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DEPENDENCE IN INFANT CARE, in CHILD CARE, and in PSYCHO-ANALYSIS.

LOS ANGELES PSYCHOANALYTIC SOCIETY.

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87 Chester Square,
LONDON, S.W.1.
4th October 1962.

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There is nothing new in the idea of dependence, either in the early life of the individual or in the transference which develops force as a psycho-analytic treatment gets under weigh. What I feel may need restating from time to time is the relationship between these two examples of dependence.

I need not quote from Freud. Dependence of the patient on the analyst has always been known and fully acknowledged, and for instance shows in the reluctance of an analyst to take on a new patient within a month or two of a long summer holiday. The analyst rightly

fears that the patient's reaction to the break will involve deep changes that are not yet available for analysis. I will start with a development of this theme.

A 30-year-old woman patient had to wait for a few months before I could start, and then I could only see her once a week; then I gave her daily sessions just when I was due to come to U.S.A. for a month. The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent. In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. This was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

The trouble was that she had not yet had time to deal with reactions to my going away, and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way. Before I went I just had time, but only just, to enable her to feel a connection between the physical reaction and my going away. My going away re-enacted a traumatic episode or series of episodes of her own babyhood. It was in one language as if I were holding her and then became

preoccupied with some other matter so that she felt annihilated. This was her word for it. By killing herself she would gain control over being annihilated, While dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she carried all her life the memory of having at some time had a total urge to die; and now the physical illness had come as a localisation in a bodily organ of this total urge to die. She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt great relief, and became able to let me go. Incidentally her physical illness became less of a threat, and started to heal up, partly of course because it was receiving appropriate treatment.

If illustration were needed this might show the danger of underestimating transference dependence. The amazing thing is that an interpretation can bring about so great a change, and one can only assume that understanding in a deep way and interpreting at the right mement is a form of reliable holding, so that in this case, for instance, the patient became able to cope with my absence because she felt she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern.

You will have observed that we can go in either of two directions, starting from such a fragment from an

analysis. One direction takes us to the analysis of reaction to loss, and so to the main part of that which we learn in our psycho-analytic training.The other direction takes us to that which I wish to discuss in this paper. It takes us to the understanding in us that makes us know we must avoid going away just after starting an analysis. It is an awareness of weakness in the patient's Ego. In innumerable ways we meet our patient's needs because we know what the patient is feeling like, more or less, and we can find the equivalent of the patient in ourselves. What we have in ourselves we can project, and find in the patient. All this is done silently and the patient usually remains unaware of what we do well but becomes aware of the part we play when things go wrong; when we fail in this respect the patient reacts to the unpredictable and suffers a break in the continuity of his going-on-being.

My object is to relate dependence in the psycho-analytic transference to dependence at various stages of infant and child development and care. You will see that I am involved in an attempt to evaluate the external factor. May I be allowed to do this without being thought to be going back on that which psycho-analysis has stood for over this past 40 years in child psychiatry, namely the personal factor, the mechanisms involved in individual emotional growth, the internal strains and stresses that lead to the individual's defence

organisation, and the view of psycho-neurotic illness as evidence of intrapsychic tension that is based on Id-drives, and that is beyond the power of the individual Ego to withstand. But here we return to Ego strength, and therefore to dependence.

It is easy to see why it is that psycho-analysts have been reluctant to write about the environmental factor since it was those who wished to ignore or deny the significance of the intrapsychic tensions who chiefly stressed the bad external factor as a cause of illness in child psychiatry.

However, psycho-analysis is now well established and we can afford even to be misunderstood.

If we accept the idea of dependence then we have already started to examine the external factor, and indeed when we say an analyst should be trained we are saying that an essential for orthodox psycho-analysis is an external factor, that is to say the <u>good enough analyst</u>. All this is self-evident, yet regardless of what it is like over here in California, in England I can still find those who <u>either</u> never mention this external factor as if it were really important <u>or else</u> talk about it all the time, ignoring the internal factors in the process.

At this point I am full of doubt; is this

subject one that is self-evident once it is named, or is there perhaps some value to be gained from giving it closer examination? I have committed myself and I shall go ahead.

In the part of our work that I am referring to there is nothing we do that is unrelated to child-care or to infant-care. We do in fact learn what to do from watching or being parents, from having been children, from watching mothers with very young babies or babies unborn, from correlating parental failures with subsequent clinical states of ill children. While we know that psycho-neurotic illness is not caused by parents we also know that the mental health of the child cannot become established without good enough parental or maternal care. There is much work published on this subject and I am not attempting to refer to it all. Alpert's corrective emotional experience is a phrase that turns up here, and I think of Sperling's

and Erikson's Identity Crisis.

But we know that a corrective environmental experience does not directly cure the patient any more than a bad environment directly causes the illness structure.

I now wish to refer back to my fragment of clinical material. Very early in the analysis this patient had become represented in her dream material by frail and often maimed creatures, and now she had dreamed of the tortoise with a soft shell. [By the way, she could also be a horse that had to be shot else it would have kicked its way out of the side of an aeroplane.] You will have noted that this points the way to a regression to dependence that is bound to come. The patient had had several years of analysis along ordinary lines by an analyst who would have no truck with regression that threatened to become acted out, and that then involves dependence on the analyst. She was therefore over-ripe for this part of the total analytic procedure, though of course needing as much as anyone else does the usual interpretations that become appropriate from day to day, or from minute to minute.

If I go a little further into the interpretative problem in the analysis of this fragment I think I can show how interwoven are these two things: the intrapsychic mechanisms and dependence which by definition involves the environment and its behaviour.

I had plenty of material in this case for the interpretation of the patient's reaction to my going away in terms of oral sadism belonging to love reinforced by anger, anger with me and all the others in her life who

have gone away, including the mother who weaned her. If I were that type of analyst I could have weighed in, fully justified in terms of what the patient had told me. But I should have been a bad analyst making good interpretations. I should have been a bad analyst because of the way the material had been given me. It had been given me in a way that indicated that the patient knew she could trust me not to use it brusquely. She is hypersensitive to all drugs and to all illnesses and to slight criticisms, and I must expect her to be sensitive to any mistake I make in my estimation of the strength of her ego. Something central in her personality only too easily feels the threat of annihilation; clinically of course she becomes tough and extremely independent, well-defended, and along with this goes a sense of futility and of being unreal.

In fact her ego strength is not able to withstand any strong emotion. Hate, excitement, fear - each equally becomes separated off, like a foreign body, and all too easily localised in a bodily organ which goes into spasm and tends to destroy itself.

The reason why the regressive and dependence dreams have appeared has to do chiefly with her finding that I do not use every bit of material for interpretation but that I store these up for use at the right moment and content myself for the present with making preparation

for meeting the dependence that is coming up. This will be very painful for the patient and she knows it, and a risk of suicide goes with it, but as she says, there is no other way. There is another way, for if her analyst is not able to meet her dependence so that the regression becomes a therapeutic experience she will break down into psychosomatic illness, which produces the much-needed nursing but not the insight or the mental care that can really make a difference.

By looking at this bit of material in this way we reach a point where we are discussing both analysis and the meeting of dependence needs. For if a good interpretation worked now it would produce anger or excitement and it is not yet possible for this patient to dealwith these all-out emotional experiences.

In the course of a talk in which we made plans for the future and discussed the nature of her illness and the risks that are inherent in going on with the treatment I said: "So here is yourself ill, and we can see that the physical illness hides an extreme reaction to my going away, although you are not able to reach to a direct awareness of this. So you could say that I have caused your illness, just as others have caused you to be ill when you were a baby, and you could be angry." She said: "But I'm not." (Actually she holds me in an idealised position at present, and tends to find doctors of the body to be persecutors.)

So I said: "The path is there wide open for your hatred and anger, but anger refuses to walk down the path." This was about her level of understanding which is intellectual and slightly bemused, and it sufficed.

This patient said to me that the thing that made her get ill so quickly was my waiting for the evolution of the analytic process and, in other words, not rushing in with interpretations at the first moment of my seeing the unconscious meaning of her dreams and free associations.

So this patient will be very dependent on me. The hope is for her sake as well as mine that this dependence will be kept to the confines of the transference and the analytic sessions.But how can we tell in advance?

Now all this introduction is to give me the chance to link up this that we do in psycho-analysis with the way parents meet the needs of child and mothers meet those of babies. Psycho-analysis was concerned for several decades with treatment by interpretation of the material verbally presented, and analysts took for granted the setting of the analysis and the analyst's obedience to the professional rules that they voluntarily adopted. In this way psycho-analytic theory waw interesting but relatively useless to parents, to teachers and to social workers.

Then psycho-analysis began to concern itself also with the non-verbal communications of the patient and with the analyst's non-verbal provisions - like being punctual, and not saying when a patient gives a dream: "I had one myself last night, about a drowning dog." Now this aspect of psycho-analysis which takes especially into account the ego organisation and the ego strength of the patient very much concerns parents, teachers, and social workers. This aspect of our work is not just interesting to them like the Oedipus complex. We must not be surprised to find that these non-analysts have much to teach us, and I want to say that those who have most to teach are unselfconscious good enough mothers and parents, who make adaptation to the needs of their babies without knowing that this is what they are supposed to do. I will choose to refer to two examples of child care that illustrate my meaning, and also I will make a passing reference to adolescence.

First I choose to talk about the phases of spoiling which parents find one child needs from time to time ~~to~~ and which brings many a child through without any doctor or any child guidance clinic having been needed at all. It is difficult to describe this without making it sound rare, but it is a matter of the experience of any parents who care for their own children. It simply happens that for a few hours or days or in a special context a child is treated as if younger emotionally

than is in fact the truth chronologically. Sometimes it happens when a child bangs his head or cuts his finger; he goes in a second from 4 to 2 and is screaming and consoling himself with his head in his mother's lap. Then in no time, or after a sleep, he is again very grownup and more so than his own age warrants.

Here is a boy of 2. He reacted very badly at 20 months to the mother's anxiety which she experienced when she conceived. This is part of her pattern. He stopped using the pot and stopped using words, and his forward progress was held up. When the baby was born he was not hostile to the baby but he wanted to be bathed like the baby. At breast-feeding times he started up thumb-sucking which had not been a feature previously. He made special claims on the parents' indulgence, needing to sleep in their bed for many months. His speaking was delayed.

The parents met all these changes and demands in a satisfactory way, but the neighbours said that they were spoiling the boy. Eventually he emerged from his regression or withdrawal and the parents were able to finish with spoiling him when he was 8 years old, after he had had a bout of stealing money from them. *

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* Case written up, to be published in The British Journal of Medical Psychology, along with Anna Freud's "Regression".

This is a common type of case in child psychiatry as I know it, especially in private practice when children are brought for symptoms that some might consider to be insignificant. It has been an important part of my education to recognise that in such a case one does not immediately think of psycho-analysis, one thinks of supporting these parents in their management of their child's babyishness. One can give psycho-analytic help, while the parents are carrying out the mental nursing of the patient, but it is a formidable matter to treat such a case by psycho-analysis if there is not a parental provision that will meet the mental nursing needs. Without the parents' mental nursing the psycho-analyst doing psycho-analysis must find the patient not only dreaming of being taken over by the analyst and into his or herhome, but also actually needing to be taken in. Occasionally I have known a child to be taken into a therapist's home and successfully treated there by analysis, but usually the psycho-analytic treatment which is reported as going well breaks down because of failure of parental support. The fact is that the first thing the analyst must provide, if he is to do analysis in such a case, is parental support or a substitute for this. And if a foster parent or a hostel for difficult children is found, then there comes into the picture a tug-o-war between the fosterparents (or hostel staff) and the analyst, each working on the basis that it is this and not that that is producing the cure. In fact, each approach is necessary

to the other.

A corollary of this is that when an orthodox psycho-analysis of a child is successful, there is an acknowledgement to be made by the psycho-analyst that the parents' home, relations, helpers, friends, etc., did nearly half the treatment. We do not have to make these acknowledgements out loud, but we need to be honest about these matters of the patient's dependence when we are theory-building.

Secondly I want to draw your attention to the part the mother plays at the time of her baby's very great dependence at the beginning. Although I believe you are fully aware of these matters I wish to go over the argument again, so that it can be discussed. It is not that the baby will die. Paediatrics does not allow that, and in any case babies do not die very easily.

What I am trying to describe is the very special relationship that exists between the baby and the mother in the early stages. Many writers have dealt with this subject, and yet I feel there is room for increased understanding, we need to understand because it really is true that if we are to treat schizophrenia we must be able to correct these very early failures and management. Is it not strange that the psychoses, in which the emotional development of the individual is disturbed at the deepest layers, turns out to be closely related to environmental

failure, failure of the environmental provision that facilitates natural growth processes. By contrast, the psychoneuroses turn out to be principally dependent on intrapsychic mechaniams and in their etiology relatively unlinked to the bad environmental factor.

Many terms employed are in description of the infant-mother relationship. One is symbiosis, but surely this psychological use of a biological term is unsatisfactory. The mother's part in this relationship has to be described in terms of the relatively sophisticated personality which is hers. She retains her own personality and her own hold on life, but she hands over the management of external world to her man, or to someone, and herself becomes preoccupied with the baby, and in fact attains a high degree of identification with the baby. This makes her vulnerable, but the phase only lasts a few months, before the baby's birth and after it, and gradually the mother returns to the state she was in before she conceived.

The baby's story is not a bit like this. Sophisticated language is out of place. The unformed or weakly formed ego of the infant gets reinforcement from the mother's ego, because of the mother's adaptation to the baby's needs, which the mother is able to make because of her surrender to an identification with the baby. The baby is, however, unable to do anything like identifying with the mother. That comes months later. The baby has not yet separated out the mother from the self, and in so far

as the baby does begin to relate to the mother, or a part of her, this is a relationship with a subjective object. That is to say, the relationship at first does not take the baby outside the area of what is part of the baby's self.

During this period of special dependence, the mother's special state enables the baby to deal with complexities - ambivalence for instance - till the mental mechanisms are sufficiently developed for ambivalence to be experienced and held, without dissociation of self-fragments. Good enough mothering facilitates processes of growth, and enables the child to integrate and to become a dweller in his own body, and to have a capacity for relating to objects that, eventually, are objects in a not-me world.

If I have conveyed my meaning, then it will be understood that in my opinion, mothers do either initiate mental health, or else they cause potential mental ill health according to whether they are good enough or not good enough in this matterof adaptation to need. (I am not talking here about satisfying the baby's instincts which can, it seems, get satisfactions outside the ego's capacity to accept such satisfactions as part of the self).

It is in these subtle matters of adaptation

to infant need that mothers could teach us, if they wished to do so, which they usually do not.

The reason is that if adaptation is good enough at the beginning then the baby really does experience omnipotence. From omnipotence the baby can turn the scale towards disillusionment, and an acceptance of the reality principle. If, however, the mother's adaptation is not good enough then the infant splits into two parts, a part gains a life of its own, hidden away at the centre or somewhere, while another part meets the environmental demands and also protects the hidden part. I like to say that there comes about an exaggeration of the split between a True Self at the core of the personality and a compliant False Self (as I called it) which protects the true self. In pathology the false self isolates the true self, but in health it takes over functions like those ascribed by Freud in early writings to the Ego when this was thought of as the part of the Id that is turned towards the external reality.

Returning now to the needs of borderline patients who regress to dependence, eventually they need us to know about the maternal failure in the terms I have tried to describe, and they need to be able to arrive at the memory of acute distress experienced in infancy at a moment of environmental failure, and eventually to arrive at anger appropriate to such a situation. But this is very

complex, and I have described its complexity elsewhere.

What I want to say is that in the analysis of my very early infancy, psycho-analysis can be pursued in pure form only if the patient is not psychotic. If the patient is psychotic or borderline then a stage must be arrived at where the analyst is dealing with the failures of what mothers ordinarily do well without even knowing what they are doing.