The **New York Institute for Psychotherapy Training**

NYIPT TODAY

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A LETTER FROM YOUR EXECUTIVE CO-DIRECTOR

DR. PHYLLIS COHEN

Dear Friends of NYIPT,

In this ninth edition of NYIPT Today, I hope you will feel as proud as I do when you read about the wonderful work we have been doing at NYIPT in our tenth year!

Newsletter articles have been written by faculty, graduates and candidates, with themes involving loss and painful adjustment in complicated, difficult situations. At first I wondered why that was. Then I realized that in recent times, we have all been touched by many people who have experienced major losses. In this difficult economic climate many have lost jobs or find themselves working in conditions of uncertainty. Our economy has been unstable and many struggle to make ends meet. Moreover, we have seen the terrible impact of natural disasters – from tsunamis and earthquakes, to hurricanes. Even in New York City, tornadoes have touched down for the first time in many years! Finally, our country has continued to be at war fighting terrorism. These situations have affected all of us, if not directly, then indirectly through the loss of a sense of safety in the world.

At NYIPT, our mission is to provide training to all those who affect the lives of children and adolescents. We work with parents, teachers and mental health workers to ensure that the adults from whom children seek comfort are prepared.

If adults have been suffering from feelings of uncertainty and anxiety, we must consider the exponential impact that our children are experiencing. Children look to us as parents, grandparents, teachers and therapists, to help them maintain a sense of safety and well-being. At NYIPT, our mission is to provide training to all those who affect the lives of children and adolescents. We work with parents, teachers and mental health workers to ensure that the adults from whom children seek comfort are prepared.

In this issue, of NYIPT TODAY, you will read how play therapy and our direct work with parents can help children. We recognize that the power of a therapeutic relationship, the experience of being with a person who is trying to understand one's thoughts, and the opportunity to express inner conflicts and concerns in play can change the course of a child's life. In our three-year training program we teach play therapy techniques to social workers and other mental health professionals,, enabling them to do this important work. In the past year, we have taught staff in mental health clinics and we have provided training for teachers and parents at schools. We have also represented NYIPT on the radio, reaching over 10,000 listeners to help them understand how children are affected when a parent is incarcerated. All of these topics are covered in this Newsletter.

To all of our past supporters, we thank you for your helping us reach this point. In the past year members of our Executive Board and our Board of Directors have worked tirelessly and have given generously of themselves in so many ways, to run the program and to raise money to keep everything going. And our wonderful faculty and supervisors have continued their commitment to our program, many of them working pro bono or accepting fees far below the norm.

NYIPT is now ten years old. To date, our excellent candidates have conducted over 30,000 play therapy sessions with children. In addition, our wonderful graduates have gone on to run programs all over the New York City area, supervising and training countless therapists who are also helping children and parents

. We hope we can count on you in the coming year to continue to support our efforts. The future of NYIPT depends on all of us.

Best Wishes,

Phyllis

Dr. Phyllis Cohen,
Executive Co-Director, NYIPT

THE NEW YORK INSTITUTE FOR PSYCHOTHERAPY TRAINING

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MISSION:

The New York Institute for Psychotherapy Training (NYIPT) for Infants, Children and Adolescents, is dedicated to improving the quality of mental health services for needy children of all ages and their families who live in the New York City area. We realize our mission by providing psychotherapy training to qualified mental health professionals, and by offering direct training services to parents, teachers and mental health workers at various agencies and schools in New York City. Our ultimate goal is to help children recover from traumatic situations by overcoming feelings of anxiety, helplessness and depression, in order to continue their development.

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

IN THIS ISSUE

pg. 1 A Letter From Your Executive Co-Director, P. Cohen
pg. 3 NYIPT News
pg. 5 The Trauma of Adoption – Emilia's Challenge, G. Ness
pg. 7 Moving the "Triangle" To A "Quadrangle," S. Sternberg
pg. 9 Reflections On Reporting Child Abuse and Being a Parent, W. Salton
pg. 11 Observations Of Play In Two Two-Year Old Children, N. Kamlet
pg. 13 And Baby Makes.....Three? A Family Systems Perspective, C. Bagnini
pg. 15 The Case of Zoe, R. Randolph & T. Simon

NYIPT NEWS

NYIPT BOARD OF DIRECTORS HOSTS A WINE TASTING PARTY WITH LISA CERCHIONE

Diana Carone, of Wooden Ship Wines, brought cases of reds, whites, and prossecos to the NYIPT Board of Directors' fund raising event on December 1, 2010. A lively group of NYIPT supporters enjoyed wonderful wines while a percentage of all wine sales was donated to NYIPT. And many who couldn't attend sent donations!

Our appreciation and thanks go out to those who donated their time, goods, and services to make this event a big success. Heartfelt thanks to Francesca Cercione, who designed the invitation. Our Board member Marilyn Merone guided her committee of Board members in creating beautiful baskets of wine and treats which were sold at silent auction (See below). Our thanks to John Linder of the Landis Pork Store and Mr. & Mrs. Tomassino who donated delicious cheeses and hors d'oeurves, to Adeline Lepore for fabulous cookies from Ferrara's Pastries, and to Lynda Brodsky for making the Avery space available and for her fantastic home-baked cookies. Finally, a special thanks to our DJ,Victor Spadaro of Victorydjs2000@aol.com, who has provided music at NYIPT events for many years. This was a delightful event and a wonderful way to support NYIPT's work helping children in need.

Baskets by Marilyn Merone and Committee.

For an upcoming calendar of events, visit us on the web at WWW.NYIPT.ORG

NYIPT CELEBRATES ITS 10TH ANNIVERSARY

On Sunday, Jan 30, 2011, a decade of NYIPT graduates were honored at the first of our tenth anniversary celebrations. The reunion was attended by many graduates from 2000 on, and by many NYIPT faculty and supervisors. It was a wonderful evening, filled with interesting conversation, and the opportunity to hear about the current lives and work of our amazing graduates.

Many people volunteered and contributed to the success of this event, from the delicious "pot luck dinner" to the lovely music by NYIPT supervisor and violinist, Jane Buckwalter, flutist, Richard Paratley, and cellist, Carl Courant. A special thanks to our faculty coordinators Gloria Malter, Kim Kleinman, Georgi Antar, Tina Lupi and Geri Ness. Also, we would like to thank our graduates Debra Harris, Marilyn Ippolito, Royanne Weiss and Erin Orjuela. Your help was invaluable. By working together and sharing our efforts, we can accomplish great things!!

Faculty Gloria Malter & Nancy Rosenbach, with Graduates Royanne Weiss, Debra Harris, Susan Caputo and Susan Stark.

NYIPT Executive Board: Tina Lupi, Regina Monti, Phyllis Cohen, Tracy Simon and Mary Tirolo. Missing from picture: Carole Grand

GRADUATE SOCIETY WORKSHOP ON SAND PLAY

On Sunday March 6, 2011, the NYIPT Graduate Society hosted a workshop entitled: "Jungian Sandplay Therapy: Engaging the Psyche," with Therese Bimka. Jungian Sandplay Therapy is a modality that promotes change with ease and fun. It uses the symbolic world of the imagination as the vehicle for healing. In Sandplay Therapy, clients play with sand using miniature figures to represent their internal and external worlds.

Therese Bimka is a Jungian sandplay expert. She presented a wide variety of client cases as examples of how sand play can be used.

Toys used in sand play

This workshop is one example of the collaboration of NYIPT with mental health clinics. It was held at the Park Slope Center for Mental Health in Brooklyn, and was offered to clinical staff at Park Slope as well as the NYIPT community of candidates, graduates and faculty.

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THE NOVICKS CREATE "A CARING CIRCLE" WITH NYIPT

On the evening of June 2, 2011 at Hunter College in New York City, Dr. Jack Novick and Mrs. Kerry Kelly Novick presented an interactive workshop for parents, grandparents, teachers, and therapists, titled "CREATING A CARING CIRCLE FOR CHILDREN." Dr. Novick,, a psychologist and psychoanalsyt, and Mrs.. Novick, a psychoanalyst, are founders of the innovative Allen Creek Preschool in Ann Arbor, Michigan.

Drawing on ideas from their newest book, Emotional Muscle: Strong Parents, Strong Children, the Novicks discussed ways to promote optimal development in children.

The Novicks spoke in an interesting, straight-forward way, illustrating their points with lively vignettes involving children of all ages. They explained that often parents think their task is to "protect" their children from experiencing any distress. They pointed out that parents can better help their children if they develop a partnership with them, supporting them as they grow, while helping them face life's challenges. The Novicks also spoke about the importance of setting realistic and appropriate limits for children, noting that this promotes trust, mastery, and competence. They explained how when children do not know their limits, they may feel anxious, behave aggressively, and may even act "entitled."

The Novicks suggested that when we speak to children about their actions, we should link pleasure with work, effort, and persistence. For example, we might say to a child: "You are trying so hard. It feels so good [to do that task or activity)," thus connecting their efforts to satisfaction and pleasure in the pursuit of their goals. This is another way that parents can promote "emotional muscle."

The importance of positively reframing situations was emphasized. The Novicks said even a crisis can be defined as an opportunity rather than a disaster. When children experience strong emotion such as anger, we can view this as a signal that something needs to be addressed. We can then ask the child to bring the "volume" down to a manageable level so that the actual problem be worked on.

In speaking directly to the therapists in the audience, the Novicks urged them to have empathy for parents. They believe parents genuinely want to do a good job in raising their children, but need tools to do their best. Our thanks to the NYIPT Board of Directors and to NYIPT Faculty Phyllis Cohen, Muriel Frischer, Eileen Kennedy and Kimberly Kleinman for a successful event!

Phyllis Cohen, the Novicks, Muriel Frischer, Mary Tirolo, and Kimberly Kleinman

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THE TRAUMA OF ADOPTION – EMILIA'S CHALLENGE

GERI NESS, LCSW, NYIPT SUPERVISOR

Ms. Geri Ness speaks:

Emilia, age 8, stuffed several dolls under my shirt and commanded me to lie down on the couch. She told me to breathe hard and cry out in pain and pretend I was holding my boyfriend's hand hard. I was then told to push hard until the babies were delivered. When I questioned Emilia about her intimate knowledge of childbirth, she informed me that her favorite TV show was all about mothers giving birth, and she watched every day. In play we reenacted these scenes many times over the next year-and-a-half. What made them so revealing was what Emilia would do with the babies after they had been born. Sometimes she would throw them on the ground or in the garbage while laughing. Other times she would be nurturing and loving towards them. She also varied in how she treated me, the mother of all these babies.

Emilia was 2 when her adoption was completed. She was born in a poor country, reportedly to a single woman who put her up for adoption when she was 8-months-old. Lynne, her adoptive mother, met and spent two days with Emilia at that time, and hoped to bring her to the United States, but because of the court system this did not happen. Emilia was placed with a foster family where she lived for over a year until Lynne was finally permitted to bring her home to the U.S. Lynne reported that the foster family had seemed loving and was sad to say goodbye. For several days after leaving the foster family, Emilia seemed to be sad and "in shock," but this reportedly abated quickly.

Children who are separated from their biological parents face many challenges. Their ages at separation and adoption are important factors in their development, as are their experiences prior to adoption. Individual strengths and vulnerabilities are also factors that affect how these children handle their new lives. The loss of biological parents is a trauma that needs to be addressed in therapy as well as other known and unknown traumas that occurred and might have affected the child. All of these factors are illustrated in the case of Emilia. At the age of 4-and-a-half, Emilia was brought into therapy with complaints from her adoptive mother that she was very clingy, following her mother around all the time, and unable to sit still or maintain enough attention to read a book. Emilia also threw tantrums when she didn't get her way, and she especially fought the idea of bedtime. In preschool, Emilia's lack of attention was a problem, but she was also described as very social and engaged easily with the other children.

Little was known about Emilia's birth mother other than that she had reportedly given up 4 or 5 other children for adoption as well. Nothing was known about her father. When Emilia was brought to the U.S. at age 20 months she was barely walking and was still being bottle fed.

Lynne was a single woman in her late 50's. She had been briefly married in her 40's, but was unable to conceive. She and her husband divorced, but Lynne was determined to adopt a child. She is a highly educated woman with an advanced academic degree. She had traveled around the world many times for her work, but was now settled into a job working for an organization that kept her in New York. During her travels Lynne picked up a chronic illness that made her frequently fatigued with a persistent need to sleep.

When I first met Emilia, I was immediately charmed. She was a particularly adorable little girl. I remember thinking that Lynne had won the adoption lottery. As we worked together it became clear that Lynne did not feel that way. Instead, she felt overwhelmed with the responsibilities of being a mother, and especially having a child who had experienced so much loss and trauma. Lynne had a difficult relationship with her own mother who had been hospitalized for a year with severe depression when Lynne was 4. Lynne described her mother as unstable and always flying into unpredictable rages. In contrast, Lynne described herself to me as having been a very independent and self-sufficient little girl who managed quite well even without her mother being a stable figure in her life.

Emilia and I worked together for six years and over this time issues relating to her past and her present life came up both in our relationship and the play therapy. Emilia's adoption history was very significant as was the collision of Lynne's needs versus those of her daughter.

It was difficult for Emilia to separate from Lynne at the beginning of our work together. For a long time she insisted that her mother join us in the therapy

continued on page 6

EMILIA'S CHALLENGE

(continued from page 6)

room, so we worked together in tripartite therapy. In her first session she used the dollhouse which she filled with babies. She was very concerned with where they would sleep. She also pretended to be a doctor who fixed sick babies and broken dolls and trucks.

Another game that showed up early in our work involved play foods and utensils. Emilia would pretend to give me food, but then would take it back and laugh at my distress. Many sessions were spent with her mother and I pretending to be babies while Emilia alternated between being kind and taking good care of us and then punishing us and putting us in the closet. Sometimes Emilia would be the baby pretending to be in her mother's stomach, coming out crying and hungry.

Over the years I was often assigned to be the victim of frequent injuries and falls in our pretend play, These situations would result in broken limbs. Emilia would send me into rooms hot with fire, where she, as the doctor, would alternate between ministering to me gently and inflicting more pain on me with long sharp needles and/or cutting off the affected limbs.

Emilia's play is typical of adopted children who have an early history of trauma. Her play themes were her way of communicating the uncertainties, terrors and pains that she experienced in the first years of her life. Over time Emilia made progress with improved functioning at home and at school, even though significant learning problems developed. I helped facilitate a transfer to a special school for children with learning issues. Collateral sessions with Lynne were vital in addressing Emilia's difficulties, including helping Lynne understand her behavior in the context of her traumatic losses. Eventually Lynne accepted a referral and began her own therapy.

Emilia's therapy was ended just before her 11th birthday when she seemed ready to say goodbye. By then she had worked through many losses and traumatic events of her past, her difficult adjustment to a new mother, and a change of culture and language at the age of two. Play therapy and her relationship with me provided a way for her to express herself. Even though some problems still persisted, it seemed like the right time for her to end therapy. Both Emilia and her mother know that they can always come back for more help if or when either feels the need.

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SCHONBERG SPEAKS TO NYIPT GRAD SOCIETY ON TEEN DEPRESSION AND SUICIDE

The NYIPT/NHG Graduate Society presented a professional talk by Dr. Ken Schonberg, on July 13, 2011 at the Montalk Club in Brooklyn. The lecture, "When Are Depressed Teens At Risk Of Suicide?" was designed to increase therapist awareness of risk factors in depressed adolescents.

While working as a pediatrician at Montefiore Medical Center, Dr. Schonberg had contact with several thousand adolescents who had been hospitalized for self-destructive behavior, diagnosed as "attempted suicide." This group had a greater likelihood of previously diagnosed psychopathology, particularly problems with concentration, boredom and loss of interest in previous hobbies and activities, depression, somatic complaints, as well as acting out behaviors such as truancy, running away, and substance abuse. Dr. Schonberg identified three risk factors for suicidal behavior: family disruption (from separation and divorce, military service, living with other than one's biological parents, and not knowing one's biological parents), family history of suicide attempts, and biologically-based depression.

Schonberg stated that the most frequent precipitants for suicidal behavior were conflicts with parents, disruption in romantic or peer relationships, loss of a loved one, school failure, and legal difficulties. He stressed the importance of close follow-up for at-risk teens after being released from the hospital. Those who attempt suicide frequently try again, and sometimes succeed; in fact, he said that the biggest risk for committing suicide is surviving a previous suicide attempt.

Dr. Schonberg stated that a quick diagnostic interview should include the questions: "Do you ever get very sad?" "Do you ever think of hurting yourself?" "How would you do it?" and, "How often do you think about it?"

Dr. Schonberg is a Professor of Pediatrics at the Albert Einstein College of Medicine in New York, specializing in adolescent medicine. He is also a member of NYIPT's Board of Directors. He will be presenting a program for parents and teachers on risk factors for suicide in depressed teens. See website for details: www.nyipt.org .

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MOVING THE "TRIANGLE" TO A "QUADRANGLE:" THOUGHTS ABOUT ADOPTED CHILDREN AND THEIR FAMILIES

SIMONE STERNBERG, ED.D., NYIPT SUPERVISOR

Adoptive families face issues that are different and more complex than those facing families with only biological children. As child therapists, we must find ways to enter the triangle formed by the biological (birth) parents, the adoptive parents and the adopted child, while at the same time being sensitive to the joys, sorrows and tribulations of all. As we enter the "triangle," we may "adopt" our patients and be adopted by them. When we are thus called upon to contain the needs of all parties, we expand the triangle into a "quadrangle."

Even if the birth parents have no further contact with the child or the adoptive parents, they still remain important figures in the internal life of the child and the adoptive parents.

The biological mother is likely to be a person with significant problems of her own. She may have been unable to parent because she was too young or lacked sufficient support. She may have been pressured to give her child up for adoption, intensifying issues of guilt, blame, shame and loss. Negotiating a mourning process would be very difficult but desirable. For the birth mother, her own therapy can be immensely helpful. If the biological parents can choose the adoptive parents as in "open adoptions," there are particular opportunities for mastery, as well as the need to master feelings of jealousy or ambivalence toward the adoptive parents.

At times birth fathers may be uninvolved or even unknown, although some information may be accessible, One may wonder: How did the conception occur? Did the father know about the pregnancy? Was he involved in the decision to give the baby up for adoption?

When working with adopted children we need to work with parents in traditional and new ways. Often, the adoptive parents have struggled unsuccessfully to have a biological child. They may have tried to conceive for years, sometimes with complex intervention from infertility specialists. At the time of the adoption, they may be significantly older than their developmental peers. As the new parent(s) plans for an adoption, they must mourn their inability to bear a biological child and come to terms with their inability to provide genetic continuity to the next generation. Erik Erikson describes these dilemmas as well as possible solutions in the stage of "generativity versus stagnation" (1963).

In an even more complicated situation, consciously or unconsciously, a child might be adopted to serve as a "replacement child" for a biological child who has died. This is difficult situation for the adoptive parents and for the child. As therapists, we need to look at how the child is accepted by the adoptive parents, and further, by the new family members and friends. The naming of the child can be a window into understanding the role the child will have in the adoptive family. Naming a child for a deceased family member is normative in some cultural groups, but can also present complicated dilemmas. Religious rituals, such as circumcision, baptism, and naming ceremonies, can be helpful in integrating the adoptive child into the family.

A major issue for adoptive families is why, how and when to tell the child about the adoption. One possibility is to tell the child as soon as possible that "We chose you." The very young child can understand this only in a limited way. Some parents wait until the child is three or four and can understand more. Other possibilities include waiting until the adoptive parents are "ready," or until the child is "ready." At whatever point the child is told, the information and its meanings will have to be reworked at each developmental phase. Some may wait until the child reaches young adulthood. And there are some adoptees who don't confirm their adoption until after the death of their adoptive parents.

The adoptive parents can be over-invested in having the child "know" or "not know," or they may be over-protective of their child and / or still mourning the "lost" or "missing" biological child. It is particularly problematic, though, if the child learns of his or her adoption from friends, neighbors, or other family members. For this reason, it is usually better for parents to have some discussion with their child about the adoption early on.

In some cases the adoptive parents' wishes and expectations for their child may be a poor fit for the child they adopted who may be incapable of meeting these expectations. The child's interests and talents

continued on page 8

MOVING THE "TRIANGLE" TO A "QUADRANGLE"

(continued from page 7)

may lie in other areas. In their disappointment the parents may blame the biological parents for perceived deficiencies in the child, they may blame the child, or they may feel that any difficulty can be compensated for by an intensified effort on their part.

The normal stress in raising children is often exacerbated in adoptive families. If these stressors are not managed, alienation between the adopted child and the adoptive parents may result. This can place added strain on the adoptive couple, in some cases resulting in separation or divorce.

Inevitably, for the adoptee, there are issues related to loss and reactive anger. Regardless of their root, the target for these feelings is often the adoptive parents. Attachments and separations can be difficult. Identity issues may come up at each developmental stage around "Who am I?" "Where do I belong?" "What will I be when I grow up?" Fantasies about the biological parents may range from very positive to very negative, as in "The Family Romance" (Rosenberg, 1992), (e.g., "My birth parents are royalty; how did I end up with these dull parents?). The child may wonder, "Why did my mother give me away?" Often, the child creates a fantasy about what led to his or her adoption. One adoptee was sure that his biological parents were in love, but too young to keep him. He then resented his "dull, plain (adoptive) parents."

In adoptive families, there is an intense interplay between the child's defenses and those of the adoptive parents. The child can be disappointed, ambivalent and angry at both sets of parents. The child may wonder, "Do they really love me?" "How much do they love me?" and "Will they love me even if I do "bad" things?" Illness, divorce or death of the adoptive parents can leave an adopted child feeling he or she is to blame. There can be a fear of a second abandonment, this time by the adoptive parents. The child may decide it is better to provoke the abandonment than to be surprised. Behavior that tests the limits is to be expected.

Specific developmental tasks of the adopted child include confronting the reality of his or her history and present situation, recognizing conflicted feelings, and working towards an integration of the psychological, biological and emotional components of their personal struggles. When this process goes well, the child can develop a cohesive sense of self.

In many of these situations, the child or family can benefit from professional help.

Adopted children are overrepresented in out-patient, in-patient, hospital and residential therapeutic settings. As noted earlier, they can feel unwanted, rejected and abandoned by birth parents and / or by adoptive parents as well. Symptoms may involve difficult to manage behavior or internalized distress and suffering. As therapists to adopted children, we fulfill a vital role. When the therapist joins the child and the adoptive family, the "triangle" can indeed become a "quadrangle."

References

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Rosenberg, E.B. (1992), The Adoption Life Cycle. N.Y.: The Free Press

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NYIPT OPEN HOUSE

The NYIPT 2010-2011 "Open House" was held on May 16, 2011. It was attended by NYIPT graduates, faculty, candidates and a group of potential new candidates. Rachel Randolph, a third year candidate, presented a difficult case highlighting how a therapeutic relationship, combined with play therapy, can help a child cope with the adverse effects of parental divorce and vying for custody. The case was discussed by Dr. Tracy Simon, who also facilitated an interesting discussion among the participants. For a detailed account of the case presentation, see page 15.

Ms. Rachel Randolph and Dr. Tracy Simon
Speaking at the Open House

REFLECTIONS ON REPORTING CHILD ABUSE AND BEING A PARENT

WILLIAM SALTON, PH.D., NYIPT FACULTY AND SUPERVISOR

I first treated Frankie when I was the director of the Family and Youth Addictions Program, a grant funded clinic for substance abusers and their family members, at Jacobi Hospital. Frankie was the middle child of three boys, each with a different father. Wanda X. was Frankie's mom. She was a forgettable stripper who worked in a backstreet bar in the Bronx. She had gone downhill from there. There was poly substance abuse, prostitution, theft, jail time and, of course, poverty. This was my time in "the trenches," as one of my graduate school professors called it. I was working within the public sector so that I could "give something back" before setting up a private practice. Although my professor suggested that every mental health practitioner should visit "the trenches" for a while, I don't believe I ever left them.

Frankie was a 10-year-old "man-child" who was a mix of many things. He was angelic and tough, naïve and streetwise, distracted from schoolwork yet focused on the Yankees and his video games. He was extremely ambivalent about his family, growing up, following rules, coming to therapy and practically everything else in his young life. One day he came into a session with a welt on his arm and a puffy lip after a fight with his mother. He begged me to promise that I wouldn't tell anyone how those bruises really happened, but I told him that was a promise I could neither make, nor keep.

Later that afternoon I attended a team meeting where we discussed what to do. A great deal of horror, condemnation and self-righteousness filled the room. "I can't believe she could do such a thing!" "She should never have had all those children; maybe she shouldn't have had any!" and, "Oh that poor little kid" were some of the comments that reverberated around the table. After I called in and reported the case to the Administration for Children's Services (ACS), it was accepted, and it fell on me to call Wanda to tell her that she would be receiving a visit from ACS within the next 24 hours.

Our conversation went like this:

Wanda: OK Dr. Salton. Yeah, I know, you're just doing your job. I got it. You probably don't even want to hear the real story, do you? Don't expect Frankie to be making his appointment next Tuesday, or any other Tuesday for that matter. We're done with you and your clinic.

Me: But Wanda, please, can't we talk about this?

Wanda: Talk, talk, talk. All you counselors ever want to do is talk. But I'm gonna have some asshole at my house in the next 24 hours while you're eating dinner at some restaurant. If you really wanna talk, then I got one question for you.

Me: Yes, and what might that be?

Wanda: Do you have any kids?

Me: I really can't understand how that might be relevant Wanda. We're talking about you, not me.

Wanda: Yeah, right. Well then, f _ _ _ you."

The receiver was slammed in my ear.

Three years later, and then going forward for the rest of my adult life, I realized that Wanda's question was indeed one of the most "relevant" questions that anyone has ever asked me. I thought about how, after a gestation period that lasted much longer than 9 months, my wife and I had adopted a 10-month-old boy from Guatemala.

Like Frankie, our only child is also a mix of many things. He is wonderful, taxing, brilliant, clueless, hilarious, gauche, loving, disrespectful, and unconditionally the best thing that has ever happened to us. But, as I quickly found out, being a parent is an unequivocal mirror on my soul. All of my emotions, unresolved conflicts, embarrassments and misgivings readily occupied front row center seats in our newly renovated nursery. I quickly learned that although I am a trained child therapist, it is very difficult to play the same games with your own child that you may have played with other kids. And most parents who live busy and stressful lives, don't usually take the time to play games with their kids in the first place, even if they think they should.

Which brings us to the question of parental anger. Most people think I'm a pretty nice guy and frankly, I do too. But as I learned early on, (unfortunately too late for my interaction with Wanda X.), parenthood can bring about levels of frustration and anger that I didn't even know existed within me. After all, it's not just any kid who isn't cleaning his room, doing his homework, eating his vegetables, taking a bath, and then saying all those awful things...it's MY KID. My progeny, my legacy, my family, my reputation, my … Let's just say it can get pretty intense.

So now I'm starting to "get it" when I think about

continued on page 10

REFLECTIONS ON REPORTING CHILD ABUSE

(continued from page 9)

Frankie and his mother. Now I understand how crazy one can get and how easy it is to "lose it." Now I understand how the intense feelings I didn't even know were possible can surface in a millisecond. Now I know how one's child can change from an angel to a monster in the blink of an eye and how that can completely rock your world for a week. Ms. X., now I understand how much you hate me for making your private life into a public case number in one phone call. Oh yes, Ms. X. Now I'm really starting to get it...

So Mrs. X, how do all of these realizations change things between us? In some ways a lot, and in other ways, not at all. Although I now have a greater understanding of Wanda's intense feelings, as a parent she still has to learn how to put the brakes on, just like I do every day. I need to help her, and others in her situation, see that there is a difference between feeling things and doing them. I'll still have to report her to ACS if she hurts her child, not just because I'm a "mandated reporter," but because hurting children is the wrong thing to do and children need to be protected. If a child is at risk, I must do everything in my power to see that that child is safe. But somehow, in some way, I would like Ms. X. to know that I know that children can make you crazy. And I now know that Ms. X. probably "didn't mean to do it." It's very few of us that really mean to do it. But if we can talk about these things, and if we can realize that all feelings are OK and that many actions are not, then maybe one's actions can change. I can now better empathize with parents because of my experience as a parent.

Of course I never heard from Ms. X. again and I have no idea about the outcome of her investigation. But I'm still working in the Bronx with children and families, and now I'm trying to help my NYIPT students understand people like Ms. X. I often refer them to Jacobs' and Wachs' book* about working intensively with troubled parents in order to help troubled children. I am heartened that I can help many of my supervisees who do not have children appreciate parents' inner and outer turmoil. In retrospect, I realize that I needed to develop a better working relationship with Mrs. X. in order to help her accept the idea that my calling ACS was both to help her to keep Frankie safe, as well as something that the law required. I needed Wanda to see me as someone who could help her be a better mother, rather than as an enforcer. I had to actually become a parent before I could begin to fully understand, empathize with, and really care about the many other Ms. and Mr. X's whom I would subsequently have to work with and possibly be called upon to report to ACS.

* Jacobs & Wachs (2001), Parent therapy: A relational alternative to working with children. Northvale: NJ, Jason Asonson Publishers.

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SAVE THE DATES

Holiday Boutique

Sunday, Dec. 4, 2011 2-5pm

"A chance to treat yourself to something beautiful and make a dent in your holiday shopping list –all the while helping needy children!" Featuring many unique items including handmade jewelry, scarves, hats... plus silk scarves and silver jewelry.

For information call Robin: 212-877-7605

NYIPT Gala Fundraiser

Sunday, March 7, 2012 6:00-9:30pm

A wonderful event with raffle baskets, silent auction, music, passed hors d'oeurves, and open bar - - at the historic Columbus Club. More information to follow, but this event is not to be missed!!

Thinking about Adolescent Depression - How to know when your child is at risk?

Week of March 26, 2012

A community education panel discussion with Dr. Ken Schonberg and others speaking about Adolescent Suicide risk factors, what parents and others can do to help, and treatment options.

NYIPT Wine Tasting Fundraiser

Thursday, May 3, 2012 6:30-9:00pm

Lots of wines to sip with plenty of food to eat. A party to enjoy while supporting NYIPT!

Details for all events will be posted on our web site at www.nyipt.org.

OBSERVATIONS OF PLAY IN TWO TWO-YEAR OLD CHILDREN

NYLA KAMLET, LCSW , NHG / NYIPT GRADUATE

Ms. Nyla Kamlet speaks:

Caila Samuels[1] is a two-year-old child with Down Syndrome. Twice a week she attends Play Together[2], a mainstream play-based preschool program that incorporates drama in play. She began the play program in September, and by late October, as the group began to come together, I noticed something remarkable. Caila was accepted as a full member of the social group, while another typically developing child was shunned from the group.

Adults are often surprised at the complex social order of young children. In every classroom there are children who are included in the core group, while others are tolerated but not accepted into the majority. Acceptance into the group provides validation and leads to self-confidence and willingness to try new things. This is what we strive for in the age group of twos and threes.

Two-year-old children play in many ways. One is physical play, in which children will spontaneously run around an object. In my classroom space, they may run around a slide while laughing together. Laughing and running become the two major components of the game. No language skills are necessary, but the children are expected to interpret and abide by unspoken rules. For example, a child should not run too far away from the circle, and if they do, they will no longer be included in the group. Children are free to join this game or drop out at any time. Children who do not want to run or who need a break are still considered part of the game if they stay in close proximity and laugh with the other children.

Caila excels in this "laughing and running" type of play. She begins to run with the other children, but after a short time, Caila simply is not strong enough to keep up. Yet Caila is determined to remain in the game and she stands at the top of the slide laughing with the other children. Caila places herself right in the middle of the group and seems to understand the rules without any intervention from the adults in the room. I have witnessed Caila do this over and over again. She seems to have an intuitive sense of the boundaries of the game and a strong desire to be with the other children. She does not simply watch the game; she finds a way to project herself into it. Caila's smile joyfullly expresses pride as she is accepted into the game by the other children.

A second category of play for two-year-olds is parallel play, in which children play next to each other but not necessarily with each other. For example, two children may be building their own individual structures with blocks right next to each other, but they are not engaging in each other's activity. This type of play is fluid and children come and go with freedom, Yet even in this fluid state, children can suddenly be accepted or rejected by another. A child who is accepted will join others in the activity and the other children will not appear to be disturbed. In fact, they seem not to notice that a new child has joined them. Caila achieved this capacity at a very early time in the school year. Her presence did not interrupt the other children; they just continued with their play.

In contrast to Caila, at the age of two, Charlie's capacities brought about a different experience for him. Charlie is a quiet boy by nature with no disabilities or developmental issues. Although Charlie has had regular play dates since infancy, he did not seem to be comfortable in the a group setting when the school year began. When a spontaneous physical game would break out, he did not join in. He would sometimes watch from afar and other times would play alone with other toys. After a few weeks, it was clear that Charlie had not been fully accepted by the other kids in the group the way Caila had been. When Charlie would join other children for parallel play, his presence often disturbed the play. The children would look at him, or get up and move to a new area.

I began to wonder about the differences between the two children. Why had Caila been accepted and Charlie rejected? What behaviors were they exhibiting that would lead to such disparate group reaction? I then realized there was one major difference: Caila was a very expressive child by nature and she was quick to laugh and smile. This was a key component to her social success. The other children knew when Caila was pleased and generally knew what she was thinking and feeling. This was not the case for Charlie. For the most part, Charlie's face remained frozen in an expressionless state. He did not show clear preferences for likes or dislikes. It was hard for the other children to read him and I began to think that this was contributing to his peers feeling ill at ease in his presence.

continued on page 12

OBSERVATIONS OF PLAY IN TWO TWO-YEAR-OLD CHILDREN

(continued from page 11)

I decided to work individually with Charlie, and I asked his mother to work on smiling with him at home. She is a concerned, sensitive mother and she understood that this "practice" at home might help him. After only two weeks, it was apparent that Charlie's demeanor was changing. He began laughing during circle time when all the other children laughed, Soon after, the children began treating him differently. Within two months, Charlie was more animated and accepted by children in the group. When I think about this change in Charlie, I know he was not comfortable expressing his emotions when he began the play group program. This was in direct contrast to Caila who had no reservations about communicating her feelings.

When I accepted Caila into the group, as a child with Down Syndrome, I was not sure how much attention she would need or whether she would be accepted by the other children. As it turns out, she needed no special attention because she had a strong desire to be with, and play with, other children. Surprisingly, Caila achieved this success of her own volition, whereas other children like Charlie have needed an extra boost.

* * *

[1] Mrs. Samuels has requested that her real name be used to promote the idea of inclusion for children with special needs.

[2] Play Together is a play-based program, founded by Nyla Kamlet, in which one-third of the curriculum involves drama. The pretend play covers many areas such as eating ice cream, being animals at the zoo and going on picnics. A portion of circle time is also devoted to making faces that express emotions. The children are directed to "Make a surprised face; a happy face; an angry face," and so on. Play Together will become an accredited preschool in the fall of 2011.

Nyla Kamlet, LCSW is a graduate of the NHG/NYIPT Training Program and is the Founder and Director of Play Together NYC. She can be reached at www.playtogethernyc.com

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CONGRATULATIONS TO NYIPT FACULTY FOR PUBLICATIONS

Carl Bagnini, LCSW, BCD:

"Object-Relations Therapy with Couples," June, 2011, a chapter in the book, Case Studies in Couples Therapy: Theory-based Approaches, D. K. Carson and M.Casedo-Kehoe, co-editors, Taylor and Francis.

"The Ambiguity of Self and Other," Fall 2001. A review of The Lonely American: Drifting Apart in the 21st Century, by J. Olds and R. Schwartz. Beacon Press, 2009. Published in Couple and Family Psychoanalysis, Vol. I (2).

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Phyllis Cohen, Ph.D.:

To commemorate the 10th anniversary of September 11, 2001 and the work of the 9/11 project with the women who were pregnant on 9/11 and their children, Dr. Phyllis Cohen has co-edited (with Dr. Beatrice Beebe and Sara Markese) a special double issue of the Journal of Infant, Child and Adolescent Psychotherapy (JICAP), Volume 10 (2 & 3), entitled "Mothers and Young Children of September 11th."

In addition, she has written and/or contributed to 6 of the articles in this journal:

"The Evolution of the Project: Helping the Mothers, Infants and Young Children of September 11, 2001" by Phyllis Cohen.

"Children's Play in the Wake of Loss and Trauma" by K. Mark Sossin and Phyllis Cohen

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"Video Feedback and the Impact of Multiple Therapists" by Phyllis Cohen.

"Christina and Bobby: The Team Approach to the Treatment of a Traumatized Mother and Child" by Anni Bergman and Andrea Remez with Phyllis Cohen and Beatrice Beebe.

"The Team Approach to the Treatment of a Traumatized Mother and Child: Ryan and Lydia " by Anni Bergman, Mark Sossin, Suzi Tortora, Lydia (Ryan's mother), Phyllis Cohen, and Beatrice Beebe

"The Therapist Group: A Transformational Process" by Beatrice Beebe, Phyllis Cohen, Anni Bergman, Sally Moskowitz, K. Mark Sossin, Rita Reiswig, Suzi Tortora, and Donna Demetri Friedman

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AND BABY MAKES.....THREE? A FAMILY SYSTEMS PERSPECTIVE

CARL BAGNINI, LCSW, BCD, NYIPT FACULTY

As child therapists we often see couples who are struggling over a decision to have a child or about a child they already have. This article is about the psychodynamics that underlie the movement from being a couple to being a family with a baby. The addition of the baby begins at the moment of conception. I mean conception in the largest sense, as the way in which spouses represent a mental "container," an idea, desire, or interest.

The desire to create a new life is influenced by cultural, religious and intergenerational factors, both conscious and unconscious. When things are going well, each partner is motivated by positive aspects of his or her self-image worth continuing or improving upon in the act of procreation. These positive motives for procreation originate in early childhood identifications with caregivers, and develop into the belief that one is capable of nurturing a new life. These internalized capacities solidify through late adolescence, and ultimately are tested in choosing a suitable parenting partner with whom a future may include bearing and rearing children.

Couples are often unaware of deeply rooted motives that impact their decisions about parenting. These motives can be obscured by engrained, socio-cultural assumptions that having a child is a right, and an enterprise that requires little psychological preparation.

For some couples, ambivalent or fearful motives may saturate positive wishes for parenting. There are circumstances in which the desire for procreation leading to a child with one's partner may be entirely absent or may exist as an unconscious split of good and bad feelings about babies. If conflicted feelings can be recognized and worked on, then a negative outcome may be averted.

John and Dana colluded in negative feelings that babies were not worth the effort, expense and sacrifice. John had much more positive feelings about babies that he kept secret. He feared that the marriage would fail if he expressed his true feelings. In their marital therapy, John expressed to Dana his wish to be a father. Dana acknowledged she had suspected they were not actually in agreement, and they were able to face their differences more directly. Although Dana remained less eager than John, the couple eventually decided to have a child together.

In contrast, a partner's hidden feelings about having a baby may be negative or deeply ambivalent. A hidden aversion to children may be evident but unspoken from the outset of a courtship, or may surface soon after marriage. This can appear in the form of a poorly disguised sarcasm around young children, in detachment or emotional indifference, or in avoidant behavior, such as putting off discussions about having children. Alternatively, these negative feelings about parenting may not appear openly until the pressure mounts. When the other spouse wants to become a parent, the couple may be forced to confront major differences between them.

The determination of one partner to become a parent can lead to the end of a marriage. Lily and Paul had married, knowing a significant difference existed between them about becoming parents. After several years, Lily suddenly announced she wanted a baby by the time she reached age thirty-five. Paul responded by becoming phobic and preoccupied with his own health. In therapy, the couple learned that Paul's symptoms reflected his panic at the prospect of having to give up his preferred, comfortable role as the "baby" husband who received great deference and care from his wife Lily. Lily's ultimatum threw the couple's mode of relating into bold relief. When Paul was unable to give up his position, the couple eventually divorced.

Some healthy couples choose to remain childless. One's childhood experiences help to shape the balance of positive or negative feelings about remaining childless. Couples who make a mutual decision to focus on their marital relationship as their major source of enjoyment and growth often receive unfair negative scrutiny from outsiders.

Couples who remain childless because of fertility or pregnancy problems may also endure painful, negative scrutiny. While their situation is often quite complex, they usually struggle with an unmet desire to have a child and the task of mourning the lost possibility of bearing a child. Such situations can strain partners' capacity for mutual support, although these situations may also offer the opportunity for greater closeness and intimacy.

Fertility problems, miscarriage, or the birth of a handicapped infant often stimulate prior unmourned

continued on page 14

AND BABY MAKES.....THREE?

(continued from page 13)

losses, at times stretching back several generations. After a miscarriage, stillbirth, or death of an infant in its first year, there is often little support for parents to mourn. When I ask such couples about previous generations' losses, I generally discover important dynamic material that neither partner realized impacted their present painful situation. When these losses have not been processed or discussed openly regarding each spouse's family of origin, the trauma is often vested in the surviving child or siblings who remain vulnerable as a result. Jeff and MaryAnne had six miscarriages, all unmourned. They were now five months along in a planned seventh pregnancy. When they came into therapy, MaryAnne had a paralyzing fear that her newborn would be kidnapped. Her terror stemmed from her previously unmourned losses and the rage and sadness associated with them. The couple's therapy provided a safe place for Jeff and MaryAnne to express their feelings and to mourn their losses, MaryAnne's fear of a kidnapping dissipated.

Sometimes deep internal conflicts surface only after the birth of the baby, or during the early childhood phase of parenting. The couple may not be capable of handling the new triangle of needs involved in providing both for the new baby and the needs of the marriage. When a child is born, the marriage may need help to refocus on joint parenting.

Feelings of abandonment, jealousy, rivalry or competition may arise after a child is born. In marital therapy, a couple can explore aspects of the decision making process about having a child as well as the timing. The couple's relationship before conception helps predict their how they will function and their attitudes as parents. To achieve satisfaction in both marriage and parenting, a couple must reconcile their needs for closeness and autonomy. They must also balance the needs of the child with their needs as a couple.

Successful parenting depends on the couple's ability to work together on behalf of a new life. Some family therapists believe that a baby can provide a reparative opportunity for couples. I would agree that this is possible for couples who can sublimate self-interests in the service of the pleasures a baby can provide. A child can also reconnect a couple to their extended family, helping to heal earlier estrangements and unresolved issues.

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"THE SCALES OF JUSTICE / HEART TO HEART" NYIPT FACULTY ON THE RADIO

Shirley Wilson and Maria Palmer produce "The Scales of Justice / Heart to Heart," a monthly radio show that explores issues affecting the 2.5 million children in the United States who have a parent in prison. When Wilson and Palmer approached NYIPT to provide a panel of psychologists for an upcoming program, NYIPT's Phyllis Cohen, Bill Salton and Tracy Simon accepted eagerly.

Our NYIPT experts were featured on July 11, 2011. They addressed the needs of children who have not only lost access to a parent due to incarceration, but who have often been exposed to the traumatic circumstances which led to the parent's incarceration, including profoundly upsetting and disruptive events such as murder, drug use, and the events around the arrest.

Our NYIPT Team discussed research that shows children who have a relationship with an incarcerated parent are better adjusted both socially and emotionally than those who do not. When contact is maintained, not only are the parents less likely to return to prison, but the children will be less likely incarcerated themselves as adults.

Cohen, Salton, and Simon spoke about the effects of trauma and it's impact throughout the lifespan. They described specific trauma faced by children with an incarcerated parent and how that trauma is manifested at different ages. They explained what can be done by custodial parents, grandparents, foster parents, teachers, religious leaders, and the incarcerated parents themselves, to mitigate the impact of this trauma on the children.

Callers-in got to "meet the experts" and ask a range of pertinent questions. One man cried about his experience of growing up with a father in prison and a mother who abandoned him. After the program, Palmer commented, "This was the best show we've ever done! You experts touched the hearts of many people last night, and for that we're so thankful." Then Wilson said, "We would be honored if you three doctors could become regulars on our show! They state, "America must be reminded that children are our future."

The one hour program is available online at:
http: / / www.blogtalkradio.com / scalesofjustice / 2011 / 07 / 11 / shirley-maria-talk-about-justice-for-the-children.

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THE CASE OF ZOE

RACHEL RANDOLPH, LCSW, NYIPT CANDIDATE,
WITH INTRODUCTION BY DR. TRACY SIMON, NYIPT EXEC CO-DIRECTOR

INTRODUCTION BY DR.SIMON

Third year candidate Rachel Randolph presented a moving case of a 5-year-old girl at the NYIPT Open House on May 16, 2011. Ms. Randolph has worked with Zoe in play therapy for one year. In her talk she captured the emotional impact of parental divorce, custody battles and family secrecy on one little girl, in addition to the ways in which child play therapy can work to promote development (See p.8).

In this treatment Ms. Randolph allowed Zoe to make use of the therapist as well as the therapy setting. She demonstrated how Zoe used her body and the play objects in the therapy and waiting rooms to reenact and work through angry feelings about secrecy, conflict and guilt about having to choose one parent over the other, and anxiety over the possible loss of a parent.

Ms. Randolph poignantly captured Zoe's need to feel that the adults who care about her could align and work together to keep her safe. Together Ms. Randolph and Zoe's mother were able to model collaboration and care, not only in the traditional therapy sessions, but especially in the three "waiting room sessions." In her description of these three sessions, Ms. Randolph humorously and sensitively illustrated the difficulties child therapists often face and the ways children force us to confront our own anxieties and insecurities.

Ms. Randolph's vignette of her therapeutic work with Zoe and her family clearly illustrates the sound theoretical understanding, impressive clinical skills, and overall thoughtfulness that she has developed during her three years in the NYIPT program.

THE CASE OF ZOE, BY MS. RANDOLPH

Walking the long corridor to the waiting room, I nervously anticipated my session with Zoe. I wondered, "Will she come willingly into my office this week? Or, will she adamantly refuse, as she has done for the last two weeks?" It felt as if I had spent an eternity conducting Zoe's treatment in a lobby full of the clinic's clients. It was not fun, and I felt exposed. When I entered the waiting room and saw Zoe, my stomach tightened. She was busily engaged with her mother on the far side of the room. I approached her, crouching down to her height. I asked, "Ready to come to my office?" She turned away from me and said, "No!" I glanced up at her mother, who half smiled and shrugged. I thought, "What is going on? Why have we been stuck in this lobby for three weeks? What happened to my actively engaged, waiting-for-me-at-the-door Zoe?"!

Zoe is five years old. Her frame is tiny, but not so her personality. She is assertive and, at times, aggressive, a solid presence in the room. While her voice can be barely audible, her body language is bold. Most of the time when she enters my office, she stands in the middle of the room casting about for whatever will engage her that day.

Zoe's parents are in the midst of a protracted, contentious divorce with custody proceedings. Though anxious and preoccupied, both parents love their child and are genuinely concerned about her. In a misguided attempt to protect Zoe, they have been secretive about the divorce, believing that their child should not know about the disintegration of her parents' relationship and should not remember the violence between them. Clearly, this is an impossible mission since her parents have great difficulty acknowledging Zoe's feelings. She seems to be pulled in opposing directions, trying to manage the demands from each parent for her loyalty. Her feelings of anger and sadness are clear, yet there seems to be no place for them, as each parent has demanded that all negativity be suppressed.

I thought, "How strange. Zoe is invited to 'talk about anything' in therapy, yet she is also told to keep secrets." Zoe brought her empty and alone feelings to sessions. In play, her doll houses were devoid of parents, children took care of daily routines, and parents were often "working all day" or dead from heart attacks. In sessions, she fed me, but I was not permitted to feed her. Her pictures had life in them, but almost always showed just one animal or person. Zoe's play revealed her understanding of her parents' secrecy and her experience of their implicit demand

continued on page 16

THE CASE OF ZOE

(continued from page 15)

that sad or angry feelings be denied. When asked by Zoe to draw or use play-doh, I portrayed a wide range of feelings. Zoe then vigorously covered my images with black marker smiles, or pinched away my play-doh frowns. In the therapy she became increasingly controlling, insisting that I copy her drawings exactly.

Gradually, Zoe began to bring more aggressive, angry material into her sessions. Her pictures had sharp objects and teeth; a simple throwing game escalated into a game of hurling small, plastic toys as high as possible against the wall with millions of points for her and none for me. She moved frantically, climbing the furniture, and using every inch of space. I understood this not only as her desire to possess and control me, but also to hurt me.

After weeks of intense sessions, Zoe's behavior abruptly changed as I entered the waiting room. I found her draped across a chair in the adult waiting area. Her skinny legs were dangling over one side with her brown hair flopped across her face. She moaned, "I want to go home, I'm so tired, mommy..." She refused to talk to me, look at me, or come with me. I sat with her and struggled to understand what she was doing and feeling, painfully aware of how much I wanted her to come into the therapy room and relieve me of the embarrassment of being a therapist in public. In the last fifteen minutes of our allotted time, she finally moved into my office.

The following week Zoe again refused to come to the office, though her activity in the waiting area made her communication clearer. Still quiet, but no longer feigning fatigue, she brought her mother and me together by getting us to play a game on her mother's iPhone. Again I felt exposed and annoyed, unsure whether to go along with the play in the waiting room or try to hustle her into my office. In the therapy room, Zoe was permitted to decide what she would do with few limits. But did that empowerment extend to the waiting room as well? The public nature of this dilemma and my own feelings about being controlled triggered a strong countertransference reaction. It made me more indecisive about what to do. Again, towards the end of the session, Zoe came into my office and she began to play.

In supervision with Dr. Jill Bellinson, I struggled to understand what was going on inside of Zoe and inside of me. While issues involving separation, the Zoe's wish to "win," and her need to avoid me, likely played some part, they did not fully explain what had been going on or its intensity. Dr. Bellinson and I began to understand these events as a repetition of Zoe's frequent experience of having to choose between her parents. This choosing reflected the demands of each of her parents, as well as those of the court.

During the third "lobby session," I proposed this interpretation to Zoe. As she sat in her mom's lap playing with the iPhone, I said, "Zoe, I wonder if you want to stay out here so you can be with your mom and with me at the same time. Then you won't have to choose one of us to be with." Zoe said nothing, nor did she look at me. She simply got up and walked towards my office. Then she ran. Then she hid. Then she directed that I was not to find her. I was now to pretend not to see her, even when she emerged from her hiding spot. She then moved about the room, instructing me to look for her, to listen for her, and to feel for her with my hands all over the office walls. At last, she settled and said, "O.K., now you can find me; use your hands to feel against the wall until you get to me, then feel my head so you can see me." When I did this, Zoe looked up at me gazing directly into my eyes. That was the last lobby session.

How can we understand what happened? Initially Zoe remained in the waiting area to protect herself from the intense feelings she had been having in my office. While I did not force her to leave the lobby, I was aware of my strong wish to "take her" into my office, perhaps analogous to each parent's wish to have sole custody of her. Perhaps this experience of my desire was part of what led her to begin using the lobby for a new purpose – to play with competitive and longing feelings and ideas related to having her two "objects" together. During these waiting area sessions, Zoe responded to my efforts to understand her, my willingness to stay with her, and my reflection of her feelings, especially in the presence of her mother. Finally, when I articulated her feelings about the loss of her "parents-together," and her longing for a time when she didn't have to choose between them, she felt ready to come back to the office, and orchestrate our reunion.

Following Ms. Randolph's talk on May 16, 2001, Dr. Tracy Simon, commented on the dynamics of the case and facilitated a lively discussion among those who attended the NYIPT Open House (see p.8).

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