Newsletter

SPRING 2014

Adelphi Society for Psychoanalysis and Psychotherapy

President's Letter

Matt Tedeschi, Ph.D.,
President, Adelphi Society for
Psychoanalysis and Psychotherapy

Years ago I read an interview in the Division 39 Newsletter. For those in our community who may not be familiar with Division 39, it is the Division of Psychoanalysis, within the American Psychological Association. I read the above mentioned interview at a time in my career when I was struggling with some significant disillusion regarding the direction the fields of clinical and school psychology were heading. As I recall, a graduate student was interviewing a relatively well known Psychologist/Psychoanalyst. The interviewee was asked, what is it like to be a psychologist, who is also a psychoanalyst? I will paraphrase the answer, which went something like this, "I was trained first as a psychologist, and later as a psychoanalyst. Psychoanalysis is a profession within the larger profession of psychology, really the only part of that larger profession that I am interested in." When I read this I felt most if not all of the disillusion evaporate. Prior to entering psychoanalytic training in 1998, I had been practicing clinical psychology for years in the schools, even though I was hired as a school psychologist. And at the time I read the above mentioned interview, I was practicing psychoanalysis both in the schools, as well as my private practice. When I was able to fully embrace my identity as a psychoanalyst, and the pride in being a member of the profession of psychoanalysis, my perspective radically shifted. As a mental health practitioner I found solace and hope in dedicating the rest of my career to practicing in, and contributing to the field of psychoanalysis, the only area of psychology that I have a real interest in.

In one of Wilfred Bion's lectures, Bion said that he hoped one would never believe that they had become a psychoanalyst. Bion went on to say that we all reach a point in time when we graduate or qualify, and may then call ourselves psychoanalysts. In contrast, to believe one has become an analyst, according to Bion, might risk the onset of stagnation, or the experience that an end point has been reached. Rather Bion hoped, one should forever be becoming a psychoanalyst. The growth and development ought to extend as long as one's career extends, and only conclude at the conclusion of one's career.

Individuals enter and leave fields, careers, and professions all of the time. The prominent psychologist Albert Ellis had qualified during his career as a psychoanalyst. His disillusion with psychoanalysis was one of the variables that led to his creating Rational Emotive Therapy (RET), one of the first, and still to this day, major schools of Cognitive Behavior Therapy (CBT). Psychoanalysis was not for Al, so he went in another direction. Others of us may have entered the mental health field as Behaviorists, Rogerians, or CBT practitioners, only to become psychoanalysts. I know of such people.

Perhaps what matters most, is where we are now, and where we are headed. So where is the Adelphi Society for Psychoanalysis and Psychotherapy (ASPP) now, and where is it headed? This is a very complex question, that has been asked over the years. For some time I have been interested in the history of ASPP. Several years ago Marge Burgard was kind enough to gather copies of all of the documents that she had relative to the history of ASPP. I am looking at a President's Message written in 1996 by the then President of ASPP Dr. Mary Anne H. Geskie. I am reading the following: "As I review my past experience with the Society, I note a decline in levels of membership and degree of involvement. I have wondered what this means and what is happening regarding our organization. This observation has been gradually noted over several years and has perplexed our Board for some time." "A frequently suggested rationale for this shift has been to blame it on Managed Care and the forces upon us to change our approach with patients, decreases in our incomes, as well as the added demands of treatment reviews."

In the Fall of 1998 I first met Mary Anne at the ASPP orientation brunch for first year candidates. I was there with many of my classmates, who had entered what was then the Four Year Postdoctoral Program in Psychoanalysis and Psychotherapy in September 1998. Faculty and supervisors of the program were present, as were Society Board members and some graduates. My analyst was there!!! I gave my dues check to Shoel Cohen, who was the Treasurer. Membership was not free for First Year candidates. I was one of a class of ten First Year Candidates who wanted to become immersed in becoming a psychoanalyst. We did not even question the necessity of joining ASPP.

ASPP Newsletter

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In 2014 it seems like it has become much more difficult to invite people into the Derner psychoanalytic community, and have them experience all of the wonderful benefits such membership brings. For those of you who are long standing members of ASPP, I know I am preaching to the choir. It is with an admixture of pleasure and sadness that I report that we currently have 89 members of ASPP for the 2013-14 membership year. I do not remember membership ever being below 100, and that is sad. At the same time I am pleased that there is that core group of members who are enjoying participation in ASPP. I believe we have approximately 500 individuals who are composed of graduates, candidates, faculty, and supervisors of the various Postgraduate Programs. I wonder how it is that less than 20% of those individuals are members of their Psychoanalytic Society. I wonder how it is that ASPP is not reaching them.

I am pleased that many of the faculty and supervisors of the various Postgraduate Programs at Derner are members of ASPP. Faculty and supervisors are leaders, mentors, and role models of the psychoanalytic community in general, and the Adelphi psychoanalytic community in particular. I certainly believed that even prior to becoming a candidate in 1998. I have spoken with many candidates in various capacities over the years who have enjoyed seeing their teachers and supervisors at Derner events, whether ASPP affiliated events or not. Similarly many faculty and supervisors enjoy seeing candidates and graduates at events. Now that I have the honor of being a faculty member and supervisor in some of the Postgraduate Programs, I share that sentiment as well. Yet I am surprised and disappointed that even more of our faculty and supervisors are not members of ASPP. I wonder why. The following is a listing of the Derner Postgraduate Programs, and the percentage of faculty who are members of ASPP for the 2013-14 membership year:

Supervision Program: 88%
(7 of 8)

Adult Program 1 and 4 year: 50%
(24 of 48)

Psychodynamic School Psychology: 31%
(4 of 13)

Group Program: 26%
(5 of 19)

Couples Program: 18%
(3 of 17)

Adult Program Supervisor List: 9%
(2 of 22)

I am pleased to note that 100% of the Program Directors are members of ASPP. I know I can speak for the Executive Board of ASPP when I thank all of those faculty members and supervisors who support their Psychoanalytic Society. I also welcome any feedback from faculty members and supervisors, whether members of ASPP or not, regarding what ASPP might of offer to better meet their needs. In addition I would welcome similar feedback from candidates as well as graduates. I hope that more candidates and graduates would consider becoming members of ASPP. Moreover the Executive Board of ASPP would welcome those members who might like to become involved with the Board or some of its committees.

ASPP recently had its annual Midwinter Party on January 26th. This year we gathered at Piccola Bussola in Mineola. The event was attended by ASPP members as well as members of their families. The feedback has been very positive. Thank you to all who attended, as well as to the hospitality of all at Piccola Bussola.

The ASPP Book Club continues to meet on a regular basis. Please look for information regarding future meeting of the book club on the listserve.

This year's End of the Year Party will be on Friday May 30th. As always, we will be honoring the most recent graduates of our programs. This year we will also be honoring Dr. Elaine Seitz. As many of you know, Elaine is the Director of the Postgraduate Child, Adolescent, and Family Program. This year's event will be at Jonathan's in Garden City Park. Further information will be appearing on the listserve in the near future. Save the date so that you may join us in honoring Elaine for her years of dedication, as well as honoring the work and dedication of our recent graduates.

As always, I would like to remind all of our current members, that members of ASPP are permitted, and encouraged to attend ASPP Executive Board Meetings. Minutes and Agendas along with dates and locations of meetings are posted on the listserve prior to the meetings. We ask that if you plan to attend you please RSVP so that we know how many to expect.

As the ASPP Newsletter is circulated via the listserve, it is available to both members as well as non-members of ASPP. Therefore if anyone who is not currently a member of

ASPP is reading this, and would like to join, please contact us. It is possible to join ASPP at any time throughout the membership year.

If you would like to contact me I can be reached at: 631-261-2085 (Office) or drmjtedeschi@yahoo.com ■

Program Director's Column

Mary Beth M. Cresci, Ph.D., ABPP

Mary Beth Cresci, Ph.D., ABPP, Director, Postgraduate Programs in Psychoanalysis and Psychotherapy

We are in the second quarter of the Spring 2014 semester and hoping that the weather will begin to reflect the season with warmth and sun. During the 2013-2014 academic year our programs, under the leadership of our resourceful and devoted directors, have offered a variety of learning experiences to mental health professionals on Long Island. We have an enthusiastic group of 5 first-year candidates for the Adult Program including two Postdoctoral Psychology Fellows. In addition, we have an advanced class of 5 candidates taking 4th year courses. The Child, Adolescent, and Family Program also has an advanced combined 2nd-3rd year class of 4 candidates. Drs. Zentman and Hyman, realizing the difficulty many prospective candidates have in committing to weekly meetings, have devised study groups and supervision groups that meet less frequently. The Couple Program has offered a twice-monthly supervision and didactic program taught by Michael Zentman and Carl Bagnini on Wednesday mornings. The Psychodynamic School Program has offered a monthly seminar/study group for school psychologists and school social workers on Thursday afternoons taught by Susan Rubinstein and Matt Tedeschi.

For all of our community we have offered a variety of learning experiences. We had a successful conference on Saturday, November 2, featuring Drs. Arietta Slade and Ionas Sapountzis who presented theoretical and clinical material demonstrating how states of fearful arousal in children and patients can be transformed through secure attachment and mentalization processes. On December 7 Dr. Andrew Karpf, director of the Postgraduate Program in Psychoanalytic Supervision, offered a conference in which our advanced candidate, Dr. George Kingsley, was supervised by two supervisors, Drs. Robert Farrell and Joan O'Donnell. Another CE credit conference is being planned for October 2014.

In addition to our conferences, we offer several colloquia throughout the year, usually on Friday evenings. The colloquia are organized by Dr. Jack Herskovits on behalf of the Postgraduate Psychotherapy Center and are co-sponsored by ASPP. Earlier this year we presented a dramatic reading from the letters of Freud and Jung featuring a group of psychoanalysts portraying these leaders of psychoanalysis. An upcoming colloquium on May 16 will provide a discussion of marital infidelity from the perspective of evolutionary psychology by Dr. Lawrence Josephs with comments from Dr. Michael Zentman.

We have also initiated a series of case presentations by our senior candidates on Wednesday evenings. On March 12 Dr. Melinda Blitzer presented on "The Analyst's Courage" with a discussion by faculty member Dr. Richard Hansen. On May 14 Peter LaMantia, LMHC, will be presenting a paper titled "Who Am I and Who Are You? A Case Presentation" with faculty discussant Dr. Bruce Tuchman and candidate discussant Eugene Tereshchenko, MSW. The presentation is at 7:30 PM in the Main Room of Alumni Hall. I hope you will join our candidates and faculty for this event.

We are working hard this spring to attract qualified candidates to our training programs for Fall 2014. We have selected two highly qualified recent graduates of clinical psychology doctoral programs for our Postdoctoral Psychology Fellowship Program. We participated in a well-attended Psychoanalytic Fair at Columbia University in February, and we had our annual Open House on Sunday, March 30, that attracted many interested mental health professionals. During the Division 39 Spring Meeting in New York City we will participate in a coffee hour on Friday, April 25, at 3 PM sponsored by psychoanalytic institutes. Please join us if you are at the meeting.

We have scheduled our Postgraduate Programs Executive Board Meeting and Adult Programs Faculty Meeting for Wednesday, May 21, at Alumni House. At those meetings we will be proposing some new programs and changes in current programs to increase our outreach of analytic candidates and ensure that our candidates receive quality training. I will keep you posted on those proposals.

I would like to thank the leadership of ASPP for their support of our training programs. A representative from ASPP joins us at our Training Directors Meeting each month. We are able to work collaboratively on projects such as the Friday colloquia and the various events that ASPP offers throughout the year.

I encourage all of you to get involved in supporting the training programs and ASPP. We need your help to continue to recruit fine candidates for our programs, to provide analytic and therapy cases for our candidates, and to maintain a professional and social network through ASPP that is a benefit to all of us. I look forward to seeing you at ASPP's end-of-year event when we will celebrate the graduation of several candidates from our One-Year, Four-Year, and Child, Adolescent, and Family Programs. ■

Casey Anthony: A Modern Day Medea

David Kirschner

David Kirschner is a psychoanalyst and forensic psychologist. He has been an expert witness and/or consultant in 25 murder/death penalty cases, including several where a mother has been accused of killing her own child.

Why the intense interest in the Casey Anthony case? Infanticide, or filicide, a mother's killing of her own child, is not a crime in the ordinary sense of the word - but a terrifying act which strikes, at the heart of civilization itself. Women who murder their own offspring, have always been considered as the epitome of "evil." And Medea is the figure against whom all women who kill their children are generally measured. Medical dictionaries, in fact, describe The Medea Complex, as "the Mother's Homicidal Wishes to her Child;" and "The situation in which the mother harbors death wishes to her offspring, usually as a revenge against the father."

Written by Euripides, around 400 B.C., Medea is the iconic story of intense love turned to such hate that Medea kills her own children to get revenge, to get back at their father Jason, for betraying her and leaving her for another woman. Medea's love turned to hate, is so intense, that she destroys what the intimacy between them produced. Her hate goes beyond a mother's instinctive need to protect her own children. Probably the most powerful and frequently performed of the ancient Greek tragedies, Medea is still captivating audiences, in modern adaptations, after 2442 years - and the story continues to serve as an immediate frame of reference, whenever we're shocked by a new story of a woman killing her children. And so, the frantic media and public obsession with the Casey Anthony trial, should not be surprising, considering that our fascination with the subject of infanticide and the myth of Jason and Medea, goes back more than 2 millennia.

But who was the "Jason" in Casey Anthony's life? Who was Caylee's biologic father? And what were the dynamiclios, god of the sun. Sadly, Casey Anthony will also get a "golden chariot" - but her chariot will be paid for by book deals, made for TV movies and continued Media, but not Medea exposure. ■

And Baby Makes... Three? A Family Systems Perspective

Carl Bagnini, LCSW, BCD

As child therapists we often see couples/parents who are struggling either to have a child or with a young child. This article is about the psychodynamics that underlie the movement from being a couple to the desire to become a family with a baby. The addition of a baby begins at the moment of a conception. By conception I am not referring to pregnancy in the physical sense but to a mental "container" that spouses represent as a pre-conception, an idea, desire, or interest. The desire to create a new life springs from a union that is influenced by unconscious, cultural, religious and intergenerational factors as well as conscious motives.

Ideally each partner is motivated by positive aspects of his or her self- image worth continuing or improving upon in the act of procreation. Positive motives for procreation originate in early childhood identifications with caregivers leading to a 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 partner with whom a future may include becoming a parental couple capable of having and rearing children. Deeply rooted ambivalent motives are rarely considered when taking on the procreative dimension of marriage partly due to socio-cultural assumptions that having a child is a right, and/or a duty. Procreation based on these expectations requires little psychological preparation due to basic assumption thinking. Without psychological preparation, however, the couple may become overwhelmed when underlying conflicts about children and child rearing are triggered by the actuality of having the child.

For some couples a circumstance of ambivalent or fearful motives may prevail when considering having a child that can saturate positive wishes for parenting. More conflicted feelings may remain dormant or if recognized and worked on sublimated in the pro-creative couple. There are circumstances in which the desire for a pro-creation leading to a child with one's partner may not be present at all, or may exist as an unconscious split of good and bad feelings about babies. In marriage therapy a couple colluded in negative feelings that babies were not worth the effort, expense and sacrifice; however, the husband kept pro-baby sentiments to himself for fear the marriage would fail if he expressed his true feelings. His positive feelings were split off from the marriage leaving his wife to believe they were united. After the husband expressed the wish to be a father the couple faced their differences and the wife indicated she had had her doubts he had been truthful before. They eventually went along with his wish although the wife remained less enthusiastic then he.

The couple's stated motives are a part of the here and now discussion about children, but there can be unconscious influences fueled by both good and ambiguous or ambivalent feelings. There may be a hidden aversion in a spouse that may be seen or expressed from the outset of a courtship, or soon after marriage. This may appear in the form of a poorly disguised sarcasm around young children, or in detachment or emotional indifference, or in avoidant behavior such as putting off discussions prior to marriage about having children. This negativity may not appear until the pressure mounts in meeting the expressed needs of the spouse who wants to become a parent but did not want to realize a major difference previously existed. The will to procreate of the one spouse who avoided a difference in motives may drive the couple down a road beset with anguish and menace. Another couple in therapy had married knowing a significant difference existed about becoming parents. The wife suddenly decided she wanted a baby by age 35, which caused her

reluctant husband to become phobic, and somatically pre-occupied. The couple discovered his symptoms were a panic over giving up his preferred role as the "baby" husband who received great deference and care from the wife who was now rebelling. The menace signaled by the wife's ultimatum brought to a head the couple's mode of relating. The husband had to give up his infantile status, which he could not do, leading to a divorce.

Motives concerning having or not having a child can bring the potential for joy and growth or sorrow and regression. One's childhood experiences always determine the level of positive or negative feelings towards remaining childless, although the decision to remain a childless couple is not always pre-determined by a troubled past. Couples that mutually decide to focus on their marital relationship as the major source of enjoyment and growth unfairly receive negative scrutiny in our culture. In couples with fertility issues remaining childless is a more complex issue since there is the unmet desire have a child. There are] special circumstances when reproductive issues delay or prevent ordinary conception and we review their affects on the couple's mutually supportive capabilities. Reproductive issues often affect the couple's optimism, patience, and self regard. In addition, experiences with previous losses may overlap a current reproductive problem or mystery.

I have discovered profoundly important dynamic material when asking about previous generation's losses, such as in miscarriages, still births, and these may not have been grieved or spoken of in a spouse's family of origin. If stoically handled the unprocessed losses are handed down to the surviving child or siblings who manage as best they can, until a similar fear emerges during a reproductive issue, or after a current miscarriage. It is amazing how losses of the unborn, or a still born, or infants who perish in the first year of their lives receive insufficient mourning. A couple with six miscarriages had not mourned any of them, and was now five months into a planned seventh pregnancy. They came into therapy because the wife was terrified her unborn baby would be kidnapped soon after birth. Unmourned miscarriages had produced a paranoid terror that made it possible for the couple to begin to experience their feelings, which reduced the projected threat to the unborn child.

There are times when deep internal conflicts surface leading to the tragic and hostile end of a marriage after the birth of a baby, or in the early childhood phase of parenting. The couple is not capable of handling the new triangle of needs in providing for the new baby and for the needs of the marriage. The marriage must be temporarily re-focused on joint parenting and a result may be jealousy, a sense of abandonment and/or feelings of rivalry or competition. Clinically, we study and explore the timing of all motives and facets of the decision making process about having a child since the relationship process before and after conception will indicate how the couple's unconscious and conscious attitudes shaped becoming parents. Marital and parenting satisfactions depend on reconciling the differences between each partner's affiliative and autonomy needs in addition to couple and child needs.

Succeeding in parenting depends on working together on behalf of a new life. Are the spouses able to sublimate self satisfactions in pursuit of a two generational family experience? Some family therapists believe that a baby provides a reparative opportunity for couples. I would agree this is possible for couples who sublimate self interests in favor of the enrichment that a baby can provide. A baby can also re-connect a couple to the kinship network thus providing the benefits of family joy and coming together.

When working with couples who are in conflict prior to having a child or in therapy after the birth of a child assessment questions should include:

1. What is the cultural background and value system concerning marriage and reproductive history in each spouse's family?

2. Did the couple desire the child, and did the actual child meet each spouse's stated needs?

3. In the course of therapy what are the unstated needs that may be unconsciously operating that are unrealistic for the parent/s and the infant?

4. How nurturing and supportive were previous relations with each spouse's parents and/or siblings?

5. Were there traumatic experiences, significant neglect, or deficits in parent-child relations in their families of origin, including losses of all types; how were these handled?

■

Psychologists and Attorneys Working Together

Neil S. Grossman, Ph.D., ABPP

The theme of this year's NYSPA Forensic Division's Conference was, Psychologists and Attorneys Working Together. During our preliminary discussions of this theme one psychologist said, "Attorneys and psychologists don't work together. Attorneys try to rip psychologists apart". This is what is known as an attorney vigorously advocating for his/her client. Such an approach usually takes place at a trial when a psychologist's report or testimony is perceived as negative to the attorney's client. In our system of justice, opposing attorneys attempt to prove their argument and discredit the argument put forth by the other side. Attorneys may attack psychologists, but it is only one of the ways that psychologists and attorneys interact.

Psychologists can have a wide variety of roles when working with attorneys. Aside from conducting a forensic evaluation and/or providing expert testimony, psychologists may consult with attorneys regarding: the strategy of a case; the best way to present material; how to cross examine an opposing witness; selection of a jury; and reviewing forensic psychological reports. Psychologists may also help prepare witnesses for trial; provide psychological support for the attorney's client; mediate an issue; provide expert information to opposing clients in an attempt to assist them in settling a dispute; or, work with

attorneys as a member of an interdisciplinary team, etc. Psychologists provide information and skills that attorneys do not possess.

There is a new and exciting way that psychologists assist the legal system. Some judges and attorneys have realized that parts of a dispute may be more psychological than legal. In these instances, a psychologist (in the role of a neutral family specialist) may be brought in to help the parties reach a resolution to that part of the dispute.

When many of us think of the legal system we picture a court room – that is a trial. This is just one of the ways disputes are resolved. It is not the way most disputes are settled, or in many instances, the best way to resolve a dispute. In fact, the litigation process may further polarize conflict between two parties. The resolution of disputes without litigation is called Alternative Dispute Resolution. Mediation is a basic skill that underlies alternative dispute resolution. This skill is different from what psychologists and attorneys have traditionally learned and requires additional training. Mediation involves negotiation and conflict resolution. Clients are directed away from taking positions and toward ways of meeting their common interests.

As psychologists and attorneys learn the skills needed for these alternative approaches, they must unlearn some instinctive skills previously acquired, or be able to momentarily set them aside. Psychologists need to be more directive and active then they typically are in psychotherapy. The focus is on the resolution of a conflict rather than on dealing with a psychiatric disorder. Psychological problems are only dealt with to the extent that they interfere with the dispute resolution process and if there is a major problem the client is referred for psychotherapy. Blame and anger are blocked and communication is facilitated. Mutual interests are emphasized and clients are moved away from taking positions. Clients are encouraged to develop win-win solutions. Attorneys need to move away from the traditional litigation skills where positions are emphasized and there is an effort to win for one's client. There is a need for neutrality, as well as assisting the clients to focus on mutual interests.

The examples of psychologists and attorneys working together, given at the beginning of this paper, involve psychologists working in the attorney's sand box. We are helping with their case. A psychologist as a member of an interdisciplinary team may be an example of the most equal partnership that presently exists between psychologists and attorneys. The professionals work together as members of a team, contributing their unique skills and perspectives as they help clients to resolve a dispute. An example of this is in collaborative practice where each client is represented by an attorney and a neutral family specialist working with both clients and the team. The professionals work with each client individually and both clients together. The team may be so parsimonious that it may be difficult to ascertain which professional is working with a particular client.

Another example of an interdisciplinary team was when an eldercare attorney asked me to help in a case that involved parents who needed help and could not live independently. The parents lived with one of their seven adult children. The adult child was given financial support by the parents but some of the siblings objected to the amount of financial support. There were a number of other major issues regarding their parents that the sibling argued about. After meeting the parents, the attorney and I held meetings with the adult children. Over the course of three meetings we were able to resolve the dispute. It was important that an attorney and I worked together as a team. I had the skills to work with this sibling/family group and the attorney had the skills and knowledge regarding the legal issues underlying this dispute. If I had worked alone, I might have facilitated a resolution of the conflict that would have had dire legal consequences. ■

Families with Pediatric Cancer: **Ripples**

Joyce Bloom, Ph.D.

Joyce Bloom, PhD is a clinical psychologist with private practices in Roslyn Heights, NY and New York City.

Family is where people turn to for love, support, warmth, security, grounding. And yet, families are complicated. Even in well functioning families, members may compete and vie for love and attention while providing it for other family members. Close siblings may argue over toys; parents may disagree with each other about big or small issues yet have a satisfying marriage; parents and children are often in conflict about boundaries, as it is the parents' role to set them and child's role to try to break them. Even the most functional of families may have some intra-family conflicts that eventually get worked out. Families are our rock. It's what we lean on when life gets complicated. So what happens when the family unit gets a seismic shift that throws the family out of kilter? What happens when a family is diagnosed with pediatric cancer?

Notice that I say that the family is diagnosed, not the child. It is my belief that when a family member is diagnosed with a life threatening disease, it is the entire family that bears the burden, not just the patient. The receiving of the diagnosis is much like what happens when a rock is thrown into a lake. The family, like the rock, is capriciously thrown into depths unknown. The landing of the rock disturbs a previously smooth surface with ripples following from the point of entry. The ripples can be infinite. The family now finds itself in a new unfamiliar place, perhaps at the beginning unaware of the ripples as they are trying to find their way through previously unknown waters. The ripples may start appearing as they start to take actions to get their child back to health and surface back to normalcy.

One such ripple is how the healthy siblings' lives are changed by the diagnosis. According to Lauren Hancock, RN, MSN of the University of Pennsylvania School of Nursing,

when exploring the impact of siblings with pediatric cancer on their healthy siblings, she found that the healthy siblings were likely to describe negative effects on their lives after their siblings were diagnosed. They may experience anxiety, depression, loneliness, guilt and shame. Often this is characterized by changes in their behavior, along with possible complaints of feeling ill themselves. She cites the Sargent et al, 1995 study which interviewed parents of children with cancer as to the reactions of the healthy siblings. The siblings experienced disruptions to their family's and own lives, a lack of attention while the ill child received significant attention, as well as fears of death. Sargent, et al also determined that there are positive outcomes for the healthy siblings. They reported greater ability for siblings to be compassionate, that family ties became closer and siblings enjoyed having novel family experiences. The authors found that age was a factor, with older more mature children having a greater chance that they would experience these positive outcomes than younger siblings.

Hancock's 2011 study looked at how a summer camp experience can enhance healthy siblings' experiences through the family's cancer trauma. She stated, "In general, the literature is supportive of camp as a therapeutic intervention for siblings, and numerous positive effects have been demonstrated for siblings after attending camp" (p. 139).

How fortuitous it is for families in the New York metropolitan area to have Sunrise Day Camp! This is a day camp dedicated to the needs of children with cancer and their siblings. For more information, contact the camp at www.sunrisecamp.org.

Another ripple is how families cope with difficulties associated with cancer treatment. Aimee Hildenbrand, Kathleen J. Hawson, MSEd, Melissa A. Alderfer, PhD and Meghan L. Marsac, of The Children's Hospital of Philadelphia in 2011 looked at the coping strategies of children with cancer and their parents during their treatment. It was determined that children are far more stressed by the treatments that they undergo than by the cancer diagnosis. The stressors encountered by these families were grouped into four main themes: cancer treatment/side effects, distressing emotions, disruption in daily routines and social challenges. Families in the study reported having few coping strategies to help them get through the aforementioned stressors. The authors suggested that early on in the child's treatment, families should be taught coping techniques to assist them through this stressful time.

Different coping strategies explored by Hildenbrand et al. (2011) for the patients includes cognitive restructuring, relaxation, practical strategies, seeking social support, expressing feelings and distraction. Cognitive restructuring is finding positive thoughts to spur one on in the treatments, such as, "I'm going to be strong," "Losing my hair doesn't mean I'll lose my friends," "I can get rid of this and not let it stop me."

Hildenbrand, et al (2011) also found that for parents, coping assistance strategies include: encouraging cognitive restructuring, promoting relaxation, encouraging practical strategies, promoting social support, encouraging use of information, encouraging the child to take control, establishing plans and routines, asking for assistance from the medical team, engaging in supportive actions, using reinforcement strategies and encouraging spirituality. It would be helpful for these families to receive training in these skills early on the treatment to help reduce the anxiety, depression, disruption in family life and overall negativity that comes along with cancer treatments.

Yet one more ripple is how the various relationships within the family, between the parents, the parents and the sick child, the parents with the healthy siblings and the siblings and their relationships are all affected by the trauma of cancer. The parents' reactions to the diagnosis and treatment can affect the patient and their other children. Here's where it gets complicated. Parents are distressed by what is happening to their child, yet cannot show the fear that they may be experiencing as they don't want to frighten their children. They may also be unable to share their distress with their partners. Communication within the family may become shunted. Healthy siblings may be unable to express their fears and concerns about themselves as well as their sibling's wellbeing. All this is before the extended family weighs in. Grandparents, aunts, uncles also have reactions to the cancer diagnosis and can be of great assistance or distraction or somewhere in the middle.

Research has demonstrated that families with pediatric cancer are at risk for having communication difficulties. It's also been demonstrated that there is a better chance for a positive psychosocial outcomes for these children when there is good communication within the family. Hildenbrand et al. says, "… facilitating communication between family members around cancer-related stress may serve as a vehicle for helping patients best support their children during treatment." I suggest that it will also be beneficial for the rest of the family members as well.

Perhaps one the strongest antidotes to the stress encountered by the family is strong social support. Staci Martin, PhD, Sarah K. Carebrese, MPhil, Pamela Wolters, PhD, Katherine A. Walker, MA Katherine Warren, MD and Rohan Hazra, MD (2012) found that families with pediatric cancer fare better with good social support than those who did have such support.

So how do families thrown into a lake of fear, confusion and pain get back to the surface? How do they get back to a sense of normalcy? Support from various networks can help get the family back to the surface.

Extended family members and friends can help lessen the burden of everyday needs such as household care, childcare, meals and such by taking care of them for the family. Psychologists, social workers, nurses and other mental health care providers can assist these families by providing counseling to help keep open communication in the family between all the various relationships. These professionals can also teach the families and the patients various coping strategies to reduce the negative impact of the cancer treatments.

In addition there are programs available to families to help nullify some of the negative aspects to cancer and its treatment. Organizations such as Sunrise Day Camp, Friends of Karen and Penelope's Odyssey works on providing children and families with resources

to handle some of the many challenges that a family is impacted with when facing cancer. Penelope's Odyssey believes in bridging the families together to help support a community that is focused on getting through the challenges and hardship of caring for a child diagnosed with cancer.

It is important to realize that "normal" may look different when treatment is finished than when it first began. And there may be various different stages of "normal" as families go through treatment. During treatment, it become normal for families to sleep in different places, patient in the hospital with either mother or father, siblings sleeping at a family member's home. Or eat at different times and places. Or to not go to school. The old family routines become disrupted and become new patterns. But the family will in time set up new patterns as well as return to familiar ones once treatment is complete.

Through the use of good communication, healthy reliance on others, use of coping strategies and accessing support programs, families can resurface from the plunge of the cancer diagnosis, perhaps stronger than they were before they were thrown into deep water.

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School Shootings and Other Mass Killings: **Is Treatment Part of the Solution, or Part of the Problem?**

David Kirschner

First, Adam Lanza, age 20, killed his mother. Then he murdered 20 children and 6 adults, at the Sandy Hook Elementary School in Newton, Conn. WHY? Was he mentally ill? Could the tragedy have been prevented with early diagnosis, and access to treatment? In 1998, Kip Kinkel, only 14 years old, killed his parents and then murdered two students and wounded 25 others at an Oregon high school. Kinkel's parents were also high-powered gun enthusiasts, as was Adam Lanza's mother. There have been no substantiated reports, as yet, whether Lanza, the Conn. Perpetrator, had ever been treated for a mental illness - but Kip Kinkel had seen a therapist, as have most school killers - PRIOR to his mass murder rampage.

As a forensic psychologist, I have tested/evaluated 30 teen age and young adult murderers, and almost all of them, had been in some kind of "'treatment", usually short term and psychoactive drug oriented - BEFORE they killed. In these cases, ACCESS to mental health care, was available, but did nothing to prevent the violence - despite current arguments in Congress, re: proposals for gun control vs. mental health access/treatment. After each episode of school killings or other mass shootings, such as the Aurora, Colorado Batman/Robin movie murders and Tucson, Arizona killing of 6 and wounding of Rep. Gabrielle Giffords and 12 others ; there is a renewed public outcry for early identification and treatment of children/teens at risk for violence. Sadly however, most of the young people who kill, had been in "'treatment," prior to the violence - albeit with less than successful results. To name just a few, Thomas (T.J.) Solomon, age 15, who shot 6 students in a Conyers, Georgia school, was depressed and taking prescribed Ritalin at the time of his rampage; Eric Harris, age 18, one of the Columbine (Littleton, CO) High School killers, was seeing a psychiatrist and on psychotropic meds before the rampage; and Kip Kinkel was treated with Ritalin and then Prozac, along with brief and superficial managed-care friendly psychotherapy, BEFORE he killed his parents and school mates. But WHY were these "'treatments" so obviously unsuccessful? Dr. Jeffrey L. Hicks Treatment Notes on Kip Kinkel are available online at PBS.com (Frontline, The Killer at Thurston High); and in my opinion. these documents should be studied for valuable clues they offer about how NOT to treat troubled, potentially violent young people - and hopefully what can be learned to prevent such tragedies in the future.

Dr. Hick's treatment plan for Kip, follows a classic "'managed-care friendly" format, conforming to the insurance companies protocols (to maximize profits, while reducing sessions) - often at the expense of the patient's psychological, emotional and real treatment needs. For example, Kip was seen only nine (9) visits, over a 6 month period. Outside of a managed care system, it is obvious that he was in need of intensive therapy (such as two visits per week, not just one visit every three weeks). And like most of the other young killers, Kip was on a psychoactive medication, Prozac, before his violent rampage and despite numerous research studies warning that these prescriptions can spark acts of violence (U.S. News and World Report, March 8, 2000).

Most of the young murderers I have personally examined, had also been in "'treatment," and were using prescribed stimulant/amphetamine type drugs -

before and during, the killing events. These medications did not prevent, but instead contributed to the violence, by disinhibiting normal, frontal cortex control mechanisms. To quote 18 year old Jeremy Strohmeyer, from his pre-sentencing murder trial statement; "'There must be a tighter rein on the dispensing of mind altering and mood altering prescription drugs." Prior to the violent event, for which he is currently serving a life without parole sentence, Jeremy, an honor student, with no history of violence, was misdiag-

nosed with attention deficit hyperactivity disorder (ADHD), and "'treated" with nothing more than a bottle of Dexedrine, following a brief 20 minute "'cost-effective" psychiatric consultation.

And so despite ongoing congressional debates regarding stricter gun control laws vs. improved access to mental health treatment; our concern should be about the quality of mental health care, not just a societal safety net insuring treatment for all children and young adults. Almost all of them are covered by some type of managed care or insurance company, and the issue is not access to preventative treatment. The real problem, in my opinion, is the quality and competence of therapy, for potential violent offenders - when insurance companies are the gatekeepers. ■

Patsy Turrini has a paper in the new 2013 book, ENCOUNTERS WITH LONELINESS; ONLY THE LONELY, edited by Kramer, Spira and Lynch, titled; *The Death of the Loved Spouse, The Inner World of Grief: A Psychoanalytic Developmental Perspective.* The paper received a good review by Dr. Richard Gottlieb, (in the book also). ■

Book Club Date Change

The book club will not be meeting on June 15th as it is Father's Day.

We will meet the following week, Sunday June 22nd.

Save the Date
July 4-7, 2014

SEVENTH JOINT INTERNATIONAL CONFERENCE

PASSION (Passione)

FLORENCE, ITALY

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ADELPHI SOCIETY FOR PSYCHOANALYSIS AND PSYCHOTHERAPY ■ INSTITUTO DI PSICOANALISI H.S.SULLIVAN ■ THE PSYCHOANALYTIC SOCIETY OF THE NYU POSTDOCTORAL PROGRAM ■ TORONTO SOCIETY FOR CONTEMPORARY PSYCHOANALYSIS ■ WILLIAM ALANSON WHITE PSYCHOANALYTIC SOCIETY

The Seventh Joint International Conference will focus on the theme of Passion in psychoanalytic work and everyday life. Psychoanalysis has been described as a journey into the interior, a creative and mutual process which enables participants to contemplate experiences, explore reactions and generate thoughts that broaden their perspectives and make them more present in life. Central in this intense and deeply personal process is the passion to make sense, to create links between the past and the present and the personal and the interpersonal, and to give voice to internal states and experiences. Yet, side by side with the passion analysts feel for the work they do is the reality of clients devoid of passion, or full of destructive if not obstructive passion. Maintaining passion in working with patients who are fearful of intense emotions, tolerating the emotional turbulence patients generate with their intense reactions and rigid beliefs, and facilitating exchanges that feel meaningful and resonant, are challenges familiar to every analyst. The conference will offer presenters an opportunity to address a range of issues related to different experiences and manifestations of passion including, but not limited to: passionate beliefs and ideas; passions that blind; passions that give meaning and structure; failure to find/maintain passion in life and relationships; destructive, self-destructive, and pathological passions; obsessive, alienating and ritualistic passions; shared passions; passions in the transference/countertransference; commodification, objectification of passion and desire; differences in passion between males and females, gay and straight.

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Honoring Dr. Elaine Seitz
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Friday, May 30, 2014
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Jonathan's Restaurant
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$75 per member
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(Checks payable to ASPP.)

RSVP by May 23rd (reservations postmarked after May 23rd will be charged an additional $10).

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Letters to the Editor

Letters to the editors are welcomed. Please send comments, submissions and opinions to gailgrace8733@aol.com.