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Promising Directions in Psychoanalysis

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PROMISING DIRECTIONS IN PSYCHOANALYSIS

Out of the interplay between classical psychoanalytic theory and treatment, the experiences with direct observation, and the applications of psychoanalytic theory, several promising trends have emerged. Much of the data for these new directions are derived from more systematic studies and descriptions of the developing child.' Experimental studies of sucking and direct observations of infants, for example, have refined questions and suggested modifications in psychoanalytic theory. Studies of the capacities of maternally deprived children to achieve partial or nearly complete recovery, as well as data from the psychoanalytic treatment of children and adults, have led to a synthesis of our understanding about normative growth. The socializing interactions between parents and children, beginning during the period of helplessness of the newborn child, have provided a basis for understanding not only the development of the child, but also for the changes that take place in the adult. These psychoanalytic studies portray young adulthood, parenthood, middle and old age as a dynamic unfolding of human experience.

In his earliest development the infant's psychology is his physiology. Yet, with the care of a responsive, competent adult—who herself, in an active role, is re-experiencing the helplessness of the young child—the infant is enabled to become progressively competent. He will give first evidence of

social receptiveness in his responsive smile at the age of four to eight weeks. Though the earlier studies of Ribble Spitz, and Spitz and Wolf furnished the basis for understanding the marasmic state, which in the pre-antibiotic era led to death in severe cases, more recent studies by Provence and Lipton, Leonard, Rhymes, and Solnit, Elmer and Gregg, and others have enabled us to understand the failure-to-thrive syndrome. Certain children are more vulnerable to partial maternal deprivation, but recent studies have suggested that the mother's vulnerability must also be taken into account in the failure-to-thrive situation. This concept has been further elaborated by viewing both the abused child and the child who fails to thrive on a continuum of maternal deprivation in which the parents are also failing to thrive.

If the parents were deprived in childhood or had their stores of energy, love, and patience depleted by adverse conditions in their adult lives, then the conditions that predispose transmission of this vulnerability and depletion to their children are increased with the advent of each successive child. The marital relationship is a crucial index of the adult's resources. Whether it will culminate for the child in under-stimulation and in the lack of a loving bond between child and parents, or whether it will culminate in physical abuse and violence is more a function of the parents' psychopathology and deprivational state than of the child's vulnerability or socializing characteristics.

Psychoanalytic theory has increasingly demonstrated that the newborn

does not have the ego capacities for adaptation, regulation, and synthesizing multiple demands and stimuli. The infant's immaturity in organizational capacities is temporarily provided for by the mother, the auxiliary ego without whom the child would not survive. It is this psychoanalytic conceptualization and the observations of infants by psychoanalysts that have still further advanced our knowledge of how children and their parents fail to thrive and develop.

The Children—Failure to Develop

In many studies of children and their parents, socialization is often taken for granted as an implicit dimension of the investigation. When socialization is untroubled, it is silent; it becomes audible only when the process is disturbed or when conflicts exist. Studies of children who fail to thrive despite the absence of detectable organic abnormalities indicate that a major factor in the failure of growth is the mother's inability to socialize her relationships with the young child. Viewed on a continuum in which child and maternal development are assumed to parallel each other, the failure of the mother's development can be the essential cause of the child's failure to grow and mature according to expected norms.

Clinical observations suggest that the child's failure to thrive stems from two extremely opposite conditions. Under the first, the child is used by the

mother or maternal figure as the basis for her own sexual and aggressive gratification. The child's normative characteristics and behavior are perceived as evocative stimuli that invite the adult's regressive reactions of unmodified impulsive behavior. It is the child of this mother who is most often physically abused. He becomes the object through whom the parent derives direct gratification of poorly modified sadistic impulses. These impulses become unbridled in response to the young child's stimulating behavior and helplessness, both of which set in motion the adult's regressive behavior. In many of these situations, the psychotic parents had been released from the psychiatric hospital under the influence of tranquilizers. Though medication permits them to be sustained outside of the hospital, they are not able to cope with their children's demands and needs; their behavior toward their children becomes damaging and depriving.

Under the second failure-to-thrive condition, the child is neglected or under-stimulated and under-gratified. Here the mother's inability to activate the child's development reflects her own depressive or depleted state. These mothers are in need of being nurtured, of being mothered before they can respond appropriately to their children. When the mother's libidinal supplies are adequate, she can provide the maternal presence and responsiveness that are sources of the crucial stimulation and organizing influences—essential conditions for vigorous development in childhood. When the mother's psychic (and often physical) energies are depleted, the investment of interest

in the child and his behavior is deficient.

Both of these extreme conditions or their combination require sustained interventions if the children are to be protected from the permanently corrosive effects of such experiences. These sustained interventions are necessary for the mother's development. They should, therefore, be directed toward assisting parents in caring for their children and in advancing their own development.

Early socialization is viewed as a complex developmental phenomenon based on a relationship of the child to the mother that promotes his capacity to postpone impulsive behavior and to accept substitutes for the original gratifications. In studies of interventions for children who failed to thrive because of under-stimulation and neglect, socialization often appears as a restitutive phenomenon presenting a paradox of bewildering proportions. These phenomena were observed in children recovering from relative maternal deprivation in the home, and in those who were placed in a foster home after living in an institution. As the individual child recovered from the disadvantage of under-stimulation, his pathway to recovery, especially with respect to the reactions of increased social responsiveness, was often misinterpreted as undesirable wildness. The "coming alive" of the child, as his drives were awakened by affection and a responsive environment, was often found by parents and foster parents to be unacceptable and undesirable.

We have assumed that this “coming alive” or activation of dormant and often stunted drive capacities produces a disharmony or desynchronization of impulsive energies and regulative capacities in the individual child. Viewed by the parents in this way, the deprived child’s drives and his capacities to transform, channel, or ward off the pressures and demands of the drive energies are out of phase. Ironically, just as these children begin to respond, to “come alive,” the (foster) parents often feel overwhelmed by their behavior, which they misperceive not only as rejection but as a lack of grace and gratitude as well. The foster parents, feeling let down, often bitterly invoke the “bad seed” syndrome, referring to the child’s background which to them represents unacceptable social values.

In their follow-up study of institutionalized children placed in foster homes, Provence and Lipton state:

> As time passed the beneficial influence of maternal care, family life, and the enrichment of experience in many areas was increasingly manifest in all aspects of development. The children became more lively, more active, began to learn to play, and to solve everyday problems. They increasingly made relationships with others. In addition, there were other signs of improvement that were not always universally recognized by the parents as signs of growth: they began now to show some provocative, negativistic, and aggressive behavior. This was a time of crisis for some of the parents and children. If the parents saw this behavior as bad or as indicating that they were failing as parents or if they felt rejected by the child, some either gave up in actuality and asked that the child be removed from the home, or withdrew some of the emotional investment and interest that were so important to his improvement. Others realized that such behavior was a necessary step in the child’s progress and were able to react to it in a

helpful way. [p. 148]

Socializing is a broad concept. It pertains to people living together, forming a unit in which the whole is greater than the sum of the parts. It embraces considerations as widely separated as social values and biological adaptation. If, for example, the mother does not feed, stimulate, and protect the infant in the context of affectionate expectations, he will die or suffer severe developmental impairments. Emotional deficiency, as in institutionalization, can and often does lead to nutritional deficiency and failure to grow, with permanent residual impairments to physical, social, mental, and emotional capacities. All studies of the failure-to-thrive child have clearly indicated that the impact of institutionalization is not an all-or-nothing condition. Furthermore, children raised in disadvantaged families and those raised by depressed or severely constricted parents can also suffer from maternal deprivation.

Parents—Failure to Develop

Studies of young children who failed to thrive despite the absence of organic disease or deficits have traced the condition to the vulnerability of the child, the failure of the depleted mother to have ample supplies of affection for her child, and the failure of the family and community to provide the personal interest, assistance, and protection for the mother and her child. The failure of adults to agree effectively on the kind of social world for which they

are preparing their children to enter as adolescents and adult citizens has also to be considered. Studies of infants suggest that one of the most critical factors in a child's failure to thrive, can be described in terms of the mother's failure to thrive. These investigations indicate the following formulation:

Maternal or motherly feeling does not always immediately accompany biological motherhood. Motherhood is an unfolding developmental phase that is activated by pregnancy and the birth of a child. The adequacy of this developmental response is multiply determined by the mother's previous social experiences as well as by the physical, psychological, and emotional resources available to her during the successive phases of motherhood. The number of children the mother has borne and cared for, as well as the support she received from her husband, parents, and other relatives and friends, can nurture or deplete the mother's supplies of affectionate energies and her tolerances of frustration and conflict.

Maternal development is influenced by and dependent on a host of cultural, physical, and psychological considerations. Included among these factors are the quality and quantity of nurturing experiences the mother received in her own infancy and childhood, and the continuation of maturing and satisfying relationships with her husband and others on whom she depends for closeness and emotional support. With the birth of each child, maternal feelings surface as the mother is able to supply the needs of her

dependent infant in a satisfying way and in turn is able to be gratified by his increasing responsiveness to her. Adequate development in motherhood is experienced by a woman as a sense of self-fulfillment in her activities as a mother. In mothering her child competently and with satisfaction, she can sublimate her instinctual drives in a uniquely creative way by adapting to the child as he responds to her affectionate demands and as he expresses his developmental needs and capacities. The experiences of mothering successive children are critical influences in shaping the mother's personality. When mothering experiences are altered by stressful or traumatic life situations, she needs considerable inner strength and environmental support to maintain an adaptive equilibrium.

Following our earlier studies of mothers of children who accidentally swallowed poison, we found that the mothers of infants who fail to thrive were also depleted, overwhelmed, and deprived. In some instances these deficits were discernible in women who had retained infantile personality characteristics and for them the first child's needs and behavior expended the scanty resources available to them before they became pregnant. Many of the mothers whom we evaluated and assisted in this clinical action-research had such cumulative handicaps as inadequate or insufficient mothering themselves; minimal or no support from husbands; several children born in rapid succession, with the last one representing a magnified expression of the cumulative depletion of their physical, emotional, and mental resources.

Many of these mothers represented the second or third generation of a family who was poor, disadvantaged, disorganized, and living in a slum community. These women were failing to thrive in their own milieu. They found it a painful or impossible demand to respond to their baby's manifest needs and behavior. They described their despair, frustration, and anger at having to care for a child whose failure to grow and develop further undermined their own sense of worthlessness and inadequacies. In this context each infant and mother reciprocally contributed to the other's failure to thrive, an instance of mutual maladaptation. Often these families lived under crowded housing conditions that also contributed to the inadequate or deviant relationships in these social units.

Thus, the mother and infant influence each other's actions and attitudes reciprocally in a progressive manner. Physiological and behavioral characteristics and deficits of the infant often initiate difficulties in the mother-child socialization patterns. These difficulties are not readily understood as different from the interactional dissonance in mother-child conflicts. However, each of these patterns can be internalized, i.e., become an internal conflict for the child that is expressed in the infantile neurosis. Depending on the origin of the infantile neurosis there may be a modification of technique in child analysis. In the case of the child's ego deficit precipitating mother-child difficulties it may be desirable to adapt the treatment to assist the child with his or her ego deficits, often providing

temporary and partial need satisfaction for the so-called “borderline” child. This facilitates development and enables the therapist to use the more classical analytic treatment with the child.

We noted at the outset that contemporary psychoanalysis is moving in several promising directions. In addition to new techniques in the treatment of children who fail to develop, there are also these new trends: First, a new approach to treatment and new developmental insights have resulted from the treatment of blind children. Second, psychoanalytic treatment of adolescents has undergone significant revision. A third trend can be discerned in the treatment of the so-called narcissistic personality in adults. Finally, there has been a rediscovery of psychoanalytic principles in the treatment of people who are underprivileged and indigent.

The Blind Child

In the deviant congenitally blind child, the process of ego formation is impeded during the critical period of nine to eighteen months. Fraiberg and Freedman note, for example, that the mouth remains the primary organ of perception, and the personality remains mouth-centered to an extent that is almost never encountered among sighted children, except perhaps for certain children who have suffered extreme deprivation in infancy. Language is rarely employed for communication or expression of need. The mother often

fails to offer stimulation or make emotional contact with the sensorily deprived infant. Walking is markedly delayed. “The deviant blind children present a picture that begins to lag at the end of the first year and fall off progressively during the second year,” say Fraiberg and Freedman, “In the third year we have the impression that development has come to a standstill.”

On the basis of her understanding of the development of these blind children, Fraiberg applied analytic insights in their treatment. In a report of a treatment during two-and-one-half years of Peter, a blind boy eight-years and ten-months-old, Fraiberg describes a number of observations that offer great promise for helping children with similar problems. For example, when the mother was led to understand how need satisfaction and constancy were the indispensable first steps in establishing human ties, Peter’s attachment to her became evident and his ability to speak expanded rapidly. As opportunities for free movement and exploration of his environment opened up to him, and as the range of his experiences expanded, his exploration and manipulation of objects became more and more absorbing. During Peter’s treatment it also became clear that the hand behaved like a mouth, the fingernails like teeth, and the pinching activity like biting. Oral-incorporative aspects of mouthing and biting, mobilized during moments of fear of abandonment, had thus been transferred to the hand. Once this was understood, a useful interpretation could be made to Peter, and his clutching and clawing behavior were brought under control. Most important, the mother, too, was able to understand that

the behavior she previously regarded as aggressive was in fact a kind of inarticulate terror. Gradually the hand, which had largely functioned as an auxiliary mouth, appeared to free itself of the oral mode, with corresponding neutralization of drive qualities.

Fraiberg points out that where vision mediates the evolution of hand autonomy in the sighted child, the absence of vision obstructs this crucial process in the otherwise healthy blind infant. Blindness, too, is an impediment to the achievement of locomotion. Without locomotion the development of the concept of objects independent of the blind child's perceptions is arrested. Fraiberg describes how the mother has to "teach" the blind infant about the permanence of objects.

What is promising about this work, and similar work done by others, is the application of psychoanalytic insights to the successful treatment of handicapped children. In addition, a bridge between cognitive theory and psychoanalytic theory in the clinical field has been established here. Piaget's concept of object permanence combined with the psychoanalytic theory of ego development can contribute to an understanding of the special care of the blind child, resulting in a useful therapeutic outcome.

The Adolescent and Development

Another trend in psychoanalysis reflects the increasing recognition that

many adolescents are able to benefit from psychoanalytic treatment. In the past, analysts have been cautioned that applying the classical psychoanalytic method during this period of rapid developmental change and narcissistic preoccupation ran the risk of evoking undesirable regressive behavior and unanalyzable transference reactions. During the past decade, however, the cumulative experience in adapting psychoanalytic technique to the developmental characteristics of adolescents has shown the usefulness of the psychoanalytic method in treating neurotic adolescents. Often the treatment has begun before puberty and has been completed during early adolescence, or the treatment has begun during mid or late adolescence and has been completed during early adulthood. There are still grounds for conservatism about beginning a psychoanalytic treatment during early adolescence, although it has been carried out effectively when the technique is adapted to the developmental tolerances of the adolescent. These adaptations are mainly centered on how and what to interpret and the activity of the analyst. Often in early adolescence the patient has a low tolerance for silence and becomes too anxious about or rejects interpretations that are not ego syntonic or which encourage regressive attitudes and behavior. As the analysis proceeds, his tolerance for reflective thought and the capacity to utilize interpretations of his defenses will gradually increase if the analysis is progressing.

Another trend in psychoanalytic research and understanding of adolescents concerns the question: has the adolescent experience changed?

There is a consensus that it has,-- but the quality and rate of the alteration are currently in need of investigation. The psychoanalytic view of this change has encouraged analysts to combine direct observation with pooled psychoanalytic treatment observations and to move toward a greater emphasis on reconstructing the adolescent experience of adults who are undergoing psychoanalytic treatment.

The question is given added validity by the knowledge that puberty occurs earlier now than it did in the past. This change in the biological timetable in the direction of a more rapid and elaborate maturation has been associated with improved nutrition and health care. At the same time, there has been a demand for more schooling over a longer period of time. These opposing pressures resulted in what has been perceived as the necessity for a longer and more complicated developmental stage in order to acquire what has been viewed as desirable education and training. The increasing discrepancy between biological timetables and social expectations appear to have intensified the conflicts and dilemmas of the adolescent in the 1970s.

Meanwhile, the psychoanalyst who works with an adolescent is sharply aware that internal psychological changes and conflicts continue as the youth copes with the developmental conflicts and the need to (1) relinquish childhood ties to parents and siblings, painfully opposed by the regressive attraction exerted by the revival of oedipal longings; (2) become aware of

himself while striving to become an increasingly independent person, a process complicated by dependence on the persons against whom he feels compelled to rebel; (3) establish ties with new long-term friends while drifting apart from the "old" crowd of friends who provided much support during the earlier phases of adolescence; and (4) seek values and ideals that are his own, but which are often in conflict with powerful sexual and aggressive appetitive impulses.

These developmental conflicts and tasks of adolescence are responsive to a changing external and internal environment. Future psychoanalytic research will undoubtedly contribute to the efforts to better understand and appreciate our adolescents.

The Narcissistic Personality

The treatment of character problems has become increasingly prominent in psychoanalysis. Among these is narcissism. People with a narcissistic personality seem to need and seek repetitive reinforcement of narcissistic supplies in order to maintain an inflated self-regard. They tend to use others for their own aggrandizement, with little if any feeling of guilt when they drop a person who no longer is expected to offer them any gains. They rarely truly depend on others. In spite of immense drive and productivity, their work is often empty and superficial. They appear to

function well in society, and do not manifest any obvious neurotic symptoms or difficulties in controlling their impulses.

What is of interest here is the increasing success of analytic treatment for such people for example, Kernberg describes the treatment of a twenty-year-old female who was initially diagnosed as having a "psychoneurotic reaction, mixed type," but who subsequently was found to have a narcissistic personality structure. The quality of her object relations, past and present, was crucial in the diagnosis. The intensity and chronicity of the patient's aloofness and estrangement was a result of a narcissistic withdrawal and denial of her pathological dependence. In this particular patient, Kernberg describes a characteristic transference paradigm: on the one hand the patient depreciated herself and felt worthless and guilty for all her extreme greediness and destructive fantasies; on the other hand, she denied and identified with her omnipotent ego ideal. Her narcissistic defenses were fully expressed and the intense negative transference was successfully analyzed. By the end of her treatment she had selected a man who permitted her to think of herself as attractive and wanted, and she began to think of herself as acceptable. Her professional activities had expanded, and she developed a more satisfactory social life.

The increased interest in persons with narcissistic characters, and the successful treatment of them, can be attributed to our broader and deeper

knowledge in psychoanalysis of the complexity of ego development. Previous focus on the so-called transference neuroses was largely an outcome of earlier interest in the libido theory. The attention currently being paid to the treatment of the narcissistic character is a manifestation of the more recent developments in psychoanalysis, particularly in ego psychology and in studies of the vicissitudes in developing aggressive drives. Interestingly, the current importance given to the psychoanalytic treatment of character disorders coincides with the recent epidemiological shift in prevalence from neurotic disorders to character disturbances.

The Underprivileged and Indigent Person

The rediscovery of psychoanalytic principles in the treatment of people who are underprivileged and indigent is particularly timely in the context of the burgeoning development of community psychiatry and community mental-health centers and programs. One example of this rediscovery is the work currently being done at the Tremont Crisis Center in New York under the direction of E. Hornick. Although called a “crisis” center, the treatment it offers to disturbed, underprivileged people is based on classical psychoanalytic principles and is highly effective. Another example is the work being done with a lower income population in the so-called Blue Collar Project in New York under the direction of M. Zaphiropoulos. Here, again, analytic principles guide the treatment of people in this restricted income

group. The notion that psychoanalytically oriented treatment is the privilege of the well-to-do is thus outdated and unfounded.

These promising directions in psychoanalysis are particularly fortuitous in the face of current mental-health problems and trends. The need to provide service to large populations has sometimes prompted the innovation of treatment methods that remain to be tested. Hence the rediscovery of the value of psychoanalytic principles in treating the indigent and the underprivileged, who for so long have been denied adequate service, is particularly important.

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