw on his belief in the child's play and art as expressions of the authentic self. Winnicott said, "It is creative appreciation more than anything else that makes the individual feel that life is worth living." Winnicott, D.W. (1971a) Playing and Reality, New York: Basic Books."

Bonnie

NYIPT PROCESS:
THE GROWTH OF A PROGRAM THROUGH THE EYES OF SOME OF ITS STUDENTS

NYIPT's well-balanced design of theory, clinical experience, and individual supervision has provided me, as someone new to child therapy, with the competence and confidence to professionally pursue a career in this field.

JUNIPER BRINKMAN, 1st year

From working as a child therapist I realize that children can teach us adults a lot of things, things that we struggle with sometimes. For example, how to be creative without putting too many preconceived thoughts into your work, but rather letting yourself experience reality and the world as if we look at it for the first time.

POLINA VOLYANSKAYA, 1st year

As a second-year candidate, my role as child therapist is becoming clearer. Instead of always worrying whether I am using the right "technique" or whether I should be making an "interpretation," I am more able to focus on the relationship between myself and the child. Faculty members often say that in the end "it is all in the relationship." As I see my relationships with the children become more long-term, this phrase has increasing meaning to me. The relationship allows the child to trust and thus to grow.

DEBRA HARRIS, 2nd year

Now that we've come to the half-way point of the training program it's good to look back and see just how far we've come. We're feeling more confident about our clinical work with children and parents as we begin to integrate the many readings and discussions we've shared. Our ease in supervision reflects our growing comfort in the program as we begin to synthesize all that we are being given.

MARILYN IPPOLITO, 2nd year
ROYANNE WEISS, 2nd year

In my second year, I have seen the therapeutic relationship with my child patients and their parents take form. I also can identify progress and movement in the flow of the sessions. Classes, supervision and the clinical experience all contribute to my increasing ability to work therapeutically with children.

SUSAN STARK, 2nd year

I am really seeing all of the pieces of the program come together. The theory taught in the classes, the clinical work with children and the excellent supervison (along with personal therapy) provides a rich learning experience. NYIPT faculty is of the highest caliber and I feel grateful for having been a student in the program.

SUSAN BOLLES, 3rd year

As I look back on the three years of training, I know that my clinical skills have been enriched by learning, excellent supervision, a wonderful support system, and a sincere dedication by faculty and supervisors to helping children and families in need. Starting this program a year after 9/11 has helped me to realize even more that with the right training you can bring hope into the lives of children who are our future. I believe that these three years are just the beginning of reaching my goal. As I look to the future, I feel excited and confident because the support of NYIPT's staff, clinicians, supervisors, and peers will be there. They are a true model of a family.

SUSAN CAPUTO, 3rd year

When I started this program, I didn't think I would make it. I have to give thanks and praise to Susan Caputo for being there for me anytime that I had questions about my cases and just to talk to me when I was feeling down. I would also like to thank Phyllis Cohen for her support and help to keep me going. In the past three years I have received the best supervision. Each year, I have learned something new, a new way to engage my clients, especially the difficult ones. I must give Jeannette Levitt the highest praise. Not only did she show me how to work with my clients, but she gave me books to read from her personal collection that clarified the articles we were reading in class. I would encourage anyone who is really dedicated and willing to work hard to request Jeanett to be your supervisor. Thank you to the staff at NYIPT.

ELEANOR CHEATHAM, 3rd year

The combination of NYIPT classes and supervision have helped me become a confident, competent, and more effective child and adolescent therapist.

ALLISON GOLDSTEIN, 3rd year

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Mary Tirolo, Phyllis Cohen, Mike Eigen, Norma Simon, Jeanette Levitt, and Sherman Schacter, old friends reunited at the "Tribute to Jeanette" on June 13, 2004

NYIPT PROCESS:

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At this time two years ago I was considering family leave because the beginning of the program felt overwhelming and difficult to combine with the rest of my busy schedule. Now, two years later I feel so comfortable and pleased with the work I am doing and the knowledge I am constantly gaining. Reading assignments, class discussions, supervision and my personal therapy have brought out a very different perspective, a new analytic approach and many personal reactions. I am very pleased that I stayed in the program, especially with my class of so many different individuals and professionals. I am looking forward to graduation and a continuation of my learning experience.

LANA GRINTSVAYG, 3RD YEAR

As a third year candidate in the program, I have experienced exceptional supervision for three years. The supervisors in NYIPT have played a major role in building my confidence as an aspiring child therapist, especially when it comes to effectively working with the parents.

NNEKA NJIDEKA, 3rd year

Through the program, I have developed more comfort, confidence and clinical intuition while working with children. That is a big change from my first, experiences, when I felt like a fish out of water. Before the program, although I felt connected with children on an empathic level, I still felt technically inadequate. Now, although I am still on a learning curve (and always will be), I feel in my element when I work with children. In that respect, the program has made a world of difference.

ROBERTA PALEY, 3RD YEAR