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EDITOR'S NOTE:

Amidst the bustle of the winter American Psychoanalytic meetings, I spent a reflective evening in a small audience at the West Side YMCA, watching Mark St. Germain's play, "Freud's Last Session." This play was inspired by Armond M. Nicholi, Jr.'s book, *The Question of God*. It imagines a conversation between C.S. Lewis and Sigmund Freud that might have occurred two weeks before Freud's death, on the day England entered World War II. The play presents a conversation between these men that spans many topics, and the majority of the words uttered by Freud are familiar—they have been taken from Freud's writings. Just as Freud held that all dialogue in a dream has been spoken or heard in waking life, this play's dialogue functions like St. Germain's and Nicholi's dream of Sigmund Freud.

A minor moment from the play has stayed with me. Lewis arrives late—the trains are not running on time that day—and Freud teases him that his dog, Yoshi, won't enter the room on account of his lateness. He later admits the real problem: the dog will no longer occupy the same room as him, due to the smell of rotting flesh that is coming from his cancer-infested mouth. This was a familiar story to me. Max Schur wrote of it in his book, *Freud: Living and Dying*. But it felt more profoundly poignant to hear it told by the vision of Freud I saw before me. The evening before, I had had a conversation with an analyst about how Freud's dog accompanied him in his consulting room every day. (The analyst had once brought his pet parrot to the office, and had been put off his technical guard when the parrot began squawking from the closet, mid-session.) We also discussed how Freud gave one of the dog's puppies to H.D. during her analysis (and by my recollection, it was ambivalently received).

We rely on our dogs for their predictability. Fickle behavior isn't in their nature. And eventually, we have to cope with our animals' mortal illnesses. I recall with great tenderness the way my cat snuggled up on the belly of my Newfoundland during his dying days. What, then, to make of this abandonment by a well-loved companion? In the play, Freud faced it matter-of-factly. He accepted it. Throughout the play, harbingers of death and loss came steadily to mind for both men. The conversation turned to Lewis' mother's early death, and Freud's daughter, Sophie's untimely death. They considered the Nazis, and Anna Freud's harassment by them in the days before the Freuds escaped Vienna. Radio broadcasts about the war were urgently attended to by both men, and at one point, an air raid siren drove the pair to rush for their gas masks. Throughout, Freud's mouth bled, and ached, and he anxiously awaited Anna's and his doctor's return to soothe him in his agony. Amidst all these

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existential pressures, Freud was resolved, neither reaching to make sense of them, nor denying them.

A few weeks ago, I re-read Freud's case study of Dora for a meeting at Dartmouth. Every time I turn to this text, I experience it differently, and this time, as a result of my recent studies of *The Interpretation of Dreams*, I was much more attuned to Freud's dedication in his extraordinary attention to the nuances of Dora's words, behaviors, and most of all, dream imagery. In the Postscript, after Dora has fled the treatment and only informed Freud of this decision in her last session, Freud admits that he fully understands that Dora's departure called for a response from him. Dora had "tested" Herr K— rejecting him, but then waiting for him to return before telling her mother of the events—and Freud understood that here, again, Dora was implicitly inviting him to beg her to return to analysis. Here are his words:

> Might I perhaps have kept the girl under my treatment if I myself had acted a part, if I had exaggerated the importance to me of her staying on, and had shown a warm personal interest in her—a course which, even after allowing for my position as her physician, would have been tantamount to providing her with a substitute for the affection she longed for? I do not know. Since in every case a portion of the factors that are encountered under the form of resistance remains unknown, I have always avoided acting a part, and have contented myself with practising the humbler arts of psychology. In spite of every theoretical interest and of every endeavour to be of assistance as a physician, I keep the fact in mind that there must be some limits set to the extent to which psychological influence may be used, and I respect as one of these limits the patient's own will and understanding (Freud, 1905, p. 109).

Again, we see Freud facing loss. Recognizing and honoring the other's will, be it Dora's or his dog's, he held to his convictions.

Themes from this Newsletter's articles have gotten me thinking about how extraordinary is this capacity to bear loss, to accept the other's ability to reject or abandon us. It is one imperative in our work, that rather than *doing something* when someone is in pain, we bear it. This requires the courage to face down a horrifying situation, and the humility to accept our powerlessness to solve another's problem. However, by knowing and bearing others' losses, we are doing something—Freud stayed on task with Dora even in their final hour, as she turned away from him. These are the themes brought to mind in considering Mitch Schwaber's account of his days of medical service in Haiti during the month after the January, 2010 earthquake decimated Port-au-Prince. Dr. Schwaber, Evelyne Schwaber's son, left his family and home in Israel in order to give himself to this work. Consider as well the report by Chris Lovett, a BPSI analyst in private practice in Newton, which describes a very engaging scientific meeting, relaying the tremendous psychological demands clinicians embrace in their work. The young boy who is the focus of Inge-Marie Pretorius's talk had witnessed his mother's murder by his father. Our own Sarah Lusk provides an interview of Dr. Pretorius that highlights the rich background that Dr. Pretorius brings to this work, and may shine a light on the aptitudes through which steadfastness is borne. Our advanced candidate, Ayelet Barkai, together with BPSI faculty and Tufts Professor Diane O'Donoghue, address a more upbeat topic—a fascinating exploration of family dynamics in the household of a lesbian couple, as portrayed in the film, "The Kids Are All Right." Their commentary is far from an exploration of trauma, yet they, too, are fearlessly entering into questions—about homosexuality, identity, and child development—that will no doubt demand a more profound acceptance of the differences that others bring to our awareness.

All of our contributors share an important ability to stare down a complicated situation, problem, or dynamic—to endure, withstand, and even be curious about situations that others have rejected from their conscious thought. What makes for that endurance is a topic worthy of further consideration.

One Year Since the Earthquake in Haiti: A Physician in the Israeli Field Hospital Remembers

Mitchell J. Schwaber, M.D., MSc

Dr. Schwaber on duty at the IDF Field Hospital.

In January, 2010, I was called to serve as one of two infectious diseases specialists in the Israel Defense Forces (IDF) Medical Corps Field Hospital in Haiti, following the earthquake of January 12. The quake struck near the capital, Port-au-Prince, on a Tuesday, at seven minutes to midnight Israel time. On Wednesday, on learning the scope of the destruction and the extent of the need, the Israeli government decided to dispatch a humanitarian relief mission, and charged the IDF with carrying it out. The major component of the mission was to be the deployment of the Field Hospital. My call-up phone call, from the Medical Corps unit in which I serve as a reserve officer, came Wednesday afternoon.

We reported for duty Thursday morning, and began to learn the details of our task. There were to be 230 of us in total: 109 logistics and support personnel from the Home Front Command, and the remaining 121 from the Medical Corps, comprising the Field Hospital staff. All had been notified of their call to duty within the preceding 24 hours.

While the IDF is well-versed in providing emergency disaster relief, having deployed in numerous stricken countries across the globe, Haiti presented a challenge unique even to disaster scenarios. First, the scale of the devastation was staggering—approximately 230,000 dead, 300,000 wounded, a million rendered homeless, and 3 million people in need of services. Second, Haiti was entirely ill-equipped to deal with such a crisis, as the poorest country in the Western Hemisphere, with no military and a government crippled by the quake, leaving no authority to administer to the local population and distribute the relief resources and personnel that began flowing in.

After receiving all the myriad immunizations we would need to protect us from infection, we boarded a charter jet from Ben Gurion Airport at 5 a.m. Friday morning, for the 15-hour flight to Port-au-Prince. We were greeted by intense heat, humidity, and evidence of destruction all around. Thanks to the excellent legwork done by the advance delegation that left Israel shortly before we did, we were able to pitch our tent hospital in a soccer field not far from Toussaint Louverture Airport.

The heavy equipment arrived Saturday at 2 a.m., and we worked through the rest of the night and morning to set up the hospital. At 10 a.m., the first patient arrived. Our group was one of the first foreign medical teams to be operational, and the first to provide the level of care we provided.

Over a dozen medical specialties and subspecialties were represented at our hospital. We had an intensive care unit, with additional facilities for neonatal intensive care. Our operating room functioned around the clock. Surgical equipment was sterilized by portable autoclave between procedures. One tent housed a laboratory. Another tent housed the radiology unit. Electronic medical records tracked the care given each patient. Medical staff from other countries joined our hospital and participated in patient care. Two mental health professionals, including one psychiatrist, were deployed in order to attend to the needs of both the local population and the hospital staff.

During the 10 days the field hospital was operational, we treated over 1,100 patients, and performed over 200 operations. Sixteen babies were born, three by cesarean section. Improvisation was the name of the game. When we ran out of screws with which to fix femoral fractures, the head operating room nurse consulted with a munitions NCO, who set out to a local metalworks factory, finding a type of screw that fit the bill closely enough for surgery to continue. When we ran low on plaster casting material, the chief gynecologist—who happens to be of Moroccan descent—managed to procure more from the Moroccan Embassy in Haiti. When we needed plasma to treat a baby with hemorrhagic disease of the newborn, a physician who happens to be blood type O-negative donated his blood, which was transfused directly into the infant to stop his bleeding.

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Dr. Schwaber being promoted to the range of major in the IDF Medical Corps reserves at the end of his tour of duty.

Ethical dilemmas abounded—issues of disaster medicine that are not encountered in routine practice. The objective of saving as many lives as possible necessitated a process of triage wherein those patients whom we knew we would be unable to help would have to be turned away in order not to occupy beds that could otherwise be used to treat patients we could help. Excruciatingly difficult decisions had to be made regarding optimal use of limited intensive care facilities for adults and babies. At discharge, we often had to send out people who had no reliable place to go, and sometimes even children who had arrived for care with no adult guardian. Every one of these cases required a decision between less-than-optimal alternatives. Ad hoc ethics committees were established by the senior medical officers to grapple with difficult management decisions that arose.

Sometimes a combination of luck, resourcefulness, and enormous goodwill were able to alleviate at least to some degree an incomprehensible tragedy. One example follows. On our very last day of operations, as we were transferring and discharging our last patients, I was brought to a 16-year-old orphan with no place to go. His arm was casted and his leg bandaged post-surgery. He had lost his entire, 11-member family in the quake. His home was destroyed. Medically, he was ready for discharge, but he didn't know where he would go, or, being immobile, how he would get there. Through a variety of connections made on-site, I managed to have him taken, at his own behest, to an orphanage not far away. It was run by an American missionary, housed 150 children and had an adjacent clinic. Shortly after arriving back home, I received an email informing me that my patient was doing great.

I was personally grateful for the presence of the mental health team. Though I would not have predicted at the outset that I would avail myself of their services, a week into the mission I found myself seeking out the psychiatrist for what proved to be a highly therapeutic, and most necessary, talk. The intensity of the experience, the distance from home, the fatigue, and above all the constant uncertainty as to whether I was performing my job adequately amidst this overwhelming need—all these took their toll, and I was greatly helped by the attentive ear and wise counsel I was given. In the difficult days ahead I would often reflect on the healing words of the psychiatrist to find strength to continue. I suspect I am not alone among my colleagues in this regard.

By the end of January, there were sufficient functioning medical facilities in the area to allow us to dismantle our hospital and return home, after having transferred those patients in need of continued inpatient care to other hospitals, and donated a vast amount of equipment and supplies to local medical providers. Just prior to dismantling, our commanding officer addressed us. He told us that the relief we provided in Haiti, and the fact that we came from the other side of the world to provide it, gave the people of Haiti reason to hope. Hope, he said, can be an antidote to the despair generated by disaster. He told us that for the people of Haiti, we were a drop of hope in a sea of despair, at times the difference between life and death. This, he said, is a tremendous privilege.

Mitchell Schwaber, son of Drs. Evelyne and Jules Schwaber, serves as Director of the National Center for Infection Control of the Israel Ministry of Health, and as an internist and infectious diseases specialist at the Tel Aviv Sourasky Medical Center and Maccabi Healthcare Services. He lives with his wife and three daughters in Modiin, Israel.

Additional details regarding the IDF Field Hospital and the ethical dilemmas encountered can be found in the following articles: Kreiss Y, Merin O, Peleg K, et al. (2010). Early disaster response in Haiti: the Israeli field hospital experience, Ann Intern Med, 153:45-8. Merin O, Ash N, Levy G, Schwaber MJ, Kreiss Y. (2010). The Israeli field hospital in Haiti--ethical dilemmas in early disaster response, N Engl J Med, 362:e38.

REPEATING AND RECALLING PREVERBAL MEMORIES THROUGH PLAY

OPEN SCIENTIFIC MEETING ON APRIL 17, 2010

Presenter: Inge-Martine Pretorius, Ph.D.
Discussant: James Herzog, M.D.
Moderator: Ava Bry Penman
Reporter: C.G. Lovett, Ph.D.

At the PSNE meeting on April 17, 2010, Dr. Inge-Martine Pretorius, a Child and Adolescent Psychotherapist at the Anna Freud Centre in London, presented her paper, "Repeating and Recalling Preverbal Memories Through Play." The paper recounts the case history of the four year analysis of a boy, beginning at age six, and explores the impact of early infantile trauma on later development and on the process of psychoanalytic treatment. During the course of her very lively and often moving presentation, Dr. Pretorius explored a number of issues central to psychoanalytic understanding. These included the multiple forms of repetition of early experience that can take place in the treatment setting, the place of interpretation versus "developmental help" in the therapeutic action of psychoanalytic technique, and the complicated relationship that exists between considerations of "containment" or providing a "holding environment" for analytic patients and the question of when such environmental provisions might represent a "collusion" with the patient's defenses.

Dr. Pretorius began her presentation with a brief review of the relevant research and clinical literature on trauma and memory. She pointed out that chronic, or cumulative, trauma and the salient traumatic event experienced in childhood influence the developing brain in different ways, and they are stored, recalled, and expressed differently. Repeated exposure to traumatic states often result in sensitivities that predispose the child to reactivate such states, at times to the degree that they become characteristic traits of the individual. While much of early experience is integrated in the realm of implicit memory, increasing evidence suggests that infants register and remember salient aspects of experienced traumatic events. An important aspect of her presentation focused on the findings indicating that the availability of language at the time of experiencing a significant event is not necessary for that event to either be remembered over a long period of time, or for that memory to be expressed verbally at some later point in development. Dr. Pretorius also pointed out that psychoanalysis has been interested in the impact of trauma occurring in the preverbal period of development and the nature of its representation in memory since Freud's (1918) case study of the "Wolf Man," whom Freud hypothesized was traumatized at age eighteen months.

At this point, Dr. Pretorius introduced the audience to her patient, Ben, and organized the remainder of her presentation around the ways in which she hoped to demonstrate through her work with this young boy the different ways in which both chronic trauma, and a horrific traumatic event, were repeated, recalled, expressed verbally and physically, and worked through, or "played through," during the course of Ben's analysis.

At the age of eighteen months, the patient had witnessed the murder of his mother by his father, by strangulation. After he had killed Ben's mother, his father blacked out for some period of time, and during these events Ben had apparently remained awake and nearly motionless on a nearby sofa. Upon waking, his father ran away with Ben for a period of four days, at which point he surrendered himself to the police. During the following year, Ben was placed in foster care, and then began the process of adoption with a couple who had no other children. Ben was brought to treatment by his adoptive mother, who complained of his aggressive and oppositional behavior, as well as an apparent inability to express affection, the combined effect of which now threatened a breakdown in the adoption. At the outset of treatment, Ben seemed unable to think about his experience, regulate his affects, or tolerate frustration, and his capacity for self-protective functioning seemed quite impaired. What this boy did possess, however, was a nascent capacity to play. Dr. Pretorius emphasized that, in light of the horror in this child's early life, which also emerged in the analytic material, she came to appreciate the necessity of play in making the pain of early trauma bearable and thus available for psychoanalytic work.

Dr. Pretorius described four phases in the analysis, based on the patient's capacity to deal with

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the memories of his traumatic past. Each of these phases was characterized by increasing levels of affect regulation, symbolic play, and the capacity to tolerate and think about "the unbearable." In brief, the four phases described were: first, initial efforts on the patient's part to forget past trauma, accompanied by the expression of such memories through persistent arousal and behavior reenacting past events; second, after eighteen months of analysis, the patient seemed to perceive the setting and the analyst as sufficiently safe and reliable, and he began to recall certain aspects of his trauma; third, after two years, three months, the patient moved from reenacting to "playing through" the past in displacement; and, fourth, the patient began "playing through" his current preoccupations in displacement. From Dr. Pretorius' point of view, each of the phases of treatment illustrates Freud's (1920) idea that compulsive repetition in children's play is a means of mastering trauma. Such repetition is not only integral to Freud's (1912) notion of transference, it also contains a reparative aspect in that the individual seeks to repeat an old object relationship while hoping that a new version could be different and healing.

Dr. Pretorius then added another level of meaning to the term "repetition" when she discussed the tendency of traumatized children to recreate conditions in their current environment that they suffered in the past. Thus, Ben's self-representation as unprotected, rejected, and abandoned was supported not only by his childhood experience, but also by subsequent experiences to which he contributed as an active, shaping participant. This seems to be especially the case in children who have been the victim of unpredictable violence, who frequently engage in provocative, aggressive behavior in an attempt to elicit a predictable response and, by that means, reinforce their shaky sense of control (Perry et al., 1995). This tendency makes it more likely that the child's past will be recapitulated in the present, and this includes the repetition that takes place in the transference-countertransference relationship with the therapist (Westen and Gabbard, 2002). Dr. Pretorius devoted a large portion of her presentation to the subject of how the child analyst often must work extremely hard to facilitate the kind of ego transformation and repair that allows for the development of less primitive, more symbolic levels of expression and repetition within the transference.

At the outset of the treatment, Ben's chaotic play, outbursts of aggression and destructive behavior suggested the expression of implicit, poorly integrated memories that were enacted through intense emotions and behavior, without his conscious awareness. His tendency to swing very rapidly from play to being extremely violent made it difficult for the analyst to be with him, and even his play often depicted terrifying, violent, yet exciting objects. During this period, the analyst's attempts at verbalizing or interpreting his states of mind seemed not simply unhelpful, but instead frightening, disorganizing and harmful. Consequently, Dr. Pretorius determined that her role was primarily to contain his strong unwanted affects, survive his attacks without retaliating, and in this way, show Ben that, "the unbearable was bearable and knowable." Dr. Pretorius referred to the work of Anne Alvarez (1992), who has suggested that with such traumatized children, the therapist may need to contain the child's unwanted feelings for long periods of time while a non-traumatic experience is built in relation to the analyst and the child gains confidence in the setting.

On the subject of interpretation in child analysis as practiced in the treatment of this child, Dr. Pretorius determined that the most promising manner in which to deal with his internalized patterns of early traumatic object relations was through, "an avoidance of interpretation per se." Instead, she attempted to avoid negativistic power struggles by using playfulness and humor, which she determined allowed Ben to "save face" after he might have done something like attempt to destroy the playroom or attack the analyst in response to frustration. In this way she considered her approach to be not merely one of surviving and containing his attacks, but also as an effort to supply him with a "new object" (A. Freud, 1965) and a different form of relationship that was consistently reparative and would allow him to build up a set of alternative, positive memories of interaction (Westen and Gabbard, 2002). This school of thinking is consistent with Anne Hurry's (1998) view that the child uses the analyst both as a transference object and as a new "developmental object," an idea derived from Anna Freud's work that emphasizes a view that change comes about as the result of the child's internalization of new models of relating, gradually acquired and built up by the joint work of the patient and analyst. Hurry reserves the companion notion "developmental therapy" to refer to work aimed directly at furthering development, such as teaching a child to play or see others as also having feelings, in contrast to the work carried out via interpretation. She adds, however, that the so-called divide between developmental and psychoanalytic work is a false distinction, as from her point of view psychoanalysis

is itself a particular type of developmental therapy. Dr. Pretorius, who currently holds a position at the Anna Freud Centre in London, reflects in her work the tradition of thinking developed there that holds that developmentally disturbed or derailed children may require a new and different emotional experience, and that such "developmental help" may set in motion therapeutic change.

While Anna Freud recognized a dual role of the child analyst as transference object and "new" object, she worried that the use of the analyst as a new object interfered with transference reactions and that children had a tendency to "misuse" the transference relationship for a "corrective emotional experience." Dr. Pretorius voiced similar concerns in her presentation, as she wondered if at times her playfulness might not have represented a "collusion" with her patient's resistance. On one occasion, when Ben feigned falling asleep at the end of a session, she spoke to him of her "hope that he would not sleepwalk to the waiting room." This prompted her patient to walk from her office to the waiting room with his arms outstretched, as if "sleepwalking," which then became their operative mode of ending sessions for the ensuing eight months. At first, Dr. Pretorius grew concerned that her helping him to "save face" in dealing with the separation at the end of an analytic hour may have aided him in avoiding the feelings involved in facing the reality of the separation and loss. Upon further reflection still, Dr. Pretorius wondered if this apparent "collusion" might be more usefully considered to be part of her containing function in the treatment, that is, to bear his unwanted and unbearable feelings until he became more confident in the safety of the setting and the analyst, and might move on to processing such feelings himself. Beyond such considerations of collusion or containment, however, one might also argue that Dr. Pretorius intuitively arrived at and provided to her patient a profoundly powerful interpretation within the playful metaphor she offered to facilitate his capacity to separate. In this moment, she provided her patient with a means to express through play the feeling of being in a place 'in between,' neither past nor present, awake or asleep, conscious or unconscious, like the mythic space between life and death, complete with all of the Orphic possibilities for travel back and forth to the underworld. Sleepwalking as a phenomenon was initially thought to represent a dreamer acting out a dream, and somnambulism has often been associated with altered states of consciousness that allow the sleeper to perform acts they would be unable to carry out in full conscious awareness. At a later point in the treatment, Ben engaged in an imaginary sequence of play in which he took "the night train to heaven" in an attempt to see his lost mother. It seems probable that Dr. Pretorius' playful suggestion may have emanated from the developing jointly created unconscious life between the patient and analyst, what Ogden (1994) has referred to as the "analytic third," and offered an interpretation within a spontaneously created scene of play that allowed her young, grieving patient a means to reunite with his lost mother in the play space in a later elaboration of the same themes.

A theme of play began to emerge toward the end of the first year of analysis that made more explicit Ben's preoccupations with loss, death, repair, and resurrection. At first, toy figures tied to string were lowered out of the window, although they were frequently dropped out and declared "dead." Rescuing them at the end of the hour, as well as then bringing them back to life again, became an important part of the play. Dr. Pretorius suggested that this represented her patient's "wishful universe in which there was no death or permanent loss." Reminiscent of Freud's (1920) description of the "fort-da" game, it appeared to reflect Ben's need to experiment with the feelings associated with death and its permanence, as well as being an expression of his need to turn passive into active and his evolving identification with the aggressor and the conflicts around such identifications. In this regard, it is significant to note that during this period of the play Ben also developed a sense that he was "good at fixing things," which seemed to announce a more developed, substantial sense of hope and perception of the analytic setting and analyst as sufficiently safe to allow such feelings to emerge.

It was soon after this that Ben began to reenact his reconstructed memories of his early traumatic experiences and to speak about events that had been "known all along, but which had remained unspoken." Specifically, Ben began to play games in which he rescued and resuscitated his mother, along with sessions in which he enacted murder scenes, at times including the murder of his analyst. During this period of work the experience of Dr. Pretorius in the countertransference became at once more specific and more overwhelming. At times she experienced labored breathing, literally gasping for breath as her patient tried to revive a wilted lily, then take it to heaven in order to provide oxygen to his deceased mother and bring her back to life. At other moments, such as when Ben was enacting acts of murder,

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his analyst often experienced difficulty speaking, and felt restrained and helpless. During this period it would appear that the nature of the patient's projections had grown more organized as his object relations became more sophisticated. Within the countertransference, Dr. Pretorius was now experiencing more specific, object-related feelings and fantasies. As her patient's use of imaginary companions had receded as repositories of split off parts of himself, his analyst was now experiencing more directly his internalized object world via her own subjective experience in the treatment hours.

During the final two phases of his analysis, Ben began "playing through" his past and then current experiences through the increased use of toy animals. Familiar themes of attachment, loss, separation, and death were present, but now were most often expressed through symbolic displacement in the play. A panda came to represent Ben most frequently, and panda and his mother were often on the brink of death, though they now always survived. At the same time, it became important for the analyst to accept and adhere to a tightly scripted role assigned to her. If she attempted to interpret the play or link it in any way to Ben's personal experiences, he immediately silenced her, admonishing her that, "Panda's mother doesn't say that, you're spoiling the game."

Despite her initial reaction of irritation at being so rigidly controlled, Dr. Pretorius chose to allow the play to remain in displacement for the most part. It is also important to note that Ben's scripts increasingly did not replicate his early experiences, suggesting that his internal object representations had expanded and evolved toward an increased level of organization and narrative coherence. It might be pointed out here that his capacity to change and "play with" differing scripts is also indicative of a growing individual creativity and the emergence of a more personalized solution to his internal conflicts. Such a capacity for creativity in living (Winnicott, 1971), essential to a healthy sense of self, has its essential foundation in the capacities for imitation, variation, and selective recombination of elements in the patient's internal world. A further question might concern whether the play in displacement that characterized the latter stages of this child's analysis represents one sort of creative play that could only be carried out within the context of a very different, more restrictive mode of play within the transference. From this perspective, the patient was able to simultaneously "play through" his past trauma and current conflicts, searching for and working toward different solutions, while at the same time transacting a different compromise in the nature of the interaction within the transference, one in which there was *no* deviation and where the patient's "sense of control and agency" was unchallenged, a kind of "director's cut." It is in this context that Dr. Pretorius referred to Winnicott's (1956) notion that if change is to be realized in psychoanalysis, the traumatic factors in the patient's life must enter the psychoanalytic space in the patient's own way and within his omnipotence. For this boy the rigid, omnipotent control by one love object of another had overwhelmingly destructive past associations. Yet in order for a therapeutic frame to be maintained, he and his analyst had to implicitly agree that they could "play with" the feelings and fantasies around matters of control and maintain the shared illusion that it was only "as if" she could not deviate from the script. According to Dr. Pretorius, it was her recognition of his need for absolute control and for the confidence that she would maintain the illusion of play that allowed her to work through her initial feelings of irritation and provide such an object experience for this boy as part of an empathic extension of herself.

The discussant for the meeting was Dr. James Herzog, who is a Training Analyst and Adult, Child and Adolescent Supervising Analyst at the Boston Psychoanalytic Society and Institute. Dr. Herzog raised the issue of how much the analyst's countertransference in this treatment provided a window into the patient's internal world, or "inscape," by way of Dr. Pretorius' attunement to "the patient's mind in her mind."

Dr. Herzog emphasized the importance in the treatment process of the analyst's effort to find a way to allow and encourage her patient to continue his play, to "keep on going" in his efforts to re-find his sense of spontaneous being and share his internal world. The ways in which trauma interrupts both development in general, and the "play process" in particular, have been a central focus of Dr. Herzog's own work for many years. To begin to convey his perspective on the work of Dr. Pretorius, Dr. Herzog shared his own definition of play: an ego function that is involved with trying on, revising, and making meaning without primary attention to the constraints of reality, in order to create the self in a manner that is permissive and allows multiple drafts. Trauma was then defined as something that occurs when what happens or does not happen overwhelms the ego's capacity to play, that is, to try on, take off, orchestrate, and re-orchestrate experience.

Trauma, according to Dr. Herzog, causes a regression or reversal of the developmental process. This regression results in play moving

from an activity that involves displacement and symbolic equivalents, to one of enactment and "interactive enactment," in which the prescribed participation of another is required. Dr. Herzog contended that Ben ultimately played in all three of these modes during his analysis. He held that Ben was helped to reclaim displacement and enactment as part of his play repertoire through the need for interactive enactment that Dr. Pretorius honored, and showed great skill in providing, during the treatment.

According to Dr. Herzog, without allowing an interactive enactment with the stringent requirements for a kind of optimal responsiveness on the part of the analyst, the "relational unconscious" cannot enter the analytic playspace or "spielraum" (Freud, 1914). In this regard, Dr. Herzog pointed out that the modes of play employed in the work of child analysis allow for a repeating and remembering that allows the original deformations that trauma inflicts on the play process to be reversed. Interactive enactment gives way to enactment, and then to displacement, and the child's playspace is expanded. Therapeutic action involves, "finding a way to create a way of looking," and, from this perspective, every child's mind can be regarded as a work of art. As such, the child analyst approaches his or her analysand as an art historian might approach the *pentimenti* of a painting. According to Dr. Herzog, the analyst attempts to provide a way of looking at the analysand's inscape, as there is always available some way in which the person is trying to represent it. In his view these efforts reveal in some form "who was there to help, who hurt, who was loved, who was hated, and how these depictions and narratives are repeated and altered as the painting is continued in the analysis." In summary, Dr. Herzog was quite complementary of both the child analysis carried out with Ben, and the clarity of the presentation by Dr. Pretorius. The spirit of his remarks was in keeping with her comment at the beginning of the day, that in the work, "the power of play is paramount."

At the beginning of the general discussion with the audience a question was raised by Dr. Axel Hoffer regarding what criteria child analysts use in deciding to take a child into analysis. From his point of view, he was impressed in both presentations by the evidence that what analysis deals with is "pain." Analysis, he continued, must therefore require not only "courage," but a "willingness" to endure. Lastly, he wondered how much might depend on the child being "likeable" vs. "unlikeable." Dr. Pretorius replied that children are not miniature adults, so psychoanalysis must be flexible in its approach and in the analyst's use of his or her skills to provide what the child needs from a developmental perspective. If the child is not likeable, then it is the analyst's job to help them become likeable, which would represent an example of the sort of "developmental help" she had referred to earlier in her presentation. In addition, she said that other criteria for analysis would include the ability to relate to the analyst as a transference object vs. a real object, the ability to hear an interpretation, and the ability to remember from session to session.

Dr. Herzog added that the question as to the criteria for analyzability unavoidably touches on the question of "criteria for whom," that is, what is the capacity of the analyst to create a playspace with each person who comes to see them, to contain the pain and to do so in the presence of this particular other. Ava Bry Penman recalled that during her time at the Anna Freud Centre, such a decision would often come down to who *wished* to see such a patient.

In response to these observations, Dr. Pretorius shared with the audience that she had read a great deal about her patient's early life before starting the treatment, but she then forgot the bulk of it as she got underway. Later on she re-read the case material when she was considering whether to write about the treatment, and she experienced many nightmares in response to this review. The material included the description of the worry Ben's adoptive parents expressed at the beginning of the treatment as to whether he was "a little murderer in the making." This was also a question that the analyst had read, but forgotten, which raised the question of whether "forgetting" is not only sometimes a goal in treatment of such traumatized patients, but also a crucial component in the construction of sufficient therapeutic optimism necessary to embark on such a treatment endeavor.

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Interview of Inge-Martine Pretorius, Ph.D. April 15, 2010

Sarah L. Lusk, Ph.D.

Thank you so much for meeting with me this morning. Why don't we start with how you made the transition from Microbiology to Psychoanalysis?

Well, in fact the choice for Molecular Genetics, which was my original field, was difficult in itself, because when I finished school I wasn't sure whether I wanted to go into medicine, dentistry, languages, art or science. And I wanted everything, as one wants when one is young and omnipotent. So I thought I could study science formally and study the arts informally. In fact while I was doing my doctorate in Molecular Genetics, I was concurrently doing a BA in Languages and Art. So I chose science, and I loved it at first. I got a doctorate and then worked in various laboratories. At Oxford University, I had a post-doctorate fellowship and then I worked in Germany for many years. But I found increasingly that it felt that I left part of myself at home when I drove to the laboratory. And it seemed more and more to me that when I isolated DNA, that DNA did not contain that part of life that seemed worthwhile to me. So increasingly I thought that DNA is answering some of my questions, but not many of the more important questions. It was then that I started reading books on psychoanalysis. In fact, the first one was Jung, *Man in Search of His Soul*, which I read in Germany. And I became more and more interested; I started making inquiries and all the people I spoke to in Germany said, "if you can speak English, go to London," which is what I did.

What were some of the questions you were looking for answers to?

Well, it seemed to me that the characteristics or qualities of life that make life worth living could not be answered by the DNA double helix: relationships. That still was eluding me; that still needed answers.

So when they said London, they meant the Anna Freud Centre?

Not, necessarily. Within North London, there are many major training schools. So they were saying London in general. I enjoyed working with children and there were some good masters programs. I thought I was going for one year initially. So I applied to the two major schools: the Tavistock , which follows the theoretical approach of Melanie Klein, and then the Anna Freud Centre. And for a number of reasons I got accepted at both. But for a number of reasons, the Anna Freud Centre seemed to me more international, which it is, and it is linked to University College London, which has a greater international standing. So I choose the Anna Freud Centre. And I made that choice without really knowing the difference between the theoretical orientations, but the more I have been there, the more I'm very pleased that I did choose that.

I was thinking about that, too, for myself, being very interested in both Anna Freud and Melanie Klein, and having not really understood the fundamental differences between the two. I would never want to leave out Kleinian, but I would rather…

Well, I think Anna Freud has a far more comprehensive theory on child development that is based on an understanding of normality, and that is so valuable. If one is trying to assess deviation or deficit, deviation from normality, one has to have a thorough understanding of normality. Whereas Melanie Klein's theory, I think although very helpful for particular kinds of disturbance, is not a chronological theory….

Or as comprehensive…

Or comprehensive on development from infancy to adolescence, or on normality for that matter.

So it sounds like you really started with child work.

Yes, I went to the Anna Freud Centre without any experience of having worked with children, apart from tutoring and a couple of odd jobs like that. But Anna Freud's approach was to encourage people from different disciplines because she thought it would enrich the field, and her aim was to train them to become "Child Experts." So I got accepted for the pre-masters, the pre-clinical training which was a one-year, very intensive master's degree. One didn't need to have much experience working with children for that because it was mostly theoretical. And so I got accepted for that and during that year we did theory of child development, psychoanalytic concepts, statistics, and of course we had to write a research project. And then we had to do longitudinal observations of infant, toddler age, and nursery age children and write observation papers on that. And if we continued to do the training, or those who wanted to and got ac-

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cepted into the training, the infant observation continued for another year. So it was a two-year parent infant observation that we had to do.

And how do you see Molecular Genetics impacting, influencing your work now as a psychoanalyst?

Well, I think the approaches of both are very similar: both use observation; both try to keep an open mind; both form a hypothesis and then test the hypothesis. And I think I draw on the training that I had in genetics in terms of observation, of attempting to define. Although I know that one can't precisely define psychoanalytic concepts, I don't think that should stop one from trying to. So attempting to reach clarity, to define as well as one can. In science, certainly my experience of working in the laboratory taught me to tolerate frustration. Not knowing what the results will be. Will there be any results? Will they be publishable? Which is important to a scientist? So all of those skills, just the not knowing, I think, and the self-discipline one needs as a scientist—all of those things inform my work as a psychoanalyst. And the doctorate in psychoanalysis that I've just completed actually combined the two. I was looking at genetic contributors and psychoanalytic contributors to the intergenerational patterns of attachment relationships.

I noticed that when I was looking at your CV. I hadn't realized that was your dissertation subject.

Yes, I tried to combine my two fields. I had 35 families, where we looked at the attachment status of the parents through the AAI. I looked at video recordings of the parent-infant interaction. I had various measures on the children. And then I collected saliva samples from all of them. (*Chuckling!*) And went into a laboratory and genotyped it for two particular genes and tried to see if there were any causality or correlations.

The AAI?

The Adult Attachment Interview–-Bolby, Mary Main—it gives an indication of the parent's attachment status, which then informs and predicts the parent's attachment with their child.

And what was your hypothesis?

Well, my hope was that neither genetics nor the psychoanalytic predispositional vulnerability, that neither of those would determine singularly what the attachment pattern was. My hope was that even if parents or families were found to have vulnerability either through their attachment relationships, psychoanalytically speaking, or through having particular genes which are vaguely related to attachment problems, that even if they had these vulnerabilities that that did not necessarily predict a disorganized attachment. I hoped that other factors like environment could mitigate. That was my hope, because I don't believe in single causal factors and I think it is simplistic to think that genes determine all one's attachment patterns singularly.

What did you find?

Well, sadly my sample was very small, so I didn't have any major findings. I did confirm a lot of what the literature says in terms of certain patterns in terms of certain genes and what they tend to predict. But I didn't find anything too major or too new. I think I would have to see my thesis as a pilot study for a bigger study in the future.

Is that something you would want to continue?

Probably not! *(Chuckling.)* Because having now been quite immersed in research in the social sciences, in the humanities, I have realized that it is quite imprecise and vague, and it's not for me. I think it is very worthwhile, but it's not really the research that I thoroughly enjoy. I prefer more precise research in the laboratory. I'm more interested in clinical work with children, and that's where I want to spend more of my time, with teaching and clinical work.

What does that look like?

Shall I describe my week? Two days of the week, Mondays and Tuesdays, I work for the N.H.S., the National Health Service, and I am based in a nursery school in an extremely deprived area of London, probably one of the most deprived—you'd call it a project in this country—in the whole of England. There are more out of job parents and single parents. Drug abuse and gang and gun crime are rife. So I am based at this nursery school where I have set up and run a child psychotherapy service for children and for parents, and supporting the teachers because they need quite a lot of support with all the problems that are there. It is very difficult and draining work, but immensely rewarding, immensely rewarding. The rest of the week, I work at the Anna Freud Centre. I coordinate and teach a master's course on the psychoanalytic perspectives of child development at the Anna Freud Centre which is part of the Master's program there. I am also manager of the Parent-Toddler Service. We run therapeutic parent-toddler groups, two in the community and two at the Anna Freud Centre. That also includes coordinating students who observe the groups as part of their training, and then the seminars, exams and papers that all follow with that.

And then, in addition to that, I do a little clinical work at the Anna Freud Center and I have a couple of private cases I see.

And you see mostly children?

Yes, yes, all children. I do some parent work accompanying children, but mostly children. And I would say more and more children under five; I thoroughly enjoy that age group.

So now you will have some more free time now that your dissertation is done!

Yes, and I hope to fill it with more clinical work with children.

Do you see there being a big difference between how child analysis is thought of in England and the United States?

I'm not sure I can answer that. I think I need to learn more about how it is seen here. So I don't think I can comment on that yet.

It definitely sounds like the program you went through was very focused and very intense.

Yes, it was. Having completed the Masters, the one pre-clinical year, I then applied for the training and had to go through three interviews, and to my surprise got accepted unconditionally. Given the lack of experience I'd had with children, I was quite surprised to get accepted. By then I was in analysis, but in fact, the training had to be delayed a bit because I had to be in analysis for over a year, five times a week, before I could actually start seeing children. So I could start the theory, but then I started seeing children a little later than my classmate. I was in a class of two! The Anna Freud classes are small, between about two and five a year.

I am in a class of one! (Both laughing)

The training included five times per week analysis throughout. I had to see three intensive cases, four or five times a week: An under five case, a latency age child and an adolescent child. All of those had to be for over a year and one had to be seen for over two years. I ended up seeing the boy for four years—the boy I am presenting on Saturday. In addition to that, on Tuesday and Wednesday nights from six to ten in the evening, we had clinical seminars, theoretical seminars, clinical groups, and so on. It was very intense, very intense. I felt it particularly intensely because I was not accustomed to looking at myself or humans so closely. (*Both laughing*.) I was accustomed to looking at bacteria and viruses, and feeling that I was separate from them! So it was extremely intense, but I found it an exhilarating experience. I mean, I felt as if my mind of being blown by some of these concepts in psychoanalysis. I found it astonishing. I still get very excited about the work. I think it is amazing stuff.

You had mentioned a connection between genetics and attachment. I'm not sure I had ever thought of that, or was aware that people in the United States were thinking of it that way.

Well, there are centers in the United States, such as the Yale Child Study Center, that are trying to look at various genes, oxytocin, in relationships, in parents; they are starting to look at that. I think my work was fairly unusual because I have some knowledge of both fields and was trying to combine it. The genes that I chose were not related directly to attachment but were linked to ADHD, with children who had difficulty maintaining attention, which then one can extrapolate and think, if the child has difficulty maintaining attention, is that then quite unrewarding for the parent? Does that then result in a somewhat misattuned relationship that then could go down the route, potentially, of a disorganized form of attachment? So the two genes I was looking at are the COMT gene, catecholamine methaltranserverase, and one of the brain-derived neurothrophic factors that have been vaguely linked, not directly linked to attachment.

Is there anything that has surprised you, coming to psychoanalysis through a wish for knowledge, and working with children? Something you weren't expecting?

Yes, I think what has surprised me in the path I have taken is to discover that I am good at playing! (*chuckling*) Which I never realized I was, but when I was an assistant in a toddler group, my leader, who was a trained psychoanalyst, pointed that out to me and suddenly I realized I was. It has made me infinitely grateful to my parents. Because I think the capacity to play is at the heart of creativity, and is something if one is lucky enough, one just learns intuitively from one's parents. I found that I really do seem to have an aptitude for it, thoroughly enjoy it, and that I love that age group. So that is a discovery I've made, and subsequently when I look at my sister and my brother, with their children, or my parents with their grandchildren, I can see exactly where it comes from. But I wasn't aware of it. So that was a delightful discovery I made that I am very thankful to my parents for.

So you really like the toddler age. That's also my favorite!

It is so passionate! (*both laughing*) It is so passionate! There's so much aggression, passion, strong feelings, overwhelming feelings. It

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is so visible; one can see all the feelings there. I think it is a wonderful age to work with.

I can imagine, I have a fantasy of you consulting to us here, how to use some of those ideas here.

I'll come back to Boston!

And I know that you are going to go after our interview to the MFA. You mentioned earlier your love of art and literature, so obviously you have been able to keep all those loves alive.

In fact, when I finished my first doctorate in molecular genetics, I took a year off—I called it a sabbatical, but of course I hadn't started working yet! (*chuckling*) My doctorate supervisor said I was throwing my good career down the drain, but of course I wasn't because I had a fellowship organized at Oxford University. But I went to Florence to study art for a while. I love watercolors in particular. I paint. I LOVE the visual arts, I love sculpture. Sculpture of the 5th century B.C. is my favorite architecture…

I have done pottery at various stages. I love looking at sculpture but I paint with watercolor. That is what I do.

Bob Gardner, one of the founders of PINE, also paints with watercolor. His work is beautiful. He is also very visual and writes about psychoanalysis and thinks about psychoanalysis very visually. You might be interested in his work.

I like what you said about learning that you could play. I think that is such a wonderful thing. I have had child supervisors tell me "just play."

And earlier we discussed the order of training—child or adult—I think certainly the training we do in London for child analysis—if one is going to do both, one should try and do that first. Because if one does the child training first, one has such a good grounding in the developmental phases of childhood, which of course informs adulthood. So I think that way ahead is more logical than going the other way around. And of course I am not an adult analyst myself, but I have a number of teachers, supervisors and colleagues who are and have done both, who corroborate that; say their child training actually informed their adult training immensely, and that is the way round that is the most advantageous.

Well, it's time for you to be off to the MFA. Thank you very much!

It's been my pleasure!

ANNOUNCEMENTS

We are pleased to announce that **Julia Matthews, Ph.D., M.D.** was certified in adult psychoanalysis in June of 2010 and **Maida Greenberg, Ed.D.** was certified in child and adolescent psychoanalysis in January of 2011 by the Board on Professional Standards of the American Psychoanalytic Association.

Congratulations are extended to **Gary N. Goldsmith, M.D.** who received the Distinguished Service Award of the American Psychoanalytic Association at the 99th Annual Meeting in June of 2010 for "Promoting psychoanalysis in Russia and Ukraine as Chair of the Russian-American Educational Exchange Committee since 1995."

We congratulate **Robin Gomolin, Psya.D.** who was awarded the Affiliate Council Scientific Paper Prize on January 14, 2011. She presented her paper entitled "The Intergenerational Theory of Holocaust Trauma: A Systematic Analysis of a Psychoanalytic Theory" at the annual meeting of the American Psychoanalytic Association in January of 2011.

NEWS AND NOTES

Ayelet Barkai, M.D. Co-led a discussion group with Diane O'Donoghue at BPSI entitled: The Kids are All Right: A Psychoanalytic Perspective on Non-Traditional Families.

Fred Busch, Ph.D. presented "Creating a Psychoanalytic Mind" at the St. Louis Psychoanalytic Society in September of 2010. In December of 2010, he presented a paper and conducted a clinical workshop entitled "Why Do We Ask Questions" at the Toronto Psychoanalytic Society. Dr. Busch presented "Changing Views of What is Curative in Classical Psychoanalysis" at a PINE Psychoanalytic Center open scientific meeting in Cambridge in January of 2011. He presented "Do Words Matter?" at a panel titled "Do the Words of the Analyst Still Matter?" at the National Meeting of the American Psychoanalytic Association in January of 2011.

Michael I. Good, M.D. was the discussant of a paper given on January 15, 2011, at the National Meeting of the American Psychoanalytic Association in New York City by Joseph Fernando, M.D., entitled "Trauma and the Zero Process."

Kimberlyn Leary, Ph.D. was appointed Chair of the Program Committee of the American Psychoanalytic Association.

Howard B. Levine, M.D. gave the Plenary Address entitled "Conflicts and Controversies between Supervisors and Training Committees" at the Education Conference of the European Psychoanalytic Federation, December 4, 2010, in Zurich, Switzerland. He presented a paper entitled "Constructions Then and Now: Revisiting Freud's 1937 Constructions Paper" at the Western New England Psychoanalytic Institute on November 7, 2010, in New Haven and at the National Meeting of the American Psychoanalytic Association on January 15, 2011. Also on January 15 at the Meeting of the American Psychoanalytic Association, Dr. Levine presented "An Introduction to the Work of Antonino Ferro." Dr. Levine was appointed to the North American Editorial Board of the *International Journal of Psychoanalysis* in January of 2011.

Kenneth I. Reich, Ed.D. was awarded the Harvard Medical School Dean's Award for Community Service "In recognition for the work of SOFAR (Strategic Outreach to Families of All Reservists)" in September of 2010. He was a supervisory consultant for a Couple Therapy Study Group Clinical Case Seminar at the Jerusalem Mental Health Center in Jerusalem, Israel. Dr. Reich presented "The Impact of War on Families and the Stigma of Mental Health Treatment: A Psycho-Education Approach" at Grand Rounds at The Cambridge Hospital in June of 2010. He was a discussant for "The Messenger" at the Film Festival at The Collaborative of NASW: Boston College and Simmons College Schools of Social Work in September of 2010. At the Massachusetts Institute for Psychoanalysis Crunch and Brunch, Dr. Reich presented "Psychoanalytic Couple Therapy: An In-depth Case Presentation."

Evelyne A. Schwaber, M.D. delivered the Fifth Annual Akhtar-Brenner Lecture on Psychoanalysis at Jefferson Medical College, Philadelphia, in February of 2011 (first female lecturer).

Morris Stambler, M.D. will be teaching a six session sequence titled "Introduction to Psychodynamic Psychotherapy with Children" for the Child Psychiatry Fellows at Children's Hospital, Boston, in the spring of 2011.

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NEWSLETTER

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