

# **The Vulnerable Child Discussion Group**

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## **Child Analytic Techniques Applied to the Treatment of Adults**

A summarized report by:

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**Presenters;** Mary Davis, M.D.

Monisha Nayar, Ph.D.

**Discussant;** Christopher J. Keats, M.D.

**Chair:** Theodore B. Cohen, M.D.

**Co-chair and coordinator:** M. Hossein Etezady, M.D.

In her presentation Dr. Davis described the dominant role of language in the “talking cure” in the treatment of adults, in contrast to regular reliance on nonverbal communication, activity and play in child analysis. She commented on how her clinical experience with children has enhanced her ability to make use of nonverbal cues in adult patients.

She presented segments from the treatment of Ms. K, a 40 year old woman who could not use language productively because in her family language was used for the purpose of concealment and invalidating emotions rather than to reveal and to connect. The story of Ms. K shows her move from being unable to use language in expressing emotions to expansion of her internal world which accompanied her first steps in verbal expression of her emotions.

In her twice a week therapy she seemed to be doing fairly well until gradually she became more depressed and unable to function. Many medications were used but did not help. She was unable to work, could not leave her bed and had little more than therapy in her life, even as she missed many of her sessions because of migraine headaches or not being able to leave her bed.

Dr. Davis said in desperation, I suggested we use art in therapy which quickly became fruitful as we both experienced intense affect which facilitated exploration of more detail in each picture. Even with the intense emotions she was unable to state what she was experiencing and could no more than assign colors to the emotions.

A series of images emerged that reflected intense and entrenched despair. My labeling and reflection of the emotion made it possible for her to recognize it but she continued to be unable to give her own words for her emotions. When I asked her to draw her depression she painted a supine body with a heavy weight on the groin, attached to a rope that would choke her if she lifted the weight. I connected her paralysis and despair to her molestation at age eight by an uncle. Silent tears slid down her cheeks. As I asked about her tears she said “I wish he was dead” This was the first time she had been able to acknowledge her grief and rage at the event which she had hidden for many years. I asked her to paint herself at a time when she felt safe. She painted a cave which kept her safe but she was filled with fear and sadness. She painted paths to others that were surrounded with dangerous and frightening colors.

I suggested that her loneliness protected her and others from her rage. For many sessions we talked about how terrible she must have felt that she could not tell anyone about her molestation while those who knew, such as her mother, did nothing. This brought no relief and for several weeks we were stuck. She painted a black pit that she could not get out of. I became concerned that my directive interventions were leading us down the wrong track, following my thoughts not hers. When I invited her to paint a picture of her confusion if she could imagine it as organized, she surprised me by drawing a picture of a woman with war paint. When I asked her to tell me about it she said, “It makes me want to yell and holler.... Kick some ass”. This was the first time she had reported a feeling and for the first time in months I felt some hope. She then missed three sessions as she could not leave her bed and returned for two sessions before my own one week long vacation.

After my vacation she drew a picture of herself behind bars. I associated to her molestation at age eight, when her experience with her mother had been a feeling of being disavowed: “You are not sad.... you have nothing to be sad about....Don’t be a baby”. She began crying and could only say, “Thank you for understanding.” She remembered in eighth grade she had spent some weeks crying daily. Her parents

made an appointment for her to see a psychologist, but when she woke up the morning of the appointment not crying, they canceled it.

For several months she was bossy and mean to everyone. I told her she was trying to hide her fears and tears by being strong and not a baby. She recalled the birth of her brother when she was three years old. She did not like him and wanted him sent back to the hospital. That must have been the first time she was told not to feel what she felt. She could be powerful but alone or loved but helpless. It was not possible to be both powerful and loved. We tried to explore the connection between feelings and words. Her language was beginning to be useful but it was still incomplete. As I frequently felt we were stuck I learned to back off from the pursuit of my lines of thought and look for where her material might lead us.

In a long series of images she elaborated on pictures of women afraid of colors which represented emotional states and who were afraid to leave their area of restricted existence. Eventually the woman in the story managed to make a raft, brave the dangers and was picked up by two rescuers. She was then able to leave the rescuers and be on her own.

At the beginning of her treatment words were toxic to Ms.K. Early in her life she had been forbidden to discuss feelings, dissatisfaction or unhappiness. In words she concealed herself as if they formed a box to protect her. In therapy, to come out of this box by sharing her feelings frightened and overwhelmed her. Using art we bypassed the constricting lies of verbal expression and tapped into the primary process source of emotional truth. Ms. K became more tolerant of the ambivalent nature of her two-sided defensive style and began to view herself as a person with entangled emotions and to turn her grief and confusion into images of strength and expectation.

Dr. Nayar's paper was titled " Utilizing Child Analytic Principles in Working with Traumatized Adults".

She described the need for flexibility, adaptability and improvisation in play and action long recognized by child analysts in their work with children. Play in this context allows the child to work through conflicts, fears and anxiety. Some in agreement with Winnicott, view play not merely as a treatment parameter but more as a route to therapeutic change in its own right. For some, change may occur through the interaction with the analyst solely within the play metaphor as interpretation becomes an adjunct rather than a primary element. Child analysts additionally recognize the role of a safe holding environment especially when the analytic space is invaded by intense affect. To this structure both the child and the analyst can retreat, take refuge, refuel and return to their common goals.

In treating adults with history of trauma eventual mobilization of traumatic affects in the throes of transference can cause re-experiencing of the trauma with their analyst. Their emotional pain is palpable and often expressed somatically. Obligated by requirements of neutrality, yet pulled toward activity called for due to the patient's plight and behavior, certain child analytic techniques can steer the dyad into further exploration of affects and memories, as painful as they may be at the time.

Dr. Nayar said in presenting the case of M. I will describe my ability to shift between adult analytic and child oriented techniques which allowed me to help her work through her conflicts, fears and anxieties.

At age 30 M. was referred for marital conflict, depression, work related problems, a life of solitary confinement and sleepless nights. A long chain of physical ailments had started after a car accident in her

twenties followed by a psychological evaluation, administering an MMPI leading to a diagnosis of multiple personality disorder.

M. was the oldest of 6 children. Her parents emigrated to US and managed a modest living working in factories. Father came home after work every night, drunk. Mother railed M. with stories of unreliable men and their pathetic sexual desires. M. fell victim to the sexual whims of the parents. The father molested her sexually, beginning at age five and her mother subjected her to humiliating semi-sexual experiences in bed. She grew up fragile and disturbed, taking refuge in the attic where she created her imaginary play mates and eventually her dissociated selves. Her only conscious recall of father's sexual transgression was at age 14, when she was dragged to the basement and raped repeatedly. Mother who had failed to acknowledge M.'s suffering later divorced her husband and remarried shortly after. M. continued living at home, did well academically and as a talented dancer participated in numerous events. Shortly after high school she married someone significantly lower in intellectual ability. In her early twenties she was in a car accident that resulted in many life changing events. She went to college, was diagnosed with multiple personality disorder and found herself unable to hold on to any job. She would experience memory losses and find herself in situations without clear recall. Her deteriorating condition resulted in reclusiveness and eventually brought her to my office seeking help. She gradually felt more comfortable in response to my attunement and maintaining a safe holding environment. As she changed and rearranged the placement of items in the office, we addressed the various meanings of her attempt to control her environment. In time fragmented and affectively disconnected alter egos began to emerge. My analytic stance permitted her to feel safe and allowed for technical variations more common in analytic treatment of children followed by interpretations that eased subsequent assimilation and integration. Before a brief vacation she was agitated and incapable of holding on to me as an intact individual and fragmentation followed. She started to take with her small items belonging to the office in order to be able to maintain a memory of me. Later she asked me to keep her lipstick so that I too, would have something of hers that I could keep.

In our third year of four times-a-week sessions she was anxious and agitated before a break. She asked to take something from my office to help her remember me as "others", i.e., her alter egos were beginning to accept me and needed something of mine to hold on to. Over time these transitional objects shifted from impersonal items to those that she imbued with meaning. This paralleled the increase in understanding of her self and the expanding insight into her functioning. After a break she returned to me the envelope she had asked me to fill with a piece of paper containing her name in my native language. She said I missed you but I had a piece of you. It helped me and the others to hold on to you.

One of the most important aspects of working through was her use of nine figures in a brief case which she left in my office and used repeatedly to re-enact various aspects of her childhood trauma and to bring me better understanding of her dissociated mind functioning on a daily basis. She was now better able to hold on to me as a good enough object which ultimately allowed for further emergence of painful affects. Reconstructing her childhood trauma, she could no longer deny or repress her anger and sense of helplessness as the object of her father's abuse. Yet she could not bring herself to disconnect from him as he was an integral part of her life which included her siblings and family. Caught in this predicament M. cried bitterly, which accompanied our work of learning to live with one's own lot, irrespective of the painful nature of that reality.

In the discussion of Dr. Davis' paper, it was suggested that the patient was unable to use language in the healing process because it had become attached to her use of a false self, and she used language to conceal her feelings, even from herself, rather than to express herself. Dr. Davis chose to use art in the therapy primarily because the patient was herself an artist -- an art educator -- and Dr. Davis was familiar with the use of art from her work in child psychoanalysis and therapy. Dr. Davis added that this patient helped her to understand that in a minority of patients language is used as this patient did, to conceal rather than to reveal. If we are not aware of that possibility we can find ourselves colluding unconsciously in the maintenance of a defensive posture.

A question was raised about the directive style which Dr. Davis used, concerning how it met the patient's needs. Ms. K had said that she was unable to find things to paint herself, so Dr. Davis did offer prompts, but tried to keep her suggestions as open ended as possible. In addition, she talked with Ms. K about her wish to be sure that they were following Ms. K's thoughts, not her own. At times of impasse, she would comment on that concern, and deliberately take a few steps back to a point in the treatment when Ms K was sure the pictures were true to her. That was one of the artifacts of the directive style, and represented Dr. Davis' attempt to make sure that she was not distorting the treatment by her unorthodox technique.

Dr. Davis added that in recent days the patient has said that she does not have the same inhibition of free association in using Play-Doh, and it is not yet clear what makes that difference. Dr. Davis was comfortable with using the art primarily because the patient herself was, and as they have moved to using Play-Doh they have moved more toward consciously acknowledging that the figure in the art represents Ms. K directly.

Dr. Christopher Keats was the formal discussant for the workshop. He looked at what may have been the mode of therapeutic action, in patients who experienced sexual traumas prior to having full access to adult words. In such a situation, the brain may be affected in ways that make it difficult to reach that experience through words later in life. Both patients showed some evidence of needing to use action to communicate feelings: Dr Nayar's patient by rearranging objects in her office, or maintaining body constancy by physical touch, Dr. Davis' patient by needing to use art rather than words. In both cases, the treatment worked to help shift the patient toward using language instead of action: Dr Nayar's patient talking about the meaning of moving the objects, Dr. Davis' patient shifting to recognizing herself in the images created.

Dr. Keats mentioned a paper by E. James Anthony from 1986, concerning the contributions of child psychoanalysis to adult analysis. Dr. Anthony had commented that techniques common to child analysis have been useful in rendering formerly unanalyzable patients analyzable, and described some of the differences he saw in the child analytic approach. Some of these differences included a greater focus on the pre-Oedipal period; greater emphasis on aggression; a tendency to be "easily caught" by the mother transference, especially in its negative form; more recognition of the real environment; less work on memory and more on current function; insight

not “pursued as relentlessly”; close focus on countertransference; etc. Dr. Keats felt that the entire field has shifted somewhat in these directions, as the effort to find ways to work with more disturbed individuals continues.

Dr. Keats went on to caution the group not to assume that because the mode of expression is the same for these adults as for children, the mental mechanism is the same. Adults use nonverbal communication because they have to, because they cannot find words to say what they need to convey. Children use nonverbal communication because that is “their way of doing things.” Children confronted in treatment with insight about the meaning of their behavior may retreat into banal language, talking rather than acting, much as adults will ward off insight by intellectualization or other defenses. We are better therapists if we can tap into these nonverbal expressions, but we must always remember whom we are dealing with: an adult who uses play to communicate is not structurally or psychosexually 6 years old or 8 years old, and it is a fallacy to treat him as if he is.

Dr. Dan Freeman mentioned that Dr. Davis’ patient’s defense of not talking was very much like what is common in Japanese culture, where everyone tends to keep the deeper feelings inside, showing a superficially appropriate self.

Dr. Etezady commented on Dr. Davis’ willingness to pursue the treatment with Ms K despite the sense of impasse. We generally rely on verbal communication in treatment, and when it is not there we are often at a loss as to how to proceed. When the patient is empty and feels empty, our attempts to mirror provide only emptiness. Dr. Davis was able to fill the emptiness for Ms K with her innovative technique. Dr. Daniel Freeman wondered what percentage of analysts would feel free to allow themselves to go with the patient in this way; he believes that it is a matter both of training and of temperament, and that women are somewhat more likely to do so than men.

Audience members commented on Dr. Davis’ willingness to allow her patient to “boss” her, to take control by saying that she could not herself come up with things to paint. We agreed that much of what was helpful was Dr. Davis’ willingness to be different from mother and other family members who had ignored Ms. K’s wishes.

Concerning Dr. Nayar’s patient, it was generally agreed that her willingness to allow the patient to do things such as rearrange the objects was quite helpful in providing a safe environment, and in helping the patient slowly to integrate the various self-states that she had been able to expose to the analyst. Allowing the patient to set the pace of the knowing, and what portions of her total self would be known, was crucial.

Dr. Davis commented that there is a relationship between the level of disturbance, and the intensity of the affect being dealt with, and the level of creativity required to be able to deal with the material. When our patients are unable to manage the affect and bring it within the hour, our attempts to help them find ways to communicate and manage the affects may require stepping outside our more usual techniques to be able to work with them.

