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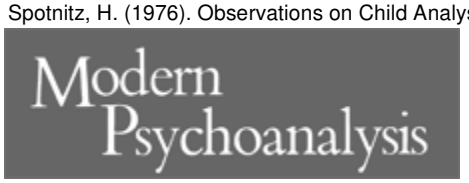

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Observations on Child Analysis

Hyman Spotnitz

There is general agreement today that a transference situation can be established in child analysis and can be managed, by and large, according to the principles applied in the analysis of adults (see, for example, **Van Dam, 1966**). WIth the discovery of effective analytic approaches to the initial treatment resistances of young children, educational measures that were originally regarded as indispensable are usually dispensed with (A. Freud, **1946**, **1965**; **Klein, 1948**). Moreover, good results have repeatedly been demonstrated in the treatment of preoedipal disorders. Child analysis is therefore applied today, with appropriate modifications, to the entire range of psychologically reversible disorders-the milder behavior disorders, the various categories of psychoneurosis, character neuroses, borderline illnesses, and psychotic conditions, including childhood schizophrenia. Thus the scope of the method has expanded, keeping pace with that of psychoanalytic therapy with adults **(Casuso, 1965)**.

While adhering to the analytic framework, the therapist needs to evaluate how each patient functions in the relationship in terms of his physical and mental limitations. All children have strong resistances against verbally mature, emotionally

significant communication. The initial resistance may be caused by inadequate maturation, which limits the child to crying or gesturing. Playing is disguised communication if the child can talk but will not do so.

As the analyst tries to get the child to talk in emotionally significant language, resistances arise, based on maturational lag, regression, unpleasant sensations connected with communication, and the need to shut out feelings and unwanted thoughts. The schizophrenic child, for example, does not want to reveal hateful impulses; he desperately wants to love himself and be admired, or perhaps he is afraid he will explode.

Demands on the Analyst

A successful child analyst can feel love and hatred for the child without being impulsive in the child's presence. He must have the proper feelings at the proper time, actually feel them-not play-act-and be able to use all the techniques needed to (1) help the child talk, (2) reinforce him in his need to be admired and loved, and (3) resolve barriers to releasing his hostile feelings.

The analyst develops the ability to feel proper feelings through a personal analysis in which he learns to discharge verbally all the emotionally significant feelings of his life. He learns to use these feelings in his supervisory experience, to recognize the emotions induced in him by the patient and to verbalize, evaluate, interpret, and respond to them in a therapeutic way. The schizophrenic child, particularly, will sense whether the analyst is disturbed in his presence or is uncomfortable about working with him. This kind of child tends to exaggerate the significance of the analyst's thoughts and feelings about him.

The main problem with children is that they are not as articulate as adults and are less willing to talk about what is bothering them. They need much more patience; the therapist sits with them for longer periods when nothing seems to be happening. To establish contact with them may require more ingenuity.

With so-called unreachable children-those who cannot

communicate-the analyst tries to understand what these children are doing by getting them to know that he is like them. To this end, he reflects any attempts on their part to get into contact with him.

Physical Contact and Play

Love is extremely stimulating for these children, and it is important that stimuli be kept at a minimum. I do not share the notion that such children generally need physical contact or play activities, though these may be resorted to at times to resolve a particular resistance. In my experience with youngsters aged six or older, physical contact or play has rarely figured in the treatment process. Most of them can talk well enough to be brought into contact through speech.

When play is used as a special form of communication, how long should one continue to encourage a child to play? A therapist who enjoys playing with a youngster must also consider whether doing so tends to keep the child at the infantile level or moves him closer to the point of verbalizing his thoughts and feelings.

Removing obstacles to the discharge of hateful impulses is crucial when treating a severely disturbed child who has been trained nto to hate or, if he must, to hate himself rather than others. The younger the child, the more necessary it is to structure the analytic situation so that he can release these impulses through the symbolic communication of destructive fantasies. Hence the need for a virtually damage-proof office, which was recognized early in the history of child analysis. If such a child, hypersensitive as he is to the feelings of others, senses that his destructive behavior either stimulates anxiety in the analyst or makes the analyst feel uncomfortable about treating him, the difficulty of achieving the release of destructive impulsivity is heightened. The analyst tends to project his own uneasiness onto the child patient more readily than he does when treating an adult **(Casuso, 1965)**.

A child's tendencies to wander off the path to psychological maturity need to be blocked: his tendencies to proceed in the right direction need to be strengthened. In addition to the

availability of a good object, these tasks require a special kind of retraining and reinforcement from an external environment that is conducive to emotional reactiveness. Under these circumstances, in my experiences, studying the fact of the child's aggressive impulses is the primary road to understanding and influencing him effectively.

Although general hypotheses about the typical nature and range of the problems of severely disturbed youngsters increase our understanding of their therapeutic needs, preconceptions that encourage an emphasis on a particular type of handling from the time a case begins interfere with meeting the totality of needs in that case.

Treating the Severely Child

The primary task in the therapy of a severely disturbed child is to discover, *by studying and working with him,* what is producing his pathological behavior and locking in his immaturity and to help him receive whatever stimuli he needs to outgrow his particular patterns of deviance. Call this a model if you will, but it is no more nor less than the basic theory of psychoanalysis-that the effects of the patient's original damaging experience must be reawakened in the transference so that the precise obstacles to maturation can be recognized and resolved. Although one can presume what these obstacles are, they cannot be determined in advance. The signs and indications that each child gives in the transference relationship delineate the model for his treatment.

To liberate a severely ill child from the handicapping effects of deprivations that interefered with the maturation of his personality, treatment needs to be aimed at restitution: that is, appropriately timed restorations of a specific nature. Consequently, I have misgivings about the notion that treatment of the schizophrenic child should be oriented toward compensating him for deprivations, including unmet needs for one or another type of sensory stimulation. Compensatory maneuvers lead to some improvement in the child's behavior because they help him feel better. Compensation for a deprivation will not, however, undo its harmful consequences. All the food in the

world won't erase a starved child's memory of starvation. It is open to question what, for example, tactile stimulation accomplishes beyond giving the child some immediate gratification to which he responds favorably.

Let us assume that an experience similar to the one which prevented the child from maturing is created in

the transference relationship and that the child demonstrates a need for some form of sensory stimulation. What is the best way to approach the patterns of maladaptation that ensued from the original deprivation?

The objection to any sort of forced feeding, no matter how pleasant the therapist makes it, is that it robs the child of control of his impulses. If the child were dying of starvation, of course one would have to force him to eat. But in a situation that is not life threatening, it is inadvisable to subject him to bodily contact until he indicates an essential need that cannot be met in any other way. If his responses to a variety of stimuli are simply investigated and his defenses are joined in the process, the child himself will develop a desire for the therapist's participation. The advantage of the voluntary approach is that it enables the child to function in harmony with his own will. This lesson is invaluable in resolving the harmful consequences of the infantile training experience.

After the child involves the therapist in his games, it is relatively easy to determine the degree of stimulation that is desirable. The therapist's participation is appropriate as long as it helps the child behave properly. If the child begins to lose control, this is a signal that he is being overstimulated and that his invitation to play should be declined. In short, the child's behavior gauges the desirable degree of stimulation.

Many children who have reached the age of eight are able to lie on the couch and communicate consistently in language, and reports that younger children are also able to do so no longer surprise us. The preschool youngster, however, is permitted to engage in his natural activities. Developing a therapeutic relationship with him is contingent upon the therapist's ability to recognize the emotional meaning of the child's communications through toys, crayons, and the fantasies the child

plays out and to communicate at his level **(Bloch, 1968)**. The therapist's comments on the patient's behavior are couched in the patient's own words, used as he uses them. Primarily, the patient needs help in putting his thoughts, feelings, and memories into language.

Although manipulating the child in the treatment situation to induce him to cooperate or to force an insight on him is inappropriate, some form of environmental manipulation may be indicated. The cooperation of parents-in some cases, to the extent of undergoing treatment themselves-is often crucial for a successful outcome in child analysis (**Abbate, 1964**; **Van Dam, 1966**).

Focus on Resistance

As the child's maladaptations come into play in the relationship (transference), the patterns are studied until the therapist understands how they were set up and why they are activated in the immediate situation. When they interfere with the patient's communications, these patterns are dealt with in the same way as are other forms of resistance. Treatment that liberates the child from the stranglehold of emotionally damaging maladaptations creates a foundation for new growth. The patient is then able to assimilate the type of experiences that will reduce his maturational needs.

An adolescent or adult can usually obtain these experiences himself outside treatment. A child can obtain them only with the assistance of adults. To the extent that his parents and other adults do not provide this assistance, the child's unmet maturational needs engage the analyst's attention. In principle, however, interventions to meet maturational needs-for feelings of being loved and understood, for reassurance, direction, and so forth-are made only to deal with resistance. The young child may want the analyst to join him in his play or games simply for the pleasure of the experience but departures from the operational principle of intervening only to resolve obstacles to cooperative functioning are undesirable.

The analyst's role as transference object is crucial for resolving maturational blockages. Unless a transference situation

exists, it is impossible to reactivate the maladaptive patterns with sufficient intensity to resolve them. The analyst who appears to the child as a shadowy figure-the “blank screen”—will find it difficult to create or maintain a transference situation. To a much greater extent than is customary in the treatment of adults or adolescents, he needs to convey the impression that he of functioning like the parent. Departures from this role may be indicated when treating a severely ill child; at times the analyst needs to participate in the child's play and fantasies-i. e., behave like the patient-to help him express his thoughts and feelings. But as much as possible, the analyst

maintains the posture of the thoughtful parent, listening attentively and seeking to understand. He does not try to share his understanding unless the child solicits an explanation and, even then, only if the information would help the child function cooperatively at that time.

The Analyst's Interventions

Preverbal patterns of resistance are responsive only to symbolic, reflective, or emotional communications from the analyst **(Spotnitz, 1966)**, which are regarded as primitive forms of interpretation. When these patterns are basically resolved, the child becomes more and more responsive to forthright explanations of his problems. Finally, he reaches the stage where interpretation alone creates the type of experience that resolves the remaining blockages, thus permitting him to resume his maturational interchanges without the aid of a therapeutic object.

Psychological reflection, a term applied to interventions that reflect the patient's communications, is often employed with young children. So-called verbal mirroring, in which attitudes or feeling-tones may be reflected rather than words, is the most common form of psychological reflection. A young child's nonverbal activities, such as gestures and sounds he makes while playing, can also be reflected. By this technique the analyst conveys the impression that the patient is relating to someone exactly like himself-a person who thinks and feels as he does, an ego-syntonic object. Repetitive use of the technique

early in treatment facilitates the development of transference on a narcissistic basis with a very young or severely regressed patient.

The same approach can be used to join the patient's resistance to communication. Resistance-joining is not only ego supportive; it has the additional effect of reinforcing the total personality **(Spotnitz, Nagelberg, & Feldman, 1956)**. Moreover, when an extremely negativistic child responds to the psychological reflection of his resistances as permission to maintain his position, he reacts less defensively to the demands of the analytic situation and often moves voluntarily into the opposite position. In this and other ways, the analyst is able to resolve obstacles to the release of impulses without exposing the patient to undue pressure. To be productive, however, these interventions should be accompanied by genuine feelings because children are especially sensitive to artificial role playing.

As the balance shifts in the analysis from primitive to more complex levels of communication, the analyst verbalizes thoughts and feelings that the child conveys nonverbally or articulates inadequately. The analyst can respond to fantasies and other psychic experiences in a similar manner, and on some occasions a summary of the child's behavior is therapeutic.

Verbalization shades into clarification, a technique that is increasingly employed when the child demonstrates interest in understanding a specific emotional reaction or behavior pattern. He may ask, for example, why he stutters or feels angry when he tries to talk about a particular subject. Although in theory the analyst does not intervene to provide understanding until it is specifically requested, unsolicited explanations from time to time may help the child cooperate.

When presenting an interpretation to make the patient aware that he is acting out a fantasy instead of verbalizing it, the analyst may have to appear as a permissive adult who does not really disapprove of destructive behavior. Nevertheless, the explanation is formulated so that the patient learns patterns of conduct regarded as socially appropriate for a child of his age.

Approach to Dreams

Early in treatment, dreams are used primarily as a source of information, and are analyzed silently. The interpretation is deferred until the child has become responsive to explanations of his feelings and is struggling to deal with them. When he is obviously withholding unconscious material, he may report a dream if he is asked whether he had one. But it is desirable to avoid giving him the impression that dreams are more important than other psychic material.

Interpretations based on one's knowledge of symbolism, general theories, or a hypothesis which the analyst in pursuing may be useful for investigative purposes, but they are not invariably therapeutic. The scientifically

oriented practitioner delays making an interpretation until the patient provides overwhelming evidence of its validity and until his therapeutic reaction to it can be anticipated.

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