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Chapter 3: How Clinical Work with Children Can Inform the Therapist of Adults

Judith Fingert Chused, M.D.

In this volume we are reversing a process that began many years ago. Child psychoanalysis developed out of analytic work with adults; here we are considering the opposite, the contributions child analysis can make to adult analysis and to other forms of clinical work with adults. Many of the therapeutic principles that I shall discuss, principles of technique which are essential in working with children, developed because of failures of adult analytic techniques in child analysis. Failures led to new ways of thinking and the development of new techniques. I am hopeful that the theoretical and technical advances in child analysis which have enhanced work with children will also prove useful with adult patients.

Looking back to the early nineteen hundreds, when children who "wanted to get back to [their] toys" (Ferenczi, 1913, p. **244**) and therapists who wanted to talk seemed to work at cross-purposes, the problems in that early work are evident. Children were expected to comply with the therapist's strategy, to talk about ideas they had not yet begun to consider. We are

now less naive; no longer do we expect that compliance in children will lead to therapeutic growth. We also know that how children hear and integrate experience is different from the way in which adults do. We know that the child's internal life, his level of ego functioning, and his psychic reality, need to be considered in choosing the form and content of therapeutic interventions.

I believe our current understanding of children and their means of communication can significantly improve the treatment of adult patients, particularly those whose ego functioning is compromised by immaturity, severe psychopathology, or transference regression. Knowledge gained from child analysis can increase our capacity to use and respond to modes of communication other than speech, and to make contact with patients who are very frightened, resistant, or psychologically naive. In addition, it can increase our appreciation for the patient's view of therapy: for what he hears, what he understands, and how he learns.

There are many contributions that child analysis can make to therapeutic work with adults. Of these, I believe the most important is an awareness that technique must fit the level of ego functioning of the patient. A child's ego functioning determines his capacity to listen and understand, to tolerate and benefit from the therapist's interventions. To use the words and actions of therapy is not a simple task. It requires a level of engagement that is not always present in children, or in adults. Ego functioning is not fixed; ego regression in response to intense transference can limit comprehension, integration, and verbalization, regardless of the presence or absence of severe pathology.

To do child analysis is to be educated in shifting levels of ego functioning. During analysis, the child's ego capacity is subject to continual variation; a therapist has no choice but to pay close attention to this in the timing and phrasing of his interventions.

Donald and Karen

Donald began analysis at age four, after he was kicked out of nursery school. Frightening fantasies, which he defended

against counterphobically, by always attacking first, had made him impossible to control. By age six, though his behavior was much improved, and he was able to remain in school with the help of a skilled teacher, he still was capable of significant destruction. I remember well his reaction, after eighteen months of analysis, when I told him about an impending summer vacation. He said, "I don't care", and began the hour, as usual, by exploring the toy chest. He then made a paper airplane, but unlike his usual planes, this one had a passenger, a metal toy soldier. Within minutes the plane was in the air, sailing right toward me. As soon as I saw it, I instinctively ducked, then slowly walked over to where Donald sat with a scared, defiant expression. As I walked, I spoke softly; "You wanted to hurt me; now you're scared I want to hurt you back". He responded, "I don't care; you don't like me and I don't like you and anyway, you're ugly". He went on to elaborate in a very garbled way that he always knew I didn't like him and that I was going away because I thought he was "yucky", but he didn't care because I was boring and he was sick of me.

Donald's reaction was very different from eight-year-old Karen's response to termination. Karen had also begun analysis at age four with marked separation anxiety, and, like Donald, incapacitating fears (of robbers, poison, kidnappers, and ghosts) that

contained the projection of her own forbidden aggressive fantasies and wishes. She was overly attached to her mother, became panicked when separated from her, and was very jealous and aggressive toward her two-year-old sister. An ever-present anticipation of deprivation had made her bossy and selfish, completely unable to share, delay gratification, or play with peers. Fortunately, Karen's analysis had proved useful, and now, four-and-one-half years later, talk of termination was in the air.

One week, during this last phase of treatment, she began to bring in cards and paints daily to work on by herself. My statement that she was showing me that I was unimportant and that she didn't need me had no impact. The more I attempted to call her attention to the solitary nature of her activity, the more pointedly she turned her back on me. Everything I said was heard as a form of pursuit, a request for her to play with

- 39 -

me, and, as her intent was to make me want her as she wanted me, to feel left out as she felt left out, my words only strengthened her resolve to exclude me. So, in silence, I waited to see what would emerge. Five minutes later she began to squirm in her chair, looking over at me furtively. Two minutes later she was bored. Slowly she began to talk about how it wasn't much fun to play alone, and eventually she said spontaneously that it hurt to know, even when she was mad at me, that it was more fun to be with me than without me.

I believe that the difference between the two children's responses reflects their ego functioning, as influenced by their age, pathology, and where each was in the transference. Both children were feeling sad and angry over an impending separation. Karen was “paying me back”—she knew she would soon be without me and so she tried to create, in our session, a world in which I would be without her and would miss her. But she did not lose touch with the feeling of wanting me, and she could understand that ignoring me wasn't going to make her feel better for very long. At this stage in the treatment, transference misperceptions had given way to a more realistic assessment of inner and outer reality.

Donald was still enmeshed in the transference. He saw my leaving on vacation solely as a response to him, and he attempted to reclaim me by regressive, sadomasochistic means, to have me be angry with him, connected with him through fighting, so that he need not feel so alone. Donald had felt helpless; his attack was both a direct expression of his anger and an attempt to master a situation he could not control.

It is clear that to have gotten angry with Donald would not have been therapeutically useful. But I also believe it would not have been useful for me to be silent, “abstinent”, with Donald as I was with Karen. I think it would have been experienced by him as withdrawal and reinforced his fear that I was leaving because of him. We all know abstinence is not the same as withdrawal; it is used to facilitate the emergence of clinical material, often through further regression, not to avoid an interaction. But for a child who is in the midst of an intense transference experience and is unable to differentiate external from internal reality, silent abstinence often *feels* like withdrawal,

- 40 -

and can lead to a further regression that serves no useful purpose. To sit silently with Donald, as with Karen, would have strengthened his transference misperception, and would very likely have led to an escalation of his aggressive attacks (in an attempt to reconnect with me as well as to protect himself from his projected anger).

Much more aggression from Donald could have led me to retaliate, even though I might try to hide my anger (from myself) by calling my response limit-setting. Donald wanted me and he was angry I was leaving. Although his fear that he was responsible for my going away was age-appropriate, his overwhelming anger and the extent of his denial and projection of feelings was a significant problem and needed to be addressed. Yet, before any interpretation could be made, he needed to be able to attend to me. This is why I slowly moved over to him. And it is why, as I stood next to him, I silently made a paper boat, in the manner he had taught me months before. I made it carefully and when the lopsided, yet accurately constructed boat was finished, I proudly held it out and said, “See, I remember how you showed me”. At this point my intent was to demonstrate, in a concrete way, that I thought of him as someone of value. This was not an analytic interpretation. However, it was a clarification and a correction of the misconception that I did not like him, provided nonverbally, albeit symbolically, through action rather than words. I sensed that concrete communication through behavior was what Donald received best at this point, that his ego was too regressed for him to be able to attend to my words. For Donald, at this point, words by themselves had no meaning. Once he could listen we would work on the origins of his intense reaction to my leaving. But first Donald had to be engaged.

This brings me to an important lesson learned from work with children. Verbal interventions, however well intended, sometimes do not work. Even in analysis, the most verbal of therapies, action is sometimes required. It is usually clear when a child does not understand. Although it may be less obvious, at times adults also do not “hear” our words. We all vary in our ability to communicate symbolically, to use words for trial action. When the analyst speaks, patients with severe pathology

- 41 -

or consumed by a regressive transference may hear only that he has spoken; the content of the words may not register. It is at these

times that the burden of communication is on the therapist. Rather than just hope that the patient will hear accurately, the therapist must communicate via a mode that the patient can understand. Sometimes this means via concrete behavior. A rageful adult patient, who alternately threatens or "guilt trips" the therapist, is similar to a child having a temper tantrum. He is helped more if the therapist listens until the patient runs out of steam, and then speaks calmly (regardless of what is said), conveying by the action of remaining calm that he is not angered or frightened or made defensive by the patient's words. Calm silence at the moment of rage can communicate more than the most accurate of interpretations. In the heat of the transference, even an accurate intervention can be hard for a patient to hear or understand.

But even when patients cannot hear words, they may be quick to "hear" what is not said, to look for nonverbal cues from the therapist about what *he* thinks or feels or wants. Thus it is important, no matter how a patient reacts, whether with agreement or defiance, that his understanding of his therapist's behavior be open to the same scrutiny as his understanding of his therapist's words, and that the therapist be tolerant of that scrutiny.

Children, engaged in the developmental task of establishing autonomy and a defined self representation, may be less likely to hide their feelings and more likely to respond directly to their experience of the therapist's behavior. Their actions often make it clear how interventions are perceived.

For example, Karen, at five, after a year of analysis, had a mixed erotic and aggressive attachment to me (a transference of ambivalence originating in the early relationship with her self-indulgent, overstimulating mother). One day, this very creative, spirited, and overstimulated little girl came into my office, clearly in a bad mood, and began to ask me to do things that from past experience she knew I would not (read her a story, comb her hair, let her into the living quarters above my office). She agreed she only wanted what wasn't available, then said there was no one to play with her, that her sister was being a

baby, and her mother was out of town. With that she fell into my lap. As she struggled to find a more comfortable position, her movements became more and more aggressive, leading me to say, "I think you don't know whether you want to cuddle or fight". She responded, "Think, pink—all you do is stink—you're a stinky poo-poo!" Turning to my desk, Karen said, "You're so messy; how can you be a feelings doctor and figure out feelings if you can't even keep your desk straight?" As she yelled at me, pointing out one flaw after another in my clothes, the furniture, and the toys, she flung herself about in my chair in a very rough manner. Silently I shifted my body away from her assaults. Abruptly her demeanor changed—her face became sad and she moved away to the other side of the room. When I said, "I think you were hurt when I moved", her only response was, "You say 'I think' too much".

Mr. D.

Karen's clear message that she had felt injured by me stands in contrast to Mr. D.'s response to my comment about shaking hands. A forty-year-old, previously successful novelist, in analysis because of writer's block, he had been in therapy many years earlier with a man who shook hands with him after every session. The hand-shaking ritual was repeated with me without question. When, after several months, I suggested there might be some significance to this "automatic" activity, Mr. D. became contrite and said that he thought all analysts trained in the Freudian method shook hands at the end of sessions. Over the next several weeks, the topic did not surface again, and there was no further material to suggest that he was concerned with it. However, his spontaneous participation in the analysis decreased and he began to complain of feeling rather hopeless about his competence to "do" analysis. Recalling Karen's sad and angry withdrawal when I removed myself from her, I asked him what my question about "shaking hands" had meant to him. After an initial denial of any meaning, he said, "I was hurt, but I understand. You want to keep it a professional relationship; that makes perfect sense".

Mr. D.'s hurt and compliant "understanding", which made me out to be the villain, also defended against an exploration of the unconscious intent of his hand shaking. So after I acknowledged his hurt, I suggested that there might be additional reasons why he did not want to talk about the "meaning" of the hand shaking. In response Mr. D. revealed that he was aware, subliminally, of my discomfort in shaking his hand, and that he had felt victorious each time this ritual was repeated. He hadn't wanted to think about his victorious feelings because they made him feel bad, guilty. As he talked of this further, we were able to explore the projection of both his aggression and superego attitudes. The projection had lead him to perceive me as a judgmental authority, censorial, intrusive, and controlling, so that it had become me hurting him, not him using my discomfort with hand shaking to hurt me.

The exchanges with Karen when she was five and with forty-year-old Mr. D. demonstrate not only how information is communicated nonverbally in the therapeutic situation but also how narcissistic injury can be used defensively to justify sadistic impulses. Both Karen and Mr. D. were hurt by my response to their physical action. Both seemingly perceived it as a rejection. Karen's sexualized, anal, name-calling suggested the impulses which led to her guilt and push for punishment and pointed the way for further exploration. Mr. D.'s withdrawal after I asked about the handshaking, while not as graphic a response as Karen's, made it clear that within the therapeutic process handshaking had much unconscious meaning.

Both patients' responses to my questioning illustrate the therapeutic dilemma when actions, enactments, or repetitions take the place of remembering. Nonverbal exchanges are less precise than verbal communications, and their determinants are often obscure. This is why we try to articulate the meanings behind even the youngest child's actions. Similarly, when a child or adult is responding to *our* nonverbal cues, this should be noted and the symbolic meaning perceived in the actions clarified. However, before some patients can attend to this type of clarification, it may be necessary to use nonverbal sensorimotor modes of communication to reach them and get them to listen.

- 44 -

Many young children, still grounded in sensorimotor cognition, use motor activity more often than words to express affect and wishes. Much of their experience has never been converted, internally, into words, so that for them physical action has the greater power to evoke affect, dispel anxiety, and so on. I am not speaking just of large motor actions, like walking over to Donald or making a paper boat as he had taught me. Changes in tone, pacing, changes in timber, volume, how we speak, and our facial expressions all convey, *nonverbally*, affective nuances of sadness, pleasure, anger, or irritation. Not only can we discuss the music that accompanies our words, we can use the music as therapeutic tools. When a patient threatens or yells at his therapist or tries to seduce with words of praise or sexual love, if the therapist does not respond with irritation, withdrawal, or increased attentiveness, he is communicating nonverbally to his patient. Often this nonverbal communication, which we call being neutral, is much more effective than saying, “I am not angry, I am not aroused, I am not flattered”. It is frequently useful, later, to articulate the difference between the response the patient expected and the response he received, but initially, the nonverbal communication, the “neutrality”, can be what engaged him and got him to listen. I think of Donald, the four-year-old I mentioned earlier. One week as he was insisting that I was an evil, ugly, threatening witch, he began to poke at me, ostensibly to protect himself. I tried to articulate the longing that was hidden behind his aggression, but to no avail. Finally, in desperation, I made two masks, one a witch face and the other, the nicest princess face I could draw. As I held them up alternatively over my own face, I said, “I think I'm both”. Donald “listened” to the concrete masks in a way he had never listened to words alone. They were the music—just as speaking slowly to an angry patient can be the music.

A therapist can do much to educate patients in the use of words; such education, even if unintentional, is an inevitable part of any insight-oriented therapy, of even the most sophisticated adult. However, when “put into words” becomes the therapist's theme song, his request for verbalization can become charged with transference significance and may lead the patient

- 45 -

to compliant intellectualizations or defiant silences. That is why a therapist must always “listen” for how he is being heard.

Thus far I have focused primarily on patients' difficulty with verbal communication, a common problem in child therapy. However, difficulty with communication can also begin with the therapist. Most therapists have made an inaccurate interpretation at least once, and we are all familiar with the concept of a therapist interpreting nonspecific material as if it were a specific transference manifestation of an internal conflict. Whether or not the patient overtly rejects these inaccurate interpretations, for the moment the credibility of the analyst is decreased and the usefulness of his words temporarily lost. Mr. D.'s polite handshake and, later, his compliance in giving it up, were part of his characterologically passive-aggressive stance. Neither had specific intent initially. Were I to suggest he took my hand because of his erotic wishes or as a substitute for hitting me, whether he said he agreed with me or not, we would have lost ground. However, through the therapeutic process, his handshake and my noting it accrued considerable meaning. When I linked his despair over therapy to my commenting on his handshaking, he indicated that he thought I was just telling him politely I did not want to shake his hand. In other words, he had heard my words as a directive pretending to be a therapeutic inquiry. This is a common occurrence with children (who expect directives from adults) and with adults in a regressed, dependent therapeutic relationship. Once it was clear that Mr. D. had misheard me as directing him to “stop it”, our task became the exploration of his misperception. Now together we could examine what this represented, what exactly he thought I was “telling” him to stop. However, were I to have made a premature interpretation, *his* misperception would have been obscured by *mine.*

My sensitivity to patients' misunderstanding or mishearing me has been heightened by my work with children. Children do not have the same experience base as adults and their point of reference for understanding interactions is often very different from the therapist's. Knowing this has helped me with the process of introducing patients to the value of examining their inner world. Very few children who come for analysis or

- 46 -

therapy have any conception of what will happen. Some don't understand why they are there and even those who come because of “problems” (such as “I can't sleep by myself … no one wants to play with me … I get in trouble all the time”) very quickly forget the reason for their treatment. If asked, most (though not all) adults could tell you why they are in therapy. However, what they say and how they behave once defenses, resistance to treatment, and transference resistances take over are two different things. At the beginning and at times of resistance, the goal of therapy, with a child *or* with an adult, may be simply to enable the patient to listen

—to himself as well as the therapist. I have found that this participatory listening is best achieved by a demonstration of its utility, just as the experience of therapy is far more persuasive than any promise or discussion of its benefits.

With a resistant child or with one who simply wants to play, I try to clarify the preconscious meaning of specific aspects of his behavior. By articulating, putting into words, that which is expressed nonverbally, I demonstrate the value of my understanding, and by choosing preconscious, relatively unconflictual material to address, I avoid linking observation to discomfort. I try to do this initially in a way unlikely to stir up much resistance or stress. For example, early in treatment, when Donald threw down the Lego building blocks after he was unable to attach the roof to a building, and then, several minutes later, tore up a picture that he couldn't get "just right", I asked, "When the Legos didn't come out right was it like when the picture didn't look good to you; like you just didn't want to see it anymore?" And later when he abandoned the puppets when the play got too close to home, I said, "I think what the puppets were doing made you worry; perhaps the fight seemed too real". These clarifications did not address transference manifestations; they were said solely to increase his understanding of himself without challenging his defenses, by speaking to behavior that was almost conscious but had not yet been articulated (even in thought). My hope was that Donald would hear what he already knew and would take some satisfaction in the experience of shared understanding.

- 47 -

Ms. K.

A comparable intervention is also useful with adults, particularly those with little experience or knowledge of therapy, with strong defenses, or great anxiety. An example is Ms. K., a thirty-one-year-old woman who came to analysis because of sudden, overwhelming episodes of depression which completely immobilized her and which she had no ability to anticipate or modulate. Ms. K. had lost her father in an auto accident when she was five. Because of her fierce attachment to her mother and the intensity of her competition with her father, her guilt over her father's death was enormous. At the same time, the loss of her father, also a loved figure, was extremely painful. Throughout her early adult life, she defended against awareness of guilt and negative oedipal impulses with a masochistic character structure of increasing rigidity. There was little pleasure for her in any of her accomplishments. She lived in terror of offending or hurting anyone and was careful always to be the victim, never the aggressor. Ms. K. was psychologically unsophisticated, with a lack of self-awareness that was startling, for she was also a woman of much intelligence and competence. By thirty-one she had already published two professional textbooks and was a recognized, accomplished pianist.

During one session, in the early months of treatment, she became silent after my phone rang. When she began to speak again, her utterances were rambling and disconnected and quickly gave way to further silence. I mentioned quietly that her silence seemed to come after the phone had rung several times. After a long pause, she acknowledged she had heard the rings; to her they seemed to start and stop in a prearranged signal and she wondered if I had developed an emergency code, a code which I shared with special patients. Without confirming or denying her fantasy, and before exploring the determinants of the fantasy, I said that if this were so, since I hadn't told her an emergency code, I wondered if she felt excluded and therefore reluctant to talk to me. She acknowledged that she *had* felt left out, but then questioned, rather naively, why this would be so: phones rang all the time at work, or when she was visiting other doctors, why would it bother her with me?

- 48 -

Though Ms. K.'s naiveté had different determinants than a child's, being more defensive and less from lack of experience, it still interfered with her capacity to self-observe. As with children, it was useful to call attention to her experience, to educate her in the task of "listening" to her inner sensations. Children frequently do not understand what "nervousness" is or that physical sensations can be part of emotions. Recognizing that "the funny feeling that doesn't feel so good" comes when one is scared is an essential piece of learning to self-observe. Adults who move almost instantaneously from anxiety to defense also need help in identifying their affects. Before his conflict can be interpreted, a patient needs to recognize that he is in conflict.

For Ms. K., separation felt like total rejection and led to such fear of abandonment, that she blocked out all anticipatory emotions. Whenever she was separated from her boyfriend or, later, from me, even symbolically (as in the change of an appointment time), she withdrew into a hyperactive state, in which all interest in (or inner engagement with) the other person disappeared. A large segment of our early work together was centered on getting her to recognize that separation from important people was an extremely unpleasant experience, associated with conflicting feelings of loss, guilt, and anger. Until she was able to make a connection between her behavior (a withdrawn frenzy of activity) and the stimulus, she was like a child who defends against awareness of his dependency and neediness with overaggressive self-reliance. At such times, no matter how much an interpretation "makes sense", it has no power. A therapist who is decathected is "tuned out" with his words unheard.

At first, Ms. K.'s "awareness" of her defensive and aggressive withdrawal whenever separation occurred was quite superficial, being primarily a cognitive recognition of the temporal connection between separation, withdrawal, heightened activity, and depression. I moved very slowly to interpretations of unconscious determinants, waiting until Ms. K. developed the capacity to recognize the presence of conflict within herself and to tolerate the recognition.

A patient's lack of appreciation of his inner world can lead to a number of problems. Children, in their naiveté, often reveal

transparently clear, albeit unconscious, information about the origins of their distress. His recognition of unconscious conflictual impulses makes the therapist useful, but if there ia a great discrepancy between his perceptions and the patient's, it can lead to premature interpretations or clarifications, which to children (and adults) may sound like superego condemnations or onmiscient declarations. It does not help to talk about sexual wishes that are obvious to the therapist if conflict and defense make them completely unknown to the patient.

When a child says he hates the analyst and pokes her with words and fingers, even though his curiosity and touching make evident that he is very attached to her, if he is unaware of his positive longings, interpreting the libidinal pleasure in his attack has no value. Unless one sticks close to manifest material, to experiences in the transference that the child “almost knows”, interpretations will be misheard as directive, critical, or for the therapist's benefit. As demonstrated by Mr. D. earlier, distortions in understanding a therapist's words are an important source of information, but they should be distortions based on the patient's transference misperceptions, not on the therapist's poor timing. When a patient hears us as critical or directive, before we interpret his “misperception” as transference, it is important to be sure that we are *not* being critical or directive. Much better to stop a child's attack directly, honestly, than to try to stop it through a directive disguised as an interpretation. Interpretations are made to increase understanding of behavior, not change it through covert suggestion. Change may follow from the understanding, but that is another subject.

This brings me to children's tolerance of the therapeutic process. With a child, if the tact or timing of an intervention is the slightest bit askew, one knows it immediately. Narcissistic injury leads to pouting withdrawal, not just to silence; premature disruption of defenses with “too deep” interpretations leads not only to denial but to aggressive reactions, with name-calling or spitting. One learns, however, not to avoid interpretations just because children are vulnerable to experiencing words as assaultive or liable to becoming assaultive themselves. Avoidance of comment will be noted and also can be troubling, increasing a child's fear of the unknown. In addition, avoidance

of transference interpretations (with the rationale that an interpretation would create too much psychic tension) can lead to serious acting out. Pain is inevitable, though, of course, the therapist must always examine the process for his contribution to the pain.

It is common for a child, perceiving me as a rival or attempting to deny a libidinal attachment, to claim that I have hurt rather than helped him. He may seize on my failure to help with homework or play Monopoly, my interpreting the defensive regression in his demands, as proof of my meanness. At these moments the nonverbal stance of the therapist is crucial. For I have noted within myself and those I supervise, that when a child challenges the “rightness” of words or behavior, there is all too often an instinctive “bristling”, an unconscious “What does he know?” or, even worse, a disregard for the response of the child as if one need not even consider his objection. Even when it is not expressed verbally, the movements, expression, even the posture of the therapist can convey a disbelief in the child's complaints. Sometimes there is a patronizing attentiveness, a pretense at taking the child's concerns seriously. This can and does happen with adult patients also, particularly those locked by character pathology into a chronic misperception of the analyst's words. The analyst may be unaware of his exasperation and irritation even though the patient notes it (and may have deliberately provoked it).

Children's complaints may be justified—and can inform a therapist when he is not listening, when he is too sure he is “right”. For example, Donald, when he turned seven, on the Monday after his weekend birthday party, decorated my office with streamers, and then added a big “Do Not Touch Donald's Stuff sign to the inner office door. He knew, from his several years in analysis, that when drawings and other constructions were left outside his private drawer, they were likely to disappear or get destroyed between one session and the next. In spite of this knowledge, he spent the whole hour on his sign and decorations. When I asked him about the party, he said it had been terrific. He sounded somewhat angry and sarcastic, to my ears, and I assumed that the party had not been as much fun as he hoped (often true of birthday parties), and that the

decorations were his way of trying to do it again. When I suggested this, his only response was, “You're crazy; I had a good time, the only unhappy people are those who didn't come to the party”. The next hour we continued on the same topic, initiated by his complaining about the lack of construction paper in my office (he had used it all up the day before making streamers). I again suggested that he was angry, and that it seemed he hadn't gotten what he wanted from the party. To which he responded, “You don't know what you're talking about; you just missed the best birthday party ever”. What I had also missed, was that it was my presence at the party that was lacking, not the party itself.

For careful as we are, our interpretations can be off. And when that happens, the patient's challenging intolerance of our errors may stimulate a defensiveness or rigidity in us that is neither conscious nor desired. Fortunately, interpretations are not the be-all or end-all of the treatment process. The aggressive or action-filled response of children to interpretations (right or wrong) forces

the therapist to focus on the process following an interpretation, on the interpretive sequence. This is often where the work gets done. Much of the subtleties of the transference are revealed in how the patient understands and responds to the therapist's words and behavior. So it was with Donald. It turned out to be no accident that I was "off" in my initial understanding or that he worked all hour on decorations that were then destroyed.

With adults, the work of the interpretive sequence becomes more difficult if the patients are compliant and silent, or rageful in a way that dries up therapeutic compassion and skill. There is no question that a 220-pound angry man scares me much more than a forty-pound angry boy. But I have learned from my work with children. A direct question to a patient such as, "Do you yell at me so I won't speak?" can lead to self-observation in a child or adult that moments before seemed inconceivable. The shift of focus, from the content of the intervention that the patient feels is being forced on him to the aggression or compliance which is being used as a defense, can clarify for both of us the distress created by my words. In general, silence and compliance remain harder for me to decipher than direct

aggression. But here too, it is what follows the exploration of silence or compliance that is important; it is the process, not the moment that counts.

The last area I'll mention in which my work with children has informed me about work with adults is in the integration of and benefit from the therapeutic process. With children, when there is relief from symptoms, inhibitions, or incapacitating dysphoric affect, I always question whether this reflects the work of the therapy or is solely a result of a developmental shift in the manifestation of conflict. We cannot rely on symptomatology as a measure of therapeutic efficacy with children; change in character structure is more reliable, as is an increased availability of psychic energy for investment in sublimatory activities (including the ability to understand or tell jokes). At the end of treatment, children, because of their immaturity, may still have a limited capacity to tolerate dysphoria or delay action. Nonetheless, one of the tasks of therapy with children, as with adults, is to enable them to give up the possibility of certain gratifications and to develop the capacity to mourn what will never be. Mourning is a key element in our work, just as renunciation of oedipal wishes is a major developmental task.

Child analysts sometimes give insufficient weight to the force of libidinal and aggressive drives. They may be drawn into educating rather than analyzing because of the dependency or "vulnerability" of the child. The same may happen with an adult patient; in an attempt to avoid an unpleasant interaction or because of discomfort with the intensity of the therapeutic experience, the therapist may yield to his countertransference inclination to educate or instruct. Inevitably, this dilutes the efficacy of the therapeutic process. Freud's understanding of infantile sexuality is still difficult for many therapists to accept. Children themselves are discomforted by their strong, biologically determined feelings and often are unable to put into words (even for themselves) what they wish/fear to do or have done to them by the therapist. But, even if he cannot articulate it in words, the child is aware of the intensity of his drives—including his rage—and this needs to be acknowledge and given credibility. By taking the patient where he is (not where we wish him to be), we provide an authentication of his

feelings and impulses, which, while not necessarily therapeutic in itself, is essential for work to begin.

In summary, not only do patients need to learn how to listen, so do therapists. Work with children, for whom listening to their inner world is such an important new experience, has taught me how important listening is in treating patients of all ages.

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