

A case discussion: The psychoanalytic psychotherapy of a mentally retarded man.

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A case discussion: The psychoanalytic psychotherapy of a mentally retarded man.

In this paper, the author discusses the psychoanalytically informed treatment of a 25-year-old patient, who was, at the beginning of treatment, severely developmentally retarded. The patient showed repetitive behaviors (tapping his fingers, tying and retying his shoe laces); visual and auditory hallucinations, delusions, vague to absent ego boundaries; inability to do simple math, tell time, read, or write; and angry vulgar outbursts accompanied by occasional throwing of objects. He was bewildering and unresponsive to various psychological and physical treatments that had been performed since his infancy. The patient had been examined by a variety of medical and psychological specialists, but he seemed to belong in no particular place in the system of health care providers. All drug regimens that were tried proved ineffective. This author presents clinical material taken from a psychoanalytic psychotherapy that resulted in remarkable improvement in the patient's capacity for self-reflective thought as well as his capacities for more mature object relationships and work. More specifically, the author discusses aspects of the treatment he thinks were most pivotal: (1) The interpretation of sensation (autistic) states; (2) The use of countertransference derived understandings of the patient's intra and intersubjective experiences to guide his interventions; (3) The use of sensation based communication in a verbal form of play.

Playing: A Theoretical Statement

...my work, which is largely psychoanalysis, also includes psychotherapy, and for purposes of this chapter I do not need to draw a clear distinction between the uses of the two terms ...When I come to state my thesis I find, as so often, that it is very simple, and

that not many words are needed to cover the subject. Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist.

Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play.

D. W. Winnicott (1971, p.38)

Introduction

It has been my good fortune to have met and treated a patient whose parents had been attempting to get help for him for many years but without success. He presented such a complex clinical picture that he was not treated as a result of a lack of recognition of his dis-ease. I am writing this after the fact, in an attempt to explain remarkable treatment results in a patient who had life-long severe disabilities. I, of course, do not know with certainty, which aspects of the psychotherapy were of greater importance; I do have some thoughts on the matter that I will discuss as the description of treatment unfolds.

In the first section of the paper, I describe how the patient appeared to me when I first met him. I will then describe his current psychological and interpersonal states (four years later). Finally, I will illustrate the varying ways in which we talked and were silent together and some of my ideas of the effects of these interactions. Before I begin, several concepts and theories should be presented to indicate what helped me in my work with this patient.

Many mentally retarded patients have shown varying degrees of maturational improvement when treated in a modified psychoanalytic manner (cf. Fromm-Reichmann, 1947;

Pailthorpe, 1929; Smith, 1976). Liss (1953) reports the use of pseudoretardation as a neurotic character defense in children and Ogden (1994b) describes a physician patient of his who, as a child, pretended not to be able to read through the third grade in an unconscious effort to forever remain her father's little girl. The patient referred to this as her "pseudo mental retardation." My patient seems to have chronically underutilized his cognitive, kinesthetic, and motor capacities; all of which were significantly enhanced in the course of the therapy. As will be discussed, the degree of organic cognitive limitation is very difficult to determine and very difficult to distinguish from the effects of psychological conflict.

I would like to emphasize that this patient required that I follow him into areas of human experience that were previously unknown to me. I had to be my own guide, but I took with me ideas from the psychoanalytic literature, which proved helpful in gaining my bearings. No single idea or set of ideas adequately describes what I encountered, but together they were of help in developing my own ways of perceiving, experiencing and thinking about what was occurring.

Theoretical Background

Ogden (1989) describes an autistic-contiguous mode of generating human experience which he suggests exists in a dialectical tension with the paranoid-schizoid and depressive modes described by Melanie Klein (1958).^[i] This concept enabled me to understand and hold steady during the trying silence of the first phase of treatment. The autistic-contiguous mode of experience is characterized by the non-symbolic sensation-dominated realm of relating to "mere phenomena based on body experiences, these being scarcely influenced by an objectively perceived world." (Winnicott, 1963 p. 183). I found these notions to be clarifying for myself in what was going on in the analytic relationship and in the shaping of interpretations of primitive

psychological states (cf. Kilchenstein and Schuerholz, 1995; Kilchenstein, 1998). The initial work, in this case, was undertaken with a nearly silent patient hardly capable of verbal expression of thoughts or feelings. The focus of the early phase of treatment was on helping the patient to develop the (potential) space, which is normally created by the mother and infant, in which the patient/infant generates the “matrix of the mind” (Ogden, 1986, pp. 1-8). Donald Winnicott’s (1967) concept of potential space suggests a location where the infant, in a non self-reflective way, “begins to be”(p.98). This space is not an intrapsychic space at the start since the infant has just begun to form a sensory perimeter (Bick, 1968, 1986; Mitrani, 1994) and lacks any “awareness” of inside or outside. The “potential space” described by Winnicott is an interpersonal space created and negated over and over by the fusion and abruption of the mother/infant unified dyad. In this space, the infant develops bodily awareness, a sense of “me” and “not me”, mental contents, structures and functions. The further elaboration of these events (in the later part of the treatment) includes symbolization, thinking, interpersonal relatedness and the capacity for distinguishing between affects and (with the birth of an historical subject) a sense of time. Ogden (1994a) adds to these ideas by suggesting that the analyst and analysand together create a “third” subject, which is the subject of analysis. This concept of the “analytic third” offers a model, which I understood to support fully the play I found necessary to create aliveness and connection in the therapeutic setting.

The use of language is a central problem in treating a patient of any age or degree of maturity (Balint 1968 pp. 92-116). It was important not to lead the patient into an imitation of the jargon of psychoanalysis, but rather, to allow him to develop a voice of his own. The patient used standard phrases almost exclusively as a means to relate. This form of imitative behavior had become entrenched and was rewarded as a form of compliance. I needed to invite B into a

form of relatedness that he could feel was his own creation and that reflected his own thoughts and feelings. Other forms of his imitative use of me (e.g., his growing a beard like mine.) took place as a precursor to identification and introjection (cf. Gaddini's 1969 discussion of "fantasy in the body"). I attempted to stay close to the language of the patient, while speaking with my own voices and from my role as therapist.

Section I

History and presenting scene

B, a 25-year-old single man, was brought to my office by his parents. Dr. O, the patient's neighbor, had become friends with B's parents and had come to like the patient. Dr. O could not understand the medical treatment that B was getting, nor did he agree with the diagnoses that had been offered (learning disorder and temporal lobe seizures). The patient had been in the care of neurologists for years and was being medically treated for atypical seizures. Dr. O took it upon himself to find a consultant for B and ultimately contacted me. I agreed to see the patient. During the seventy five-mile ride with his parents from his home to my office (over 90 minutes each way) the patient screamed a seemingly endless list of obscenities. He kept hitting the interior of the car and windshield so violently that his parents were convinced that they could never bring him again. I met them at the door and his parents introduced themselves. His mother then turned to B and said, "B, this is Dr. Kilchenstein." B replied, "Fuck him, he's a dumb jerk anyhow." I felt that B's introducing himself to me in this way reflected both low expectations of what he felt might come from meeting another doctor and his fear of a doctor who met him at his front door and who might provide a new and unknown form of relationship.

During the initial consultation the patient cried and apologized for his behavior. His mother, Mrs. S. (both of the parents were present during this meeting.) went to him and started to pet his head saying, “Don’t cry.” I asked why she pet him like a wounded animal and did not let him cry. She responded that her mother also said that she always did too much for B. She was then able to tell me that she could not bear to see or even imagine him in pain. She feels compelled to do something to relieve him from discomfort at once. She confessed that she even tries to protect B in situations where B feels no need to be protected by her.

B could not read or write or count. It would be an exaggeration to say that he could speak since he only used phrases that were standard imitative vernacular. (E.g., Fuck him, he’s a dumb jerk, etc). He was only responsive to questions with yes or no answers and got by with cliché greetings and social proprieties. He could not maintain a conversation. He lived with his parents and they felt it was unsafe to leave him at home by himself. When he was left alone he called 911 (the only number he could dial) to be rescued from his terror and rage. B had recently become more of a behavior problem and on two occasions in the preceding six months, he was hospitalized in a psychiatric unit for violent psychotic outbursts. When B was troubled by the effects on him of large social gathering he would attempt to create the experience of a defensive perimeter (a “second skin” [Bick, 1968, 1986]) by outbursts that would demarcate and alienate him from the rest of the group. Mrs. S said, “Until this last year, B was the nicest kid you could ever want.”

B had been diagnosed as “Mildly Mentally Retarded” throughout his school records. He had been seen by psychologists, neurologists and numerous educational and health care specialists every year since infancy. Each educational consultant commented on how cooperative and eager to learn the patient seemed, and yet, for unknown reasons, was unable to

learn. The file B's mother gave to me of tests done by psychologists, neurologists and school specialists was 2.5 inches thick. His I.Q. ranged from 45-66. Two psychologists commented on B's quiet refusal (belligerence?) to perform tasks during testing. One examiner insisted that he do the tasks or they would not leave the table. B immediately set out to perform the tasks and got 20 points higher on the final score than on other tests. His test scores were low and variable but he functioned higher in social interchange especially when standard language was called for (e.g. during greetings and partings). All of the testers said in their subjective reports that he seemed "bright". I understood him, from my impressions, to more accurately be labeled as alert, responsive, and engaging with quick up-beat phrases when he was not angry or physically sick. From three years of age, neurologists noted that he lagged in verbal abilities, drooled, was clumsy and shifted from left to right-handedness during the first four years of life. Later, neurologists diagnosed him as having temporal lobe epilepsy on the basis of his temper tantrums, hitting other children when he was frustrated, locking his mother out of the house, resistance to accepting instructions, and other social unpredictability. There were no psychiatric evaluations prior to his hospitalizations six months before he first consulted me. The psychiatrists at the prestigious major University Hospital offered diagnostic labels including schizophrenia, manic-depressive, mental retardation, autism and temporal lobe epilepsy (The patient's EEG is normal.). When I first saw him he was taking Haldol (his drooling returned on this drug), Lithium and Tegretal. At that time, he was being followed by a neurologist. The diagnosis I developed as I worked with B is pervasive developmental disorder.

His sense of humor was slow to emerge in the treatment situation but when he came to be more alive he was quite able to appreciate my humor and playfulness. B's ability to sometimes understand complex interpersonal situations became apparent to me, but it was I who had to put

the issues into words. Once an event or object was worded, he could respond verbally (usually monosyllabically) indicating his agreement or his disagreement. These responses were accompanied by a limited range of affects and facial expressiveness, but even fewer verbal phrases. He was unable to name his feelings when I would ask how he felt when he appeared to be experiencing painful feelings. At home, he would have outbursts of rage, banging the wall or table with his hand, throwing things and screaming obscenities. B could not identify or express verbally who or what troubled him: rather, he would convulsively explode with expletives calling everyone an asshole or faggot. Sometimes he would half-heartedly hit his mother or father or slap at a book or newspaper held in their hands when he felt irritated. When overwhelmed with anger, he would project the feeling in a paranoid fashion. For example, his mother gave B's coffee cup to his brother to take home without asking B's permission. B said nothing at the time, but minutes later the devil appeared to him on the ceiling of his room, telling him not to listen to or talk to "those people anymore." The patient made no connection between the events of the evening and his hallucination.

Before treatment, he had severe spatial disorientation and very poor muscle coordination. For example, he would struggle to put on his coat, unable to discern what was keeping him from putting it on. With little or no sense of inside and out, left or right, he could not put on a jacket and would require help in doing so. When anxious, he walked in an exaggerated slow motion, actually watching every step that he took in order not to fall down. Often, he would be in obvious distress as exhibited in mood or facial expression and, after a few days, would be found to have a throat or ear infection.

The patient's family was very active and supportive in their church. B was taken to the church several days a week, where he would help with janitorial tasks and yard work. This "job"

was a recent development at the start of the analysis, and there was quite a bit of enthusiasm on the parent's part about it. The arrangement seemed, to me, to be more like babysitting than an actual job.

Section II

Over the first four years of treatment, B learned to read at a second to third grade level and developed a conversational ability much more appropriate for his age. Gradually, B was able to begin to separate and individuate from his parents. For the first two years, his mother and father took turns bringing him to my office. The patient had to be physically restrained by his father while the patient's mother drove them to the initial meeting. Since then, two years and 9 months ago, a man whom the parents hired has brought B to both visits each week.

Arrangements were made for him to move into a home of his own. The original living situation resembled a halfway house. B and another emotionally disturbed man lived with a young married couple. After the first year the house parents and the other disabled man left, and B then shared the house with a graduate student. B occasionally took meals with the student but, for the most part, the two lived very separate lives. B now lives alone and enjoys the separateness from his family and others. He cares for himself and the house in a very satisfactory and personal style. He cooks (simply), cleans and shops for himself. Concurrent with the gradual evolution of his autonomy, B joined a discussion group at church and has attended parties and gone to dinner with members of the group.

The job at church grew boring, and B began to work in his father's company. For two years, he assisted his father's truck driver in making deliveries. With the passing of time, B had increasingly frequent outbursts of swearing and hitting his fist against objects at work. The anger was directed at the entire work group and would often occur after his father left for the day

and did not take B with him. After a particularly intense instance of this sequence of events, I was able to convince the parents to discontinue B's job. The patient then took his present job at a major food store close enough to his home that he can walk to and from work. He now sees his parents mainly on weekends and holidays and calls his mother no more often than his siblings do. He has been well received at work and has been given increasing levels of responsibility. He loves his job and has not had a single rage reaction in the eight months of his employment. He is now able to think about and even anticipate difficulties. He makes frequent changes in his schedule to accommodate his coworkers' or manager's needs; these involve multiple telephone calls and executive functioning, which he had never before been able to manage successfully. He is able to protect himself from rage. For example, his sister recently called him to ask if she could stay with him when she was in town on business. B quickly welcomed her but added that if she was going to wash her hair she should buy some shampoo for herself since he only had a little left for himself. He is self-confident in social interactions and even-tempered in the face of hostile customers. His behavior and conversation with his family and at large social functions have never been so enjoyable and gracious. His sense of humor is delightful (He helped a woman carry a huge turkey to her car and jokingly warned her not to eat the turkey all at once). After not seeing his mother for several weeks he recently said, "I haven't seen you lately mom, how are you doing, tell me about yourself."

Simultaneous to these developments the patient became more sure of himself as a physical being. During the first and second year of our work together, I could tell if he was in distress from his way of walking. When he did not feel well, he would watch himself walk, slowly lifting and placing his feet carefully from one step to the next. This would be most pronounced when he was physically ill, or when I was about to leave for a vacation. This

behavior has disappeared with the gradual development of his confidence in all areas of his life. He now walks faster and more gracefully; he can locate his arms and legs spatially in a way that allows him to dress without confusion. B can also verbally label and report physical pain or illness when it occurs.

Section III

The treatment experience

I was very interested in B and agreed to see him twice a week face-to-face and to speak on the telephone once a week with his parents. I hypothesized that a vicious cycle had been set in motion between B and his parents. In light of his mild neurologic impairment, professionals had advised that not much could be expected of B, and the parents, therefore, did things for him that they had not done for their older children. B responded by not progressing in ways that he may well have been capable of, letting his parents do things for him. My “counseling” of the parents consisted of interrupting this cycle by direct suggestions (e.g. do not shave him, do not cook for him, let him walk to and from work even in the rain) and encouraging reassurance (e.g. “Think of your pain [from seeing B frustrated] as labor pain from which you will be rewarded with a grown son”). All medications were tapered and discontinued over the initial months of the therapy. At the times of his severe rage reactions, he would use resperidone (1 mg at bedtime) for a day or two. B has not needed any medication since he started his current job.

The treatment can be divided into three general types of interaction, which I will present by offering brief verbatim fragments of interest from the sessions. In this way, it may be possible for the reader to gain a sense of what our interaction felt like. First, I will describe the silent sessions that went on for months. Second, I will focus on the intermeshed autistic and psychotic states that were experienced by the patient along with my attempts to suggest a

meaning for his utterances and silences at a sensory level. Third, I will illustrate the sensation dominated verbal play that occurred during a period when B was able to make dramatic progress in his life.

The first part of the treatment took place mostly in silence. The patient often slept through the latter part of the session. It was clear that he identified both himself and me with my dog Luke, who regularly lay quietly on the floor of the consulting room through the day. He often came into the office saying hello to the dog but not a word to me. I understood this to indicate several things. First, it seemed to me that the dog was only another form of me and that, since he said hello to Luke, he felt no need to say hello to me. It would be like saying hello twice. Second, he was identified with the dog and alienated from humans who have treated him as a pet throughout his life.

Throughout these early months, in response to his mother asking, "How was your session with Dr K. today?" B would say, "Real good." or "Dr. K was funny today." These comments were hardly elaborate enough for a man in his third decade of life. Many of the sessions were spent in almost complete silence, yet his mother's report to me, of his simple good/bad description of the type of connection and experience he had with me during a particular session, would closely correspond to my own inner experience of the session. I could only infer that our unconscious intersubjective connection was in harmony, that we were in some way enjoying one another without the mediation of verbal interchange.

The following is an example of the way in which the countertransference was used to catch the drift of major internal events of the session. (While this use of the countertransference was often a slow process, it was critical to the treatment.) During the course of the verbally silent first year of treatment the patient bought several watches. His mother said he liked to

collect watches as did his grandfather. I began to think about a watch that I had ruined by getting salt water into the movement. A strong feeling grew in me to have that watch repaired, which I did. Some years before, I had given up on the watch along with another aspect of my life that I had valued, specifically, a relationship with a friend who seemed to have sunk into himself and lost interest in the world and other people. It was clear to me that the transformational experience of working together with this patient was affecting both of us. He was being born into the middle of his life (a very strange experience) while I was inspired so by his willingness to take up the task of living that I put myself into the relationship fully. I spoke to the patient about this or perhaps more accurately, from this experience:

“I was thinking about your interest in time and watches, and while I was doing that I thought of an old watch of mine. I had given up on it, and then, for some reason perhaps having to do with you, I decided to get it fixed and see what it felt like having this watch at this point in my life. The patient did not reply but looked at me with a somewhat curious expression and then smiled with a hint of a blush.

In the initial two years of therapy, most of my interpretations were addressed to sensory experiences. For example, I said to him that it appeared to me that when he was worrying about something, he seemed to have to walk very slowly while watching every step, as if he were shaking inside. He responded that he did feel that way and had to be careful not to break anything [or himself].

I sensed that my comments about his sensory experience provided a means of communicating, not communicating, organizing experience, and furthering the relationship. I was thinking in this phase of the work of Tustin's (1980, 1984) and Ogden's (1989) work on autistic sensory experience and Winnicott's (1963) work on the importance of privacy. All three

of these analysts emphasize the importance of the freedom not to communicate. Given what I was conceptualizing as an autistic matrix and sensation dominated experience, I attempted to speak with B in his language perhaps only a few days or weeks ahead of where he was developmentally, as a mother speaks slightly ahead of her infant's speech development.

I made repeated, but tentative, efforts to introduce verbal relatedness, all of which were met with polite one-line answers by the patient.

What did you do over the weekend? "I don't know."

What's on your mind today? "Nothing."

How did you enjoy your vacation? "Real good."

What is it like being here with me today. "Real good."

His answer to my question "What are you thinking" was "Nothing." He told me that he has only a few words going on in his head but that he feels all the time. In my work with him, I have had to remind myself of this lest I enter a symbolic soliloquy, which would only underscore how little I understood him at that time. The material, which follows, illustrates the sensation-grounded, unsymbolized nature of the interactions. The flatness of B's atemporal and largely non-verbal world is shown by the lack of subjective interpretive activity.

LONG SILENCE

K: So what do you think?

B: All right, I think the weather's good.

K: You think the weather's good, huh?

LONG SILENCE

K: What does it feel like to be here today?

B: Feels good.

K: It feels good to me too. You must work out most all your problems inside, on your own.

B: Yeah?

K: Cause you don't talk about them much here.

B: I don't?

K: No. You don't talk about problems very much. You think about them I think.

B: How?

K: How? Well, since you don't talk about them much I can't tell much about how you think.

B: You can't?

K: It goes on inside. It's not something I can hear unless you speak it. I can tell, sort of, whether you're in a good mood or bad mood by how you look and how you walk and how you sit and how you breathe but I can't tell what's on your mind without your telling me.

B: You can't?

K: No, I can just guess.

LONG SILENCE

This is an example of an early session. The entire time would have been spent in silence if it were not for the "interruptions" that I have just described. If I could relive this period of the work with B, I would attempt to speak to him in a way that is less prodding and more understanding of the importance to him of remaining a separate person by keeping me in the dark about what goes on in his mind.

The beginnings of symbolic activity

The patient came in and I said, "Hello." He did not answer. He sat down, several minutes passed. The patient said, "Hot out today." This was the first time in the 21 months of

therapy that the patient spontaneously started a session. I was excited, but not surprised by this event in that this development had been adumbrated by the fact that for some time he seemed to have begun to speak with a voice that was less filled with echolalia or timeless reporting of events. Ten minutes later, I asked, "How do you feel today?" (He had a sore throat at the time of the last session.) He answered, "I don't feel anything."

K: Do you feel something when you feel OK?

B: No.

K: Do you feel something when you feel bad?

B: Yes. Aren't you that way?

K: Well, bad feelings do feel different from good feelings. Bad feelings feel heavier, and they press on me, while good feelings are lighter, like air and hold me up the way water in the ocean does.

B: Yeah!

During the silence that followed, I was (more consciously) thinking of his infancy. While his mother held him during his infancy, she cried and was in emotional pain nearly all of the time according to her account. B was born during a "terrible period" in his mother's life (There was a painful estrangement between her and B's father.). I imagined that he was accustomed to intense affect of a painful nature and may have felt a relative void when not experiencing pain himself or in the person caring for him. This could still be the case and may contribute to the vacuum he seemed to live in most of the time. I was not conscious of the fact that my metaphor of being held up by ocean water was an allusion to the good feeling of being securely held in one's mother's arms or in her womb. Nonetheless, that level of meaning was central to what was being communicated. I was gentle, quiet, and very mindful of his fragility. My behavior was

influenced by my realization that he was being shaped by the look on my face, the sound of my voice, and the ambience of the room. He was not a typical 25-year-old. I was particularly careful not to draw the patient prematurely into words, which would feel fake and imitative to both of us.

Given the sensory dominated quality of the patient's experiential world, I had to speak to him, be silent with him and relate to him actively. By this, I mean gestures, smiles, shown concern, statements that maintained the frame of treatment, etc. B could not think in sentences and very little in words. He was feeling his way through life. I asked him if it was better for our work together if we talked or sat in silence. He quickly replied that silence was better. I continuously indicated my interest in his mental and emotional life and respect for his opinion. My belief that his mind worked had a very powerful and encouraging effect. He reported, with excitement, to his mother: "Dr. K thinks I am smart enough to learn to read." At the same time, I understood his need to remain in a world without words. An abrupt demand for a verbally mediated connection between us would feel as if I were literally tearing the two of us apart, like a nipple being torn out of an infant's mouth taking with it all the skin of the inside of the mouth. (I was thinking here of Tustin's [1990] description of the autistic child experiencing separation.) This silent, sensation dominated posture served to remind me of the fragility of his symbolizing abilities.

Throughout this period of silent sessions, I was given weekly reports from the parents (usually the mother) of "amazing changes for the better." Mrs. S could not understand the improvement as "having earthly origins." She felt that it was the work of God. I discussed with her the need to give B credit for the progress and that it was not God, her, or myself who could

take credit for what he does. I was attempting, in a non-judgmental way, to interpret her anxiety about B's developing a separate life.

On numerous occasions in the first year, B became lethargic, irritable and was apparently in pain. He was unable to tell anyone what it was that was bothering him. At these times I suspected that he was physically ill and recommended that he see the family doctor for an examination. Each time he was found to have a throat or an ear infection. He quickly recovered his usual temperament when treated for the infection. These events forced me to remember that, in many ways, despite his age and social abilities, he was still like an infant and could not be relied upon to adequately inform his doctor or his family of his needs.

Two factors, also, had very positive effects on B. First, I never felt any doubt about our being able to create a good outcome in our work together. I was very impressed by his willingness to ride 150 miles for each session given that his parents had told me that he does not like to ride in cars. The patient also verbalized his desire to see me, a complete turnaround from his prior attitude about seeing a psychiatrist. Second, I quickly came to view B as having far more capability than had ever been suggested to him before.

The dawn of symbolization and imagination

Although the playfulness had begun in the first year, I realized suddenly that we had become more playful and imaginative in our conversations during the second half of the second year. Often, the talk was about the animals (my two cats, that he would often see in the hall outside the office and Luke, who was often lying in my office) and my relationship to them, their relationship to one another and how my wife fit in. He created a family, far more in sensation than in imagination, consisting of himself, my household and me. His experience of Luke, my

dog, for example, was of a soft warm shape more than as a character with a history and personality.^[iii] I talked with B very much in the way he talked but I would insert other phrases that suggested meanings that were not so sensation dominated. For example, the patient said, “Luke got a haircut.” I responded, “No he didn’t, but he sure needs one.” This is an example of a sensation based form of communication (his inner response to what he sees and to the tactile quality of what he sees). We spoke in what sounded like very concrete, mundane, non-analytic ways. In this interaction I remained with the sensation based comment about the dog’s (meaning the patient’s or my) state of softness or bristliness while challenging his magical equating of the B’s wish for the haircut (a harder or more orderly state) being the same as having a haircut. I am attempting to delineate what an interpretation in a world of surfaces, temperatures, textures, loudness, etc. sounds like.

In the forward and backward movement of B’s willingness to be out on a limb, the following conversation represented a leap, as well as a slight falling slightly backward, in the development of separation. He asked, “Will Luke get married?” I responded, “What would you advise him to do?” “Stay single”, B said. Then he asked, “What would you tell him?” I answered, “If he asked me, I’d tell him not to marry unless he loved the dog.” All of this was accompanied with laughter, and B went on to say “women will bring you nothin’ but trouble.” Repeatedly, I allowed myself to become a party to the creation of a make-believe world that was the first verbal manifestations of the patient’s capacity to play. The above interaction illustrates his progression in complexity of mental activity over the first years of treatment.

Six months later:

The following interaction was very playful with laughter.

K: I am going to take off a few days in the beginning of June.

B: Why? Where you goin'?

K: Where do you think I'd like to go?

B: Maine.

K: Maine, huh? Chilly up there in June. That's an August place.

B: Buffalo.

K: Buffalo- I've never been to Buffalo. That's a rainy, snowy place.

B: California.

K: That's the place.

B: Dallas.

K: California.

B: Yellowstone.

K: Are these all places you'd like to go yourself?

B: Yeah. Does Luke like to go?

K: He's never been to those places.

B: Luke and Max [my cat] are asleep. [I understood this to refer to different aspects of himself not yet alive and awake.]

Still later:

The following was accompanied by laughter throughout and is typical of what I am thinking of as verbal play.

B: I ate a biscuit. Sausage biscuit.

K: Sausage biscuit.

B: That's right, you didn't have anything did you? Squash?

K: CHUCKLE Squash for breakfast?

B: How about bananas. [He is smiling.]

K: Fried bananas with ice cream.

B: Or you could throw them in the microwave.

K: Did you put your banana in the microwave yet?

B: I...[laughing so hard he is tearing. I am laughing just as hard.]

K: You didn't microwave your bananas?

B: At home, she does.

K: Who? - Your mom?

B: No.

K: She - who's she?

B: My sister - she does it. She fries bananas in the microwave.

K: She fries bananas in the microwave!?

B: Browns it with brown sugar on top.

K: And she puts that in the microwave?

B: Well--does it matter?

I asked B if he remembered what we talked about in the previous session. He said, "No." I then, for some reason, asked, "Do you know what remember means?" He said, "No." I was ashamed that I had not realized I was not speaking timelessly [in his way]. My discovery that I used a word that he could not make use of required me to illustrate the experience itself. I gave examples of remembering and forgetting, which he seemed to understand, and the session turned out to be pleasurable for both of us. I could see that much was explained for him,

something fundamentally important fell into place, with just a few sentences. Great pleasure showed on his face as he rolled my words over in his mind. I was introducing symbols. Words were being given to him, and he was able to learn in a way that he had previously been unable to do in the world of verbal symbols. He was learning the enormous power of words to make sense of an experience for himself and to allow him to generate ideas about what was going on, to gain his bearings and not to feel beat about by the concreteness of things-in-themselves being hurled at him.

The next session he came in and said to the dog, “Hi Luke. Are you the same dog?” I understood this to reflect his “remembering” and of telling me that he no longer felt himself to be the same person he was before he learned to use verbal symbols. He then addressed me, “Use your bathroom?” He kept on walking toward the bathroom not needing an answer. I responded, “Sure.” When he returned to take his seat he announced, “I had feelings when I left here the other day. I got angry. Bad feelings.” I asked, “What were they about?” “I got angry in the car over Mitchell Bland’s funeral. They buried him yesterday.” “When did you start to feel the feelings?” “When I was leaving here.” I suggested, “Maybe my stopping the session made you mad.” “You didn’t do anything wrong, why would it make me angry?” I said, “We were having fun and I said our time is up for today. And you got up and left and felt angry even before you got to the car.” “That is true. Why does it do that?” I ignored his use of the impersonal as too complex to address and went on at his level, “We were having fun then, boom, it’s over.” He then said, “That could be what made me angry. Use your bath room again.” [I noticed that he, again, dropped the pronoun and I inferred that his fear of hurting me with his anger had led him to seek out the safety of a magical psychological (anal) state in which damage could be

seamlessly undone (flushing).] When he returned he said, with some force, “Our session is not over, it will be a long ways before you tell me it’s time.” I responded, “Seven minutes.”

In this session, there was a powerful sense of the patient innocently trusting me as a holding, attentive transference mother. I was in the position of a mother offering the patient names for the elements of his experience in order that he might use these names in his efforts to locate himself and assemble the sequence of events that make up his inner subjective life. I was telling him that what he felt could be named and connected to particular events. This is the equivalent of a mother, while lifting her baby, uttering a “Whooopsie baby” with the attendant soft music, saying “That’s all right” when her baby is crying after being startled by a loud noise. Mrs. S is convinced that B’s problems were caused by her continual efforts to protect him from frustration and pain, which resulted in her doing too much for him. When a frustrating moment occurs, she now says, “B, that is all part of being an adult.” She supports and advises but no longer protects him from having an experience.

My experience of the work with B is exciting and also hard to believe. It is as if I am teaching a formerly retarded person who somehow has had his mind become available to him for the first time or a jungle boy or Helen Keller who had enormous nonverbal intelligence but who, before Annie Sullivan taught her, never had thought or spoken in words. Trying to be mindful that B has almost no temporal awareness was a recurring difficulty for me, since my “reverie experience” (Bion, 1962) is not as free from temporal concerns as his. This separates me from him and sometimes leads me to say things that are off the mark.

B planned to introduce me to his brother, and during the week before his brother was to accompany him to my office, the patient said that he did not want Johnny to come into the office. He suggested that it would be best if I went outside to meet him. I understood this to

mean that his brother's entry into my office would feel like too much of an intrusion for B given the state of his barely intact, newly forming sense of his perimeter (skin). The patient grew increasingly anxious about the meeting and finally told me that he did not want me to make fun of Johnny. This interaction illustrated an important new capacity to express not only fears of attack by his projected anger (e.g. B is often angered by Johnny's teasing him) but also to experience the pain of anticipated loss of a beloved person (in fantasy). He had come to trust me and love me enough to introduce me to his brother yet was aware of the possible loss to him if I should be blind to his fear that I would prefer his brother to him.

The session was remarkable in that he used longer sentences than ever before, covered more topics in a complete way, and remembered so much from our previous session. He expressed ways in which he is different from other members of his family. He said, "We are looking for another church." He frequently says "we" when referring to his mother, father and self, but as the treatment progressed, B began to be more specific and was able to draw clearer boundaries and finer distinctions. For example he said he did not have to change churches just because his mother and father did, and then added, "I am not as religious as my parents." It seemed to me possible that part of the patient's enhanced verbal and intellectual capacities represented an unconscious effort to compete with his more mature and far more verbal older brother. That capacity to dare to compete was itself an enormous accomplishment for B.

The following occurred as B was walking into the office. He began smiling as he started to tell me that I should get a new dog because Luke was old and would die soon and go to dog heaven. He then told me that a long time ago his cat had been run over by a car and was road pizza and went to cat heaven. I responded that I knew that. He, while smiling, asked how I knew. I told him that Patty (another of my cats) had told me. I added, "Patty, Luke and Max

have an airline transport company flying cats and dogs to heaven. Patty is the pilot, Luke is the copilot and Max is the navigator.” He was roaring with laughter before I could finish the first sentence and joined in the conversation with questions about how Patty had managed to buy an airplane, where she learned to fly, etc. He regularly spends parts or all of the sessions teasing me playfully about the animals. For example, “Did Luke cook your breakfast?” “Does Luke like carrots?” No. “Does he eat ochre?” No, he is a carnivore and eats meat. “Did you kick Max around the room last night”? Why would I have done that? “Does Patty answer the phone for you?” Only a cartoon cat could answer the phone. (Laughing) “Patty is sleeping somewhere. She talks on the phone to the patients when you are not here.”

The preceding illustrates the highly evolved use of imaginative play as a means of metaphorizing conflicted beliefs and feelings of sadness and loss as a means of conveying to me his desire to remain an infant forever. I said to him, “We both know the world we are describing is a mixture of craziness and not craziness, but you are comfortable in there and it’s a nice place to live while you are not sure you can make it in the regular world.”

It is a continuing challenge to gain access to the non-psychotic/ “non-retarded” part of him. He knows when I am trying to speak with him in a mature way. When he is anxious about the matter being discussed, he will fend me off with a form of laughter or nonsense that feels non-object related, that is, it feels as if he no longer is speaking to me or playing with me. He needs the option of remaining a baby. B has limited confidence and does not feel grown up in most domains. He admits to the fear that if he acts grown up consistently that he will lose everybody. His claim on everybody is that he is a helpless baby that they are stuck with no matter what.

Discussion

There has been a collusion that resulted in B remaining in an infantile state far more primitive than his actual retardation would have determined. It is not known what, if any, “actual”, “hard wired” impairments this patient suffers. Any testing of the patient at this time is felt to be certainly damaging to B’s image of himself and not of any therapeutic value.

The patient initially engaged in numerous sensory defenses, e.g. tying and retying his shoelace, walking in exaggerated slow motion, lengthy tapping of his finger against his leg. Less obvious but more crucial to the project was the period of silence: sitting in my big chair. During this phase the patient was allowed to take shape and begin to know himself as contained in his own skin. His instruction that I remain silent was understood by me as a request not to impinge upon him. During this time, I purposely would not focus on the patient by occupying myself (e.g. by reading or writing notes).^[iii] This created a place for him to experience himself as an isolate in my presence (Winnicott, 1958). He would frequently say at the end of a silent session, “Today was a really good meeting.” I would sometimes say, “I think that we are doing good work together.” He would nod and enthusiastically agree.

The establishment of boundaries and a containing skin allowed him to experience muscular coordination. This occurred in the presence of a transference “mother as environment” (me as a passive attentive presence) and was interfered with when I intruded as an active “mother as object” (Winnicott, 1963).

Interpretive work in a sensation dominated experiential world in which anxiety derives from a sense of not being intact or solid or cohesive is primarily concerned with the dangers of falling apart or leaking into empty space (Bick, 1968; Meltzer, 1968; Tustin, 1986). The goal is to provide labels (words) in which the patient can begin to contain anxiety. The very recognition

of the patient's sensory state offered relief to his sense of isolation. For example, I said to B, "You walk like you feel very shaky inside." He responded "I do." With this response, a look of relief and comfort came over him.

The enormous gap between the words to which B had access and his subjective experience resulted in a state of terrible isolation. The chasm kept him from making a connection between the past and the present, which imprisoned him in an eternal present that had no history and no imagined future. I had to provide the substructure of symbolic language for the two of us together to form a bridge, which he could use to build an integrated continuous sense of self. There developed a depth of connection between us, which reflected a complexity and sturdiness of personality that he could make use of in his efforts to loosen his infantile connections to his mother.

Concluding comments

I do not have anything approximating a full answer as to how B was able to progress in so many ways that seemed miraculous to his family, doctors and neighbors. Clearly, something happened for the good but cannot be reduced to any single event or dimension of the therapeutic relationship. There is always a mystery in the treatment of a patient (just as there is in the mothering of a child) about how a person is helped to mature. We can often only marvel over what has occurred and wonder "How did he do that?" and "What part, if any, did I have in it?"

He is very encouraged by my positive attitude about his potential and very sensitive to any hint that he may be "dumb"(See Fromm-Reichmann [1947] on her treatment of a mentally retarded young woman). Many practical life impairments have disappeared over the course of B's treatment. However, he still does not drive a car, write, do simple math, read at age level or converse in a fully adult manner. He may overcome these challenges in the future.

I believe that the combination of sensation based communication and extensive verbal play were major factors that helped enable the patient to interact with me and become aware of our existence as objects and then as subjects. At first, the treatment relationship seemed to take the shape of shadowy touches in a silent playground. Gradually we were able to create a language together that equipped the patient for more mature interactions as he became able to use his own voice in directing his life and relationships.

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^[i] The term *autistic-contiguous* mode of generating human experience, under normal conditions, constitutes the sensory part of experience. Used as a defense against the threat of dis-integration, this form of experience may take the shape of chattering endlessly, prolonged masturbation when orgasm is more of a disappointing ending than a sought after result, rocking, joyless marathon running and the like. The use of the term autistic-contiguous is to be differentiated from pathological autism just as paranoid-schizoid and depressive positions are to be differentiated from schizophrenia and major depression.

^[ii] Of course, when I am referring to sensation experience, I am viewing it as a dimension of a more complex sense of people and things that are always conglomerates of sensation concretization and symbolic imagination.

^[iii] “The guiding principle during these periods is to avoid any interference that is not absolutely necessary...” Balint (1968, p.180). “Also I often relieve my mind by writing down interpretations that I actually withhold.” Winnicott (1971, p.57)