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Expanding the Clinical Utility of the Concept of Developmental Help to Engage the Severely Disturbed Adult Patient in a Psychoanalytic Process

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SUMMARY. In this paper I demonstrate the clinical utility of techniques referred to as ' developmental help' in the psychotherapeutic process with a very disturbed adult patient. The proximal goal of the suggested interventions is to engage the patient in a more 'classical' psychoanalytic psychotherapy. Case material and discussion are provided to clarify and show how these interventions facilitate the process of engaging these difficult to treat patients.

In 1954 Anna Freud presented a paper entitled 'The Widening Scope of Indications for Psychoanalysis' which proposed that variations and/or modifications of procedure and technique may be necessary to meet special therapeutic conditions and individual circumstances. Specifically, she reported that clinical experience had led her to believe that certain selective variations and modifications in technique were required to treat patients with severe disturbances, particularly those with developmental deficits, disharmonies or deviation, e.g. borderline cases, severe depressions, etc. I prefer to use the term 'developmental deviation', which Neubauer (1989) has defined . . . 'as processes that reflect time factors and are an expression of deviant structure formation' (p. 451). To Anna Freud, the 'widening scope' implied that psychoanalytic treatment needed to expand its technical repertoire with the ultimate purpose to engage these patients in a psychoanalytic process.

Anna Freud was very much influenced by Aichhorn's understanding of engaging delinquent adolescents in treatment, specifically with technical variations which proved successful in work with severely disturbed adolescents. Since then many clinicians, particularly those who have worked with the more disturbed, non-neurotic patients, have struggled to adapt, modify and apply 'classical' psychoanalytic technique to a wider variety of patients.

Anna Freud pointed out that pathology may not necessarily be the result of neuroses and regression but instead may be caused by development gone awry. Such an occurrence would subsequently result in pathological psychic structures and defences being organised layer upon layer as maturation and growth proceed. Psychic change can be viewed, developmentally, in terms of structure formation where psychic

conflicts as well as developmental deviations coexist, to some extent, in all of our patients.

Psychoanalysis has always held as a fundamental tenet the intimate relationship between conflictual life events and the 'adequate' consolidation of psychic structure.

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To quote Eagle (1984): `Part and parcel of early traumas which presumably led to developmental impairments and structural deficits are conflict-laden wishes, longings, and other affective reactions' (p. 129). Therefore, both conflicts and the impact of developmental deviation must be addressed in all of our patients. It is my belief that psychoanalysis, in keeping with the spirit of the `widening scope', permits for a greater range of technical variations and modification necessary in the treatment process of these more disturbed patients now frequently encountered in our therapeutic work.

In this paper I will illustrate how the recently introduced concept of `developmental help' and its technical implications apply to work with adult patients. I will discuss pathology from a developmental viewpoint and demonstrate that analytic work with severely disturbed adults requires amendments and alterations in the technical approach comparable to approaches employed when working with children and adolescents. A discussion of specific technical interventions will also be presented, using case material, in an attempt to better clarify and define the concept of `developmental help', as it may apply to work with adult patients.

Developmental lines (Freud 1963) and pathways (Biven 1980) are influenced by unconscious psychic life as well as external real life events throughout an individual's life. When pathology occurs during the early years, whether it be considered primarily conflictual or a developmental deviation in nature, the more difficult it will be to amend, alter or resolve the resulting subsequent layering of psychic organisations, structures and adaptive styles. These individuals will, psychologically, `limp on' in their development and course in life. There is no such thing as absolute fixation nor regression and subsequent development will be quite uneven.

It is not uncommon in our clinical work to encounter patients who, as a consequence of early disruptive influences in their lives, had an uneven psychological development which resulted from deviations and conflicts, later becoming the source of pathological structures and defences. Very often, these pathological influences occurred during the pre-oedipal years and tend to be difficult to analyse except in derivative manifestations. These individuals have been unable to experience or consolidate pleasurable experiences which form the basis for developing love for and trust in the primary object. This is not to say, however, that trauma in later life cannot result in symptom formation and significant impairment of the ego apparatus and its functioning.

Ego resilience depends, primarily, on the impact of developmental deviations which offset the normal facilitating environment of early childhood. Therefore fixation and regression will hinge on the particular period affected by the factors which define the individual's developmental deviation. The severely disturbed patients seem to have achieved only limited success negotiating developmental tasks and achievements (Erikson 1959). For the more disturbed patient, phase dominance has not occurred in any stage past the oral nor anal stages. This is not to say these people have not experienced life, physical development, nor met social expectations. For these individuals, ego development and functions are often uneven and inconsistent, object relations less integrated and consolidated and that mature genital sexuality is never achieved.

Life span, representing development and maturation, is understood as relative contributions of constitutional, environmental and maturation/growth factors which are also impacted by timing, intensity and interaction between each factor and by other developmental lines. What an individual is today results from their internal and

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external world that preceded the present. Every moment is an unfolding, transforming and amending process for the individual. Not only does childhood and adolescent development include an active course of moving forward, but adulthood also has a development flow which includes an active course of moving forward. Sandler and Sandler (1992) state . . . `psychic development throughout life is characterized by structural change' (p. 35). I will not detail the differences between pre-adulthood and adulthood except to acknowledge that adulthood is understood as that time when the individual's character becomes relatively structuralised, there is no longer a primary reliance on the parents and that finding a spouse and becoming a parent become developmental markers separating these life phases. Also, adulthood includes the slowing down of physical growth and aging. Nevertheless, the flow of life and time inevitably continue. At no time is an individual in a static position. No developmental line matures nor remains static in the course of life.

Developmental Theory and the Widening Scope

Anna Freud believed that psychoanalysis `proper', alone, was useful when working with neurotic patients and that patients who suffered from more severe pathological or developmental deviations (e.g. borderline pathology, narcissistic disturbances, etc.) required special variations in techniques, and that the end result would be to engage the patient in an interpretive, psychoanalytic process. Work at the Anna Freud Centre in London has continued to explore the widening scope in regards to working with the non-neurotic patients, particularly those felt to suffer from developmental deviations. In a paper titled `Proximal or Distal Aims of Child Analysis', Hansi Kennedy and George Moran state (1990, p. 107):

> Where a disturbance is due not so much to internal conflicts as to a mixture of early neglect and inconsistent objects and other sorts of adverse environmental influence, the analyst will have to recognize that it is difficult to restore something to a child that was missed in early development. At best, the therapist can help the child make adaptations to such deficits and the consequent distortions of development. This work is based on psychoanalytic needs and involves an admixture of interpretations and ego-supportive elements within the context of a one-to-one relationship ... we have come to refer to this as 'Developmental Help'.

Shane (1990) points out how experienced analysts have determined that establishing and maintaining the classic psychoanalytic frame are often impossible when working with severely disturbed adult patients (e.g. borderline and psychotic patients) and that traditional techniques must be modified, taking into account developmental theory. In regard to work with these patients, Shane (1990) writes: 'Adult analysts ... have conceptualized this growth-promoting experience in various ways; for example, the old and recently reassessed corrective emotional experience and, more prominent today, the self-object experiences of self psychology' (p. 64). I believe that early psychic structures are enduring, persist, and that only their organisation may be altered. Anna Freud felt that treatment never changes the conflicts, rather, treatment changes the solutions to the conflicts. These new solutions, in the context of work with a new object (the therapist) may permit the child or adult to come to new solutions facilitated by the flow of development and life. 'Developmental help' facilitates a better synthesis of developmentally acquired organisations which were pathologically established. The ultimate goal of treatment, as proposed by Anna Freud, was to return the child or adolescent patient to the normal path of development. It is my contention that

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widening the scope of technical application also allows for adult analysts to assist the patient to return the patient to the normal course of life, so that they may strive for healthy, age appropriate gratification and pleasure in their day-to-day living.

Fred Pine (1985) believes that it was often necessary to modify psychoanalytic method and techniques when working with adult patients unsuited, psychologically, to work in a traditional psychoanalysis. He found that alternative approaches seemed most effective if based on developmental thinking and considerations. He states that therapeutic work . . . `involves a view of the parental role in not allowing things to be either too easy or too difficult for the growing child, a view that optimal growth comes at various junctures with optimal strain' (p. 24). He suggested that for patients who are fragile, unable to modulate affects or are fearful of the frustrations and intimacies that come with the traditional methods, the analyst must actively support the patient in the here and now to allow for interpretive work to take place. He goes on to say (p. 24):

> the intent, to increase the defense and object-relational support structure while increasing the anxiety level (through the introduction of sometimes painful interpretive content), is to support the patients' tolerance for strain at a higher level of demand.

To quote Wallerstein (1986), `the supportive aspects of all therapeutic modalities, psychoanalysis proper included, certainly deserve more respect and specification than is usual in psychoanalytic literature' (p. 730). It appears that the work by those at the Anna Freud Centre and that of Pine convey similar thinking, despite the fact that they are speaking of different age groups.

I will describe several types of interventions which provide `developmental help' and offer additional technical recommendations consistent with this line of thinking as it applies to adult work. The most common intervention from a `developmental help' perspective is that which improves and clarifies reality (Kennedy & Moran 1984, 1990; Szydlo 1985). Clarifying and understanding the external realities of life can reduce cognitive confusion as well as help modulate the intensity of affects. Often, severely disturbed patients have an impaired capacity to distinguish between reality and fantasy. In the analysis of a child, Szydlo (1985) demonstrates how actively clarifying that certain beliefs the child held were not real resulted in reducing the child's anxiety to a level where interpretive work could proceed. The process of appraising reality, as with all techniques derived from the concept of `developmental help', is an intervention paired with other psychoanalytic interpretive interventions which we may use in the interpretation of conflict or ambivalence. For example, one may interpret distortions of reality as the result of neglect, abandonment and inconsistent parenting: `you have wished this to be real so much that it has become to feel real, and that you think these things when you are feeling alone and frightened'. Clarifying reality with a patient also promotes separation and differentiation rooted in a pathological attachment to the primary object. A crucial point to be emphasised is that many of our patients retreat from reality due to chronic and severe unpleasure, disappointment and trauma during the earlier years, in the wishful hope of obtaining pleasure and safety in these fantasies. This ego regression impairs object relations, distorts reality and seriously limits the capacity for insight.

A second intervention involves assisting a patient in separating cognition (thoughts) from affect states (feelings). My experience is that many patients confuse what they think with what they are feeling. For example, when a patient is asked, `How did that make you feel?', they may say `I did not know what to think'. My work with suicidal

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patients has made me aware that often patients say that they `feel suicidal'. An intervention would be to clarify the cognitive material and assist the patient to recognise and explore the associated affects, separately. Doing so serves the function of reducing the intensity of affects and the compelling component which may result in an active solution manifested by means of a suicide attempt.

A third technique focuses on Krystal's (1985) work with traumatised individuals diagnosed as being alexithymic. He proposes that traumatised patients must be helped to deal with early memory traces which are primarily affective and devoid of a verbal component. He suggests that a necessary prerequisite to psychoanalysis must be a phase where the patient is helped to recognise and label affects. Loewald (1970) states that: ` giving words to feelings ... is a kind of gratification by verbal action, by establishing communicative links between different psychic elements and levels' (p. 62) which are not only a medium of hypercathexis but also shifts functioning to `the higher organization of psychic life' (p. 63).

A fourth and related technique is to promote the use of words rather than rely on action, reenactment, acting out, etc. With children, we restrict aggressive patients in the treatment by physically holding them while providing interpretations to address the aggression and anxiety (Daldin 1992). Restrictions, limit setting and the provision of rules are an important part of the therapeutic frame with all patients. However, these parameters are more commonly employed with children in analysis (Kennedy & Moran 1984,1990; Szydlo 1985) where, as in our work with adults, acceptance of many basic ` rules', such as appointment times, payment, free associations, etc., are assumed and then readdressed if the treatment process is threatened or disrupted.

Those who treat disturbed adults need to address direct forms of acting out (e.g. suicidal, homicidal, criminal, or even excessive absences from treatment) which present a clear and urgent threat to the continuation and efficacy of their treatment. I have found that suggesting a patient come and talk about their thoughts, feelings and compulsions before they put any of it into action to be a helpful intervention which facilitates the interpretive psychoanalytic process.

A fifth technical approach hinges on Fonagy's (1989) proposal that children who suffer from developmental deviations due to deficient caretaking are unable to integrate newer developments into earlier structures, which results in the child being unable to develop a theory of mind (p. 97):

> For its emergence, theory of mind depends upon a degree of consistency and safety of object relations which permit the child to experience the manifestations of other peoples feelings, a range of intentions, and a predictable social environment in which rules can be seen to apply.

The patient must be able to know and understand the content of their own and the object's mind for the development of normal object relations. If this is not achieved, the patient is likely to experience other's thoughts, feelings and intentions as being meaningless, chaotic and disturbing. Fonagy (1989, p. 103) states that ... `interpretations are based on a cooperatively established shared reality', which before the patient could only comprehend one reality at a time. An example could be that the therapist would point out that the patient's perceptions of others were being seen in one way, but that he wished that others, including the therapist, would not respond to him in a perceived unexceptable way. Another example may be to point out how well the patient understands how others feel when it appears that the patient becomes cognisant of how others may be in a situation which would make them feel or think as

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the patient does. Where Krystal's approach is to assist the patient label affects, Fonagy (1989) focuses on helping the patient . . . `label thoughts as thoughts' (p. 102).

Case Material

Mrs R was a 35-year-old woman who entered treatment after nearly fifteen years of psychiatric hospitalisations and psychiatric group home placements. She had been given a variety of diagnostic labels including schizophrenia (catatonic type), bipolar disorder and psychotic depression during past hospitalisations. At my first meeting with Mrs R, I found her to be physically rigid such that she walked in a stiff, robot-like fashion. Her eye contact was a consistent blank stare while she sat with her coat on and purse held close to her body. She was often silent for protracted periods and appeared to withdraw into fantasy. My association was to that of a `zombie'. Treatment was a gradual construction and reconstruction of the past as will be highlighted by the following case material.

During the first few weeks of treatment, Mrs R would sit, silently, showing no clear visible signs of any affects. She perceived my active listening as reflecting disinterest and neglect which resulted in a passive silent withdrawal and a retreat into fantasy, as I was later able to determine. Silence, during the early phase of treatment, did not encourage nor motivate verbal communication but instead resulted in her being more disengaged and isolative. Defence interpretation and conjectures which addressed her apprehension to talk met equally with little response. My counter-response led me to comment on her drifting away into private fantasies which excluded me and expressed both defensive hostility and fear. This left me feeling disengaged and alone, which was later determined to be an early experience of being with her mother - a depressed, unresponsive mother.

Her latent hostility may have unconsciously influenced my decision to shift the focus of my interventions. Stein (1981) proposed that active questioning combined with interpretations which address and connect the defences to unconscious conflicts can facilitate an analysis. Busch (1986) stated . . . `rather than being anxiety-provoking, questions can be anxiety-reducing'. He continued (p. 459):

> With appropriately timed questions we: express our interest in what the patient is telling us; stimulate his curiosity about aspects of his life he hadn't thought about; give some structure to the meeting; and show our understanding of what kind of information might be helpful in explaining behavior. From this perspective questions have a facilitative rather than disturbing effect upon the beginning of the analytic process.

Initially, my brief inquiries regarding her life, past and present, were responded to with brief, vague details.

However, she seemed to listen intently to my words as she soon did with her own words. Mrs R would become ruminative about `worries' which were current in her life. Her rigid but brittle defences guarded against unacceptable memories and affects emerging into conscious awareness which were influenced by feeling vulnerable and ambivalent about the analytic situation. Mrs R said she lived in a psychiatric adult group home, separated from her three-year old daughter who lived with her parents. She had been in this home for over one year following discharge from the most recent stay in a psychiatric hospital. She reported being unable to recall previous psychotic episodes and, instead, had to rely on reports of what had been told to her by others. She had been told that she was dressing `weird', leaving her home and `walking around ...

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going nowhere' and that her apparel was inappropriate for the weather conditions outdoors. In the early months of treatment, her words brought few external signs of affects, except some puzzlement that she could not recall these events, which I shared with her and added that I was also quite curious about her impaired recall of important memories.

As therapy progressed, we discovered that she had been brutally raped while in college fifteen years earlier precipitating her first `episode' and hospitalisation. She would obtain work periodically, returning to psychiatric hospitals where she eventually met a man to whom she married and lived with for eighteen months. Her husband, an abusive, violent alcoholic, often inflicted physical injuries so severe that the patient had to be hospitalised. The patient finally left him after the birth of a daughter when he threatened to kill the baby and had severely beaten Mrs R. Following the divorce and a year of making verbal threats to shoot himself with a gun he owned, this man eventually committed suicide.

Her words were spoken in a bland, factual manner. The exception was some tears in her eyes regarding the husband's suicide. This provided an opening to assist her to shift to a role where I was able to address her sadness and thoughts about his death. This phase of treatment included my active efforts to assist and encourage her to identify and put words to affects. Often she would say `I do not know how I feel', `I'm not sure' or 'I'm confused' which I found to be conveying cognitive and emotional confusion as well as expressing ambivalent and conflicting feelings which she could not modulate nor tolerate.

Another focus of this phase of treatment was to help her clarify reality, past and present. At times, she was uncertain as to what were current or past events (memories) wishes and fantasies, etc. Reconstructive work included Mrs R's faulty reality testing starting with her confusion of dates, order of life events and `recollections', whether it represented a construction based on what she had been told by others or possibly was a wish and fantasy created in her mind. It became apparent that during her childhood many confusing, unclear and disturbing events occurred. She believed and reported that important events and issues were not discussed with either parent as she grew up. For example she reported that her sister (three years older) died of a gastrointestinal disease when they were both early adolescents. She said the parents rarely mentioned this sister and never discussed the cause of death. I suggested that this collusion of silence was a shared opinion that the sister's death was a taboo topic, leaving her feeling alone with her mixed fears and fantasies. I was able to interpret her ambivalent attitude toward and passive wish to reunite with the envied, idealised sister by means of her silent withdrawal; an act of identification.

What is important to emphasise is that, as she reported feeling less anxious in the treatment, she became more engaged, more curious, insightful and object related. She seemed to improve her reality orientation and ability to sort out what she knew to be an actual memory and question some of what she has held to be `real' as being the result of withdrawing from reality and turning to fantasy and an internal psychic life. For example, she would ask if I would think or feel as she did in the past or does feel in the therapy sessions. My interventions often addressed how she may be concerned or curious if I share her thoughts and feelings and that I can *know* how she feels or thinks from what she says. At times I would share my thinking about her thoughts. This usually resulted in a reduction in anxiety and an increase in self examination.

Fantasies and distortions of life events grew and were transformed and/or repressed

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as her life progressed. Further analytic exploration found that Mrs R's fantasies were tied to her jealousy of her sister whom she both envied for her artistic abilities and social skills, but felt guilty that she received better academic grades which brought her father's praise and preferential treatment. She consciously believed that her father's `ignoring' the sister resulted in his 'ignoring' her medical symptoms and his lack of response until it was 'too late'. These events were manifested in transference fantasies tying any passivity or silence with being neglected, rejected and at risk to her own health and safety. Oedipal fantasies were experienced as destructive, which she related to the death of her sister. Another facet was that if her father could allow this to happen, would I fail to protect her while in treatment?

As her level of safety in the treatment increased, we were able to explore another dimension of her silence. It was found to represent the rape where she felt paralysed and unable to call for help. This determinant was analysed in the transference, particularly with my being a male therapist. Fear and safety were always of concern to her. The rape resulted in a deadening of physical and emotional pleasure. She felt that 'all my feelings' were destroyed by the rape. She experienced phallic penetration as a frightening, damaging attack which she was forced to accept passively. This dynamic was instituted in her decision to marry an abusive man who indeed beat and raped her. The patient stated that, if it were not for his threats to harm their infant daughter, she believes she may have not divorced him. Her fear of penetration and harm predominated any manifestations of penis envy. She once said: 'Why would I ever want to have a penis. .. all they have ever done to me is hurt me and cause pain ... They've ruined my life'. Only in the course of the treatment was she able to feel safe enough to reveal wishes to have a penis, firstly, to protect herself, secondly, to master the trauma actively and thirdly, also to gain her mother's love and admiration.

The parents' inability to provide adequate protection, safety, empathic attunement and attention, the sister's death and then being raped resulted in her fearing that she would become vulnerable by the closeness inherent to the treatment situation - that it would be dangerous, or that I would ignore her or, worse yet, watch her in pain as she felt her parents had done when her sister was ill before she died. She had become the depressed, self-absorbed mother who would provide no nurturance nor sense of safety. Many aspects of her identifying with her mother were interpreted which included my pointing out that this defensive manoeuvre showed that she knew what it was like to be like her mother as I knew what it was like to be in her situation when she was a child. Initially, she was unable to label affects clearly. My interpretations assisted her in designating names for affects and putting into words what she felt (past and present) rather than to deny, somatise, externalise or retreat into her mind and away from the world around her. For example, I would say: 'It sounds as if you felt angry at your husband for what he had done to you and threatened to do to your daughter, as well as feeling frightened that he may harm or kill you and your daughter'. She always felt he could kill, which was actually realised when he shot and killed himself. She had fantasies that her leaving the husband had in fact actually destroyed him. In her perception, anger could not be contained in fantasy and activated tremendous guilt and anxiety.

The treatment also provided her a safe arena where we could explore memories, associations and the experience we both shared during this process. As she developed the ability to put thoughts and affects into words and explore wishes and fantasies, her anxiety and depressive affects lessened and her reality testing and object relatedness

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improved. For the first time (since adolescence) she began to be consciously aware of sexual wishes, fantasies and desires which could be worked with in an interpretive mode, without her concern for safety. Following a year of intensive treatment, Mrs R was able to return to a job and be a more adequate mother to the daughter she wanted so much to parent. She was a bright, engaging woman with wit and humour - a much changed woman. She was referred for continuing treatment to another therapist in the city where she had relocated.

Discussion

The case material demonstrates the clinical utility of the techniques known as ' developmental help' in the treatment of a disturbed woman. I provided details of a treatment where an admixture of developmental help and more traditional interpretations engaged a very disturbed and withdrawn patient and facilitated a shift to a primarily interpretive, reconstructive psychoanalytic process. Developmental help, in this case, consisted of: (a) clarifying what was reality and what was fantasy; (b) assisting the patient to separate cognition and affect states; (c) recognising, identifying and clarifying specific affects; (d) promoting the use of words and supplanting the use of action or psychotic withdrawal, and (e) developing her ability to know and understand others' thoughts and feelings as well as her own. These interventions assisted the patient to engage in an object-related, interactive therapeutic relationship which promoted ego integration and synthesis, employment of more effective and mature defence mechanisms, reduction of intrusive primary process fantasies and discouragement of a withdrawal from reality which permits the patient to associate freely without experiencing overwhelming, disturbing affects and fantasy material. As in the example of the techniques proposed by Fonagy (1989), these provide. .. 'mental terms between experience and response' (p. 106) and provide the patient with. .. 'the requisite distance to achieve control over some of his overwhelming affects' (p. 106) and 'facilitate the acquisition of a mental structure' (p. 106). In utilising such techniques where the therapist shares thoughts and perceptions, one must be careful of pathologic counter-transference interference and be keenly aware of one's own wishes and fantasies so they will not interfere with the unfolding in the analytic situation.

Bion (1954) suggests that a psychotic withdrawal results from a profound hatred of reality. I see it as the consequence of developmental deviation based on fear, emotional neglect, deprivation and traumatic overstimulation. The pain of existing in reality is avoided and defended against while pleasure and safety are obtained through fantasy based on unfulfilled wishes. The proposed technique changes convey safety in reality, that the patient will not be neglected nor taken advantage of. Instead the patient will be safely engaged in a therapeutic relationship with a new empathic and available object which promotes a 'facilitating environment' (Winnicott 1965), a 'secure base' (Bowlby 1988), and what Sandler (1987) refers to as a 'background of safety'. Patients who experienced developmental deviations and related psychic conflicts require interpretive work which addresses not only repressed conflictual content, but also promotes a construction of the past where meaning had not been established due to the direct unavailability of pre-oedipal material (Killingmo 1989). The combining of developmental help techniques with traditional interpretations encourages new solutions to past conflicts which were impacted by deviations during development. What has been missed or lost in the past cannot be regained in the future, but rather

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constructed or reconstructed, understood and reorganised by means of the psychoanalytic process.

For Mrs R, the trauma of a brutal rape at the age of 19, a time when she was making steps essential to the transition from adolescence into adulthood, resulted in ego fragmentation and defensive regression, leaving her unable to manage the conflicts from her childhood which were based on a disturbed mother-child relationship and which had become repressed with continually modifying layers of poorly organised structures, superimposed one upon another. Yorke *et al* (1989) state (p. 112):

> an inadequate response by the mother to an infant's instinctual needs creates dangers and external conflict. The consequence of such disharmony are most evident when structuralization is not sufficiently advanced to assimilate psychic pressures caused by external and internal stresses.

Life progressed as did her attempts to adapt to and function adequately in her world. Early deviations and conflicts persist, usually in a disguised or derivative form, which are transformed by inter, intra- and extra-psychic life in an ongoing fashion. Her object relations, as with most aspects of her life, became destructive and increasingly more traumatising, as enacted in her destructive marriage to a violent, abusive man. As Bollas (1987) points out (p. 111): `traumas are not experienced as events in life but as life defining' or what is also known as organising life events.

This patient's masochism was not completely analysed due to its being interwoven in most of her object relationships throughout her life. The passive masochistic traits evident in her early treatment were able to be analysed as we explored the multiple meanings of her silent withdrawal. She feared being a helpless victim of destructive people around her but would attempt to control and master her trauma by becoming `easy prey' in most areas of her life. The omnipotence in this behaviour was tied to her feeling special in her suffering and being the object of sadistic attackers. She was attempting to transform the pain and inadequacy of the early mother-child relationship based on . . . ` the real failure to achieve competent interactions with others' (Novick & Novick 1992, p. 307) forcing the child to turn to omnipotent fantasies where clinging to pain makes the child feel special and invulnerable. Since masochistic traits are often impervious to interpretations and require years of analysis, this aspect was to be a crucial issue to be addressed later in her treatment.

Her initial silence and inability to engage in treatment were consequences of her overwhelmingly intense affects which she could not express with words due to words being unsuitable vehicles for highly emotional states (Bion 1962). Techniques of developmental help facilitate understanding and have a clarifying role which, along with interpretations, reduces the intensity of affects and cognitive confusion so that words will adequately express both cognition along with affects in a safe and comfortable setting.

This paper points out the importance of object-relatedness based not only on visual contact but also on auditory connectedness. Verbal interchange, particularly empathic, interpretive work, using the techniques of developmental help, not only establishes a tie to a therapist as a new object, but also promotes identification with the therapist. It creates a means to communicate wishes and affects in a safe way, to delay the compelling tendency to acting out so that her own aggressive wishes and fantasies would not kill me as she unconsciously believed had killed her sister and husband, and to provide the ego the opportunity to judge and clarify reality, and a means to discharge drive energy (Katan 1961).

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I do not mean to imply that the techniques of child analysis are identical and directly applicable to adult work and vice versa. In the spirit of the widening scope concept, I have come to find that the theory and principles, based on treatment of children with developmental deviations, and in an altered form, may be applied to the treatment of adults who are disturbed due to developmental deviations. Fonagy *et al* (1993) state (p. 28):

> The notion of unutilized, inhibited mental processes offers a preferable conceptual bridge between psychoanalytic work with children and adults and makes clear that `developmental help' does not imply gratification or education, but true psychoanalytic work

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