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Idiosyncratic development and therapeutic reconstruction

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The author discusses the relevance of new perspectives in early child development for psychoanalysis and especially for therapeutic reconstruction. Two fragments of psychoanalytic case histories are presented to illustrate how insight into a patient's developmental idiosyncrasy may facilitate and enrich the psychoanalytic reconstruction.

Key words: early development, developmental deviations, reconstruction, therapeutic reconstruction, psychoanaly-

Psychoanalysis naturally takes a keen interest in studies on child development. Indeed, the last five decades have produced a voluminous output of developmental research and have led to a major revision of our views about the psychic life of the neonate, the infant and the young child (cf. Osofsky 1979). Such new knowledge has had a considerable impact on psychoanalytic theory, but there is scant evidence of its effect on the practice of psychoanalysis or psychoanalytically-oriented psychotherapy. This paper will attempt to clarify how a better understanding of early child development can contribute to the therapeutic process.

The most salient conclusions that emerge from recent developmental studies can be summarized as follows:

a) The behavior of a newborn infant is more highly organized than previously assumed [3,7]. In other words, some ego functions, such as modulation of affect, sensory discrimination and differential response to novel vs. familiar stimuli, are present at birth.
b) There are significant innate variations among neonates in regard to these ego functions, e.g. in responsiveness to novel or distressful stimuli, habituation, activity level or response to physical closeness. Such differences naturally affect the way the infants *perceive* their environment, *react* to it and help to *shape* it [4].
c) Infants play a far more active part in their own development than previously thought. They control the input of stimuli by following movements, they initiate dialogue by eye-contact, smiling and vocalizing, and they terminate interaction by turning away or crying [5,6]. Babies also "teach" their caregivers how to comfort them (many infants have their own individual preference for being comforted) and how

to interact playfully, e.g. whether the infant prefers vigorous or gentle games.

d) There is an intricate relationship between perceptual, motor, and cognitive development on the one hand, and emotional and interpersonal development on the other. Therefore, even minor impairments in the "autonomous" ego functions may have a profound effect on emotional development, especially on the formation of the self, as well as on the early child-caregiver relationship. This aspect of early development has received scant attention, even though it is especially relevant to psychoanalysis and psychoanalytically-oriented psychotherapy [1].

The purpose of this paper is to illustrate how insight into deviations in early development can contribute to the therapeutic reconstruction of childhood experiences and enrich the treatment process. To this purpose I am presenting fragments of the psychoanalytic treatment of two patients:

CASE I: Mr. G. was a young college drop-out, with a history of excessive drinking and gross impairment of social and emotional functioning. He was prone to uncontrollable emotional outbursts, especially paralizing anxiety or rage, obsessed by paranoid suspicions and violent fantasies, although he never became physically abusive. As a child he had been irritable and prone to uncontrollable rages which led to considerable tension between the patient and his father. Their relationship deteriorated during Mr. G's adolescence and at the time the treatment started there was a deep chasm between father and son.

Mr. G. expressed bitter resentment toward his father, whom he blamed for his internal confusion and chaotic life. He described the father as excessively critical, bitingly sarcastic and berating the patient for his angry outbursts, making him feel worthless and "a little monster". On one such occasion the father actually called Mr. G.: "little Hitler".

Mr. G's father was a highly successful attorney, a man endowed with considerable aggression for which he found an outlet in his work and for which he compensated by his liberal, humanitarian political views and a mild, courteous manner. He would, however, become sarcastic and derisive when drinking. He was emotionally involved with his three children, but the relationship with Mr. G. was often stormy and deteriorated to what appeared a point of no return.

Mr. G's mother, by contrast was perceived by the patient as "stolid", by which he meant dutiful and tolerant of his shortcomings, but emotionally uninvolved.

The diagnosis at the beginning of analysis was "Borderline personality with narcissistic and paranoid features". At the time of the initial diagnostic assessment the neurologist found signs of a mild cerebral dysfunction: a limp due to the slight shortening of the right leg, a slight motor deficit on the right side, mixed dominance and finger dysgnosia. Tests revealed an impairment of working memory relative to superior scores on most cognitive functions. The consulting neurologist diagnosed a "Mild Congenital Encephalopathy" (presumably mild C.P.), but its relevance for psychiatric assessment was not appreciated at that time, perhaps because of the conspicuous psychopathology.

Mr. G. was strongly motivated to engage in psychoanalysis and, despite his habitual

diffidence quickly established a positive transference and a solid working alliance. During the early stages he engaged in testing my tolerance and acceptance of him. He expressed radically right-wing harsh political views, obviously assuming that as a psychoanalyst I would be a "liberal". He also expressed a haughty disdain for mental health professionals (although he professed to exclude me from that contemptible lot). This was clearly a repetition of his childhood intellectual battles when he used to annoy his father by criticizing everything that his father admired and cleverly digging up facts which his father found distasteful. The transference image of me was complex: in some fantasies I appeared as a nurturing mother in others an intrusive, threatening one. As a Jew I was suspected of harboring liberal inclinations; as an Israeli I would appear as some kind of "psychoanalyst-soldier", holding a book by Freud in one hand and a rifle in the other, a man to be envied for being comfortable with his own aggression. That image was also an echo of his early memories when his father, then in active service, would come home in his resplendent officer's uniform and spend time with the boy (the only child at that time) reading stories.

I was not unduly bothered by Mr. G's aggressive ideas and murderous fantasies, nor by the intense anger one could sense emanating from the young man. I assume that I perceived, under the veneer of threatening aggressiveness, the confused little boy struggling for control of his violent emotions and yearning to be accepted as he was: unpredictable and at times out of control. He was obsessed with the idea of a mythical, primordial Evil, expressed by the following fantasy:

"The Great White Hunter in Africa suffers from a mysterious illness. From time to time he retires to his tent, not allowing anyone near him. His body becomes covered by boils, which break open and little black devils crawl out of them". The fantasy represented Mr. G's attempt to get rid of the Evil inside him by projecting it, i.e. his paranoid defenses. At the time, however, it also referred to the father-son relationship, i.e. the "Great White Hunter" giving birth to a little evil monster.

An examination of this fantasy in the context of the "psychoanalyst-soldier" transference led to a slow, gradual re-assessment of the father-child relationship. Mr. G. *was* a difficult child. We know that children with minor neuropsychological deficits feel frustrated and tend to be angry. They are often also impulsive and prone to rage. Moreover, such children often feel inadequate, especially if they happen to be intelligent, and narcissistically vulnerable [1]. In this case, Mr. G's father proved totally incapable of containing the boy's rages and handling the expression of impulses that he rejected and feared in himself. His reaction, berating and belittling the son was the worst possible way to deal with an emotionally unstable and narcissistically vulnerable child. The relationship, which began as a warm and close one deteriorated into bitter mutual disillusionment.

The re-assessment of the father-child relationship in analysis seems to have led to a slow but conspicuous change in the patient's attitude and a mellowing of the emotional storms. Mr.G. became more trustful of the analyst, his radical views lost their fierceness and his anxiety subsided. Though still narcissistically vulnerable he became more comfortable in his emotional relationships.

Mr. G's transference relationship also underwent a change. His begrudging, envious

admiration, i.e. “idealizing transference”, gradually gave way to more overt need to be accepted and to the expression of a deeply repressed yearning for a nurturing parent, a ”secret formula” I supposedly possessed.

CASE II: Ms. C. was a single woman in her early thirties, a capable professional, whose main problems were under-achievement, loneliness, a pervasive sense of inadequacy and a general dissatisfaction with her life. “I live next to life” was her way of expressing it. She felt anxious in new, unfamiliar situations, and dreaded facing deadlines, which often lead to a paralyzing anxiety.

Ms. C. was strongly attached to her mother, but their relationship was difficult. The mother did not hide her disappointment with Ms. C’s meager social and professional accomplishments, not commensurate with her considerable talents and a brilliant scholastic record. Ms. C., on her part criticized the mother for being too intrusive and critical.

The treatment moved forward at very slow pace and I became conscious of a rising impatience, not a common reaction of mine, as if something was there, but it was taking too much time to drag it out. It was not difficult to realize that I was being drawn into the role of the pushing, impatient mother the patient had described. An examination of that counter-transference reaction led to an extensive analysis of the mother-patient relationship and the conflicts that marred it, from early childhood until well into adulthood.

M. C. had been a bright and attractive child, but was overweight, slow and clumsy. Even as an adult her gross motor co-ordination was poor, her movements slow and limp. Quite likely she had been a hypotonic infant. We know from clinical experience that children with impaired gross motor co-ordination tend to be insecure, lack assertiveness and have a low self esteem [1].

Ms C’s mother, in stark contrast, was described by the patient as a vivacious, energetic woman, with a quicksilver temperament, the center of every party (in her younger days), surrounded by friends and admirers. She was also proud of “knowing how to get things done”, of being able to persuade people or to achieve her aims.

I had no difficulty visualizing that woman’s frustration with her slow, clumsy, insecure and socially inept daughter. During the lengthy process of analysis we were able to elucidate a further aspect of the relationship: The patient’s mother was not happy in her marriage: she felt that she had given up her youthful glamour and her rich social life for a man who gave her little affection and less appreciation. She had hoped, quite consciously, that her little girl would fulfill some of her lost aspirations.

She could not perceive that such aspirations were totally beyond the capacity of a slow, clumsy, insecure child, who had a great charm of her own but of a very different kind. They were, indeed, “biological strangers” [2]. The result was that Ms. C. developed a deep-rooted sense of failure and incompetence, became harshly critical of every least failure and withdrew further into her world of inactivity.

I have presented here only limited fragments of prolonged and complex analytical processes. I wish to illustrate how insight into the developmental idiosyncrasy of a patient can contribute to reconstruction of early parent-child relationship and enrich the analytical process. Developmental idiosyncrasies, such as extreme variability of

a temperamental characteristic (e.g. hypo- or hyper-reactivity) or subtle neuropsychological deficits, present a handicap to a child's emotional development. Moreover, they constitute a challenge to the parents' competence, sometimes beyond their capabilities. Integrating a developmental perspective into the therapeutic reconstruction helps to achieve a more balanced picture of the parent-child relationship.

Some analysts consider any supposedly *objective* element of reconstruction as irrelevant, claiming that the patient's *subjective* experience of his or her childhood is all that counts, as far as therapy is concerned. This is a misunderstanding. There is no question that the subjective "psychic reality" is at the root of the present maladjustment and its reconstruction is an essential task of the analysis. It is important, however, to remember that the subjective psychic reality developed in the context of a real situation, i.e. failure of the parent-child relationship, and that the present maladaptive personality traits were relatively adaptive emotional responses to a stressful life situation. The importance of "psychic reality" is not diminished by insight into the objective reality of the failure of parent-child relationship (including the child's unwitting contribution), but enriched by it. Re-examining the child's developmental idiosyncrasy helps the analyst, as well as the patient, to empathize with the bewildered little child trying to cope with forces beyond his control or understanding and with the helpless, frustrated parent dealing with an unusually difficult child. Last but not least, insight into the mutuality of parent-child relationships helps the patient to resolve the infantile idealization and vilification of the parent, the last vestiges of fantasies of parental omnipotence. The fantasy of parental omnipotence is deeply rooted in us all. It transpires in all of our therapeutic endeavors, but it is also reflected in many case discussions and theoretical formulations. Hopefully, a developmental perspective will help our profession to lay to rest the infantile image of the omnipotent parent to whom all that is wrong can be ascribed.

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