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On Feeling and Being Felt with

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ABSTRACT

The development of feelings in early childhood is traced, with special emphasis on the mother's role during the toddler phase when she facilitates her child's transition from sensorimotoric discharge to the mental experience, ownership, and use of modulated affects. Many child analytic patients use defenses to ward off feelings, many have not even reached the developmental level of experiencing feelings. How this difficulty manifests itself, the reasons for the developmental lag, and the analytic means of helping such patients are discussed and illustrated.

WELL OVER 40 YEARS AGO, WHEN I PRESENTED THE INITIAL ANALYTIC work with my first case at Anna Freud's seminar, she focused her discussion on the contrast between the earlier need for an introductory phase and the interpretation of defenses against affects—then a recent technique—as a way of helping a child to engage in the analytic process. She attributed this helpful innovative change to the work of Bornstein. This sparked my interest in Bornstein's work and led to my lifelong appreciation of her ability to feel with her patients' most warded-off feelings, to assist them in getting in touch with them, and to use this approach, not only as an introductory device, but as the ongoing basis for the child analytic work. Her feel for Frankie's helpless littleness behind his fantasy of occupying the omnipotent throne **(Bornstein, 1949)**, or for the obsessional Sherry's love of her father, hidden under ostensible fear and anger at him **(Bornstein, 1953)**, are classics we are all familiar with. Yet, although we all value and use Bornstein's emphasis on feelings, the understanding of their development and role has been a bit of a child analytic stepchild. Thus, A.

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Freud's **(1962)**, **(1963)**, **(1965)** and Nagera's **(1963)** diagnostic profile work contains no section on affects. Likewise, analytic observational studies of toddlers have not focused on the development of feelings. Even Greenspan's **(1989)** recent work on early communication does not include this aspect.

There have been some notable exceptions. Two of these have been especially helpful to me. The first is A.

1. Katan's **(1961)** deceptively brief "Some Thoughts about the Role of Verbalization in Early Childhood," a classic in its own right. A. Katan stresses the importance of a mother helping her toddler to name feelings and express them in words. She points out that this developmental step not only channels motoric into verbal discharge and hence behavioral control, but has a pronounced effect on the developing functions of thinking, reality testing, and integration. A. Katan discussed emotionally disturbed youngsters who, unlike Bornstein's patients, whose feelings were defensively banished from consciousness, had missed out on the developmental step of learning to put their feelings into words. She described how, at the Hanna Perkins Nursery School, their parents and teachers often could belatedly help them with this step more quickly through daily educational interaction than an analyst could in individual therapy. Since many children enter preschool without having fully accomplished this developmental task, it is frequently a main focus of our treatment via the parent **(R. A. Furman and A. Katan, 1969)**; **(E. Furman, 1957)**, **(1969)**.

R. A. Furman addressed this topic in greater detail in 1978. This is the second of the two contributions I referred to. He used two cases to illustrate his points. In the first case, mother and child neither verbalized affects nor could they feel in themselves or with each other. Here the teachers started by feeling for the child, encouraging his feelings and responding to his feeling needs, such as comforting when they noted sadness. Gradually, "words were offered in the context of a caring and protecting environment that wanted to meet his needs and help him acquire mastery and control" (p. 193). In this environment the mother, by being included, could take the steps with her child. Having and

communicating feelings became a tool for understanding a situation and knowing what to do about it. The second case was a treatment via the parent which, over several years, traced the later steps of the role of the mother in helping her child to make this function an integral part of his personality. This boy already experienced feelings, and putting them into words was a first and relatively easy step. But he found it hard to endure intense feelings and to resign himself to the fact that they could not always be relieved through action, even when communicated. His mother, in turn, found it hard to

recognize that her son had feelings of his own. Even after she could acknowledge this, she still found it difficult to help him own and use them. Instead, as with a much younger child, she made it her own job, either to relieve them through helpful action or to struggle with the frustration of there being no relieving action. The boy was in kindergarten when mother and child finally succeeded in his owning and using feelings and her appreciating his doing so.

For both boys, verbalization of feelings was an important accomplishment, but only one step in a complex developmental process. In the one instance, it was first necessary to create an emotional milieu in which the caring adults appreciated feelings and responded to them with relieving actions. In the second instance, verbalization of feelings had to be followed by helping the child to endure and use them as his own, and even to forego relieving action, including verbalization, whenever this would be the appropriate way of coping, e.g., in elementary school, where being angry at a teacher is often thought but not said. In tracing the successive steps and the mother's changing role in them, R. A. Furman rightly suggested that the developmental unfolding of every ego function undergoes a similar process.

In this paper, I shall focus on what I consider the first and most crucial step in the development of feelings, namely, the sense of being felt with. I shall trace some of its beginnings in toddlerhood, then apply it to the analytic work with patients, and discuss some of its effects on personality functioning and the analytic relationship.

Honoring Marianne Kris on this occasion, I hope that this paper would have pleased her. She is well known and respected for her teaching in the area of its topic.

THE DEVELOPMENT OF FEELINGS AND THE MOTHER'S ROLE DURING THE TODDLER PHASE[1]

Whereas initially the infant responds to distress with bodily forms of discharge, in time he experiences his discomforts mentally, i.e., he feels uncomfortable. This first real feeling is always related to recognizing bodily discomfort or pain, and the baby uses it to protest, to seek and accept comfort. This major achievement is usually accomplished by the latter half of the first year and is linked to the related achievement of feeling good **(Hoffer, 1950)**. In "On Fusion, Integration, and Feeling Good" **(1985)**

2. I described the mother's role in helping her child to

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1 This section is adapted from *Toddlers and Their Mothers* by Erna Furman, copyright Erna Furman, 1992. Reprinted by permission of International Universities Press.

experience both of these basic feelings. For the purposes of this discussion, and assuming a relatively normally endowed child, I wish to underline two of the prerequisites on the part of the mother: (1) her own ability to feel bodily good and bad; and to know, bear, and contain these feelings sufficiently so that she can use them to initiate appropriate responses; (2) the mother's ongoing libidinal investment of her infant **(E.**

Furman, 1969). This investment has to contain sufficient narcissistic elements (the child as a part of herself) so that she is able to feel and do for him what she can feel and do for herself, i.e., recognize and gather up his diverse sensations and motoric discharges and give them affective mental form and content with a name: "That feels good," 3/. "That feels bad." At the same time, mother's investment has to contain sufficient object-libidinal elements (the child loved as a separate person) so that she can recognize and appreciate his feelings when they are different from hers and can value and support his knowing, bearing, and using his feelings (not make them her own). When all aspects of these two prerequisites are available to a "good enough" extent, the mother can feel with her child or, as we tend to say, she is "in tune." She is in a good position to embark on the intricate gradual steps of transferring to him her own appreciation and know-how of having and using feelings and of supporting his increasing ability to do so, while remaining in feeling touch, usually even after he has made this an integral part of his personality, independent of her.

Even though feeling bodily pain is the first feeling acquisition, it remains vulnerable. It is easily lost during the early years when mother is absent or emotionally unavailable, e.g., toddlers in daycare often fail to experience and protest pain and recover their ability to do so only on reuniting with mother, or even not at all **(E. Furman, 1984)**. It also tends to be the last feeling to be used independently to initiate appropriate action, long after this has been achieved with many later affects. Thus it is the rule, rather than exception, for college-aged young men and women to call home first when they are ill, and only then to contact their local physician. In spite of this prolonged developmental process, the early achievements of feeling and protesting pain and seeking and accepting mother's comfort not only are crucial to survival but are the basis for the mother-child work on other feelings. In our Hanna Perkins Mother-Toddler Group **(E. Furman, 1989)**, **(1990)**, **(1992)** we have therefore learned to pay close attention to our toddlers' and mothers' attitudes to bodily pain, try to understand just which aspects facilitate or impede mastery, and to help educationally and therapeutically.

Chris, a healthy infant, had suffered much discomfort from teething. At 18 months, and with the help of his mother, they related that

morning's experience: Chris had called his Mom, looked teary and unhappy, pointing with his finger inside and to the back left of his mouth, and reached out to her. She picked him up for a hug, told him she understood he had a toothache and was so sorry it hurt. He then took her to the refrigerator where he pointed out the bottle with a local analgesic they kept for relieving teething pain and took part in applying it. They could both feel the bump. The medicine helped, but throughout the day Chris remained aware of his discomfort and alerted Mom to it. She offered him a Tylenol she had brought along and at one point he took it. Mom sympathized and praised his choice of cold soft foods to eat. She also told him how good it was that he knew it did not feel good, that the hurt was coming from a new tooth, that he could tell her and find the right things to do for it. Although Chris was subdued, he maintained his usual good functioning.

Kent, also a healthy and loved infant, had suffered several strep throat infections. When he was over 2 years old, I noticed one day that he was listless, irritable, poking his hand into the back of his mouth, yawning. I shared my observations with his mother. She was aware of them, added that he had not eaten well and woken during the night. She thought a tooth might be bothering him, but she had not talked with him about it, nor was she solicitous of his evident discomfort. I told her I thought Kent was not feeling well and had a sore throat. She disagreed, then suddenly and matter-of-factly asked him, "Does your throat hurt?" He resented the intrusion and pushed her away with an angry "No." The next day Kent's functioning had deteriorated. He fell twice, screamed and kicked with the least frustration, messed with his snack. When Kent at one point coughed as if choking and grabbed at his neck,

his mother phoned the doctor at once and rushed him off to be examined. Had I not interfered, she would not have stopped to explain all this to her boy and to prepare him. Kent had a very sore strep throat and was put on antibiotics, which she administered conscientiously. When she complained that he spat out his medicine and pushed away the squirter she used to insert it, I sympathized with mother and child how hard it was not to feel good and not to be able to make it feel good and, since both of them wanted to make the throat better, perhaps Kent would like to suck the medicine off a spoon himself, and she might have a candy ready afterward to alleviate the bad taste. This helped with the medicine and with the hard feelings between them. The mother's deep distress and hurt at having failed to diagnose the illness prompted her to work on this in the treatment via the parent which led her to a beginning appreciation of her child's feelings as well.

Let us now look at a less drastic case to illustrate how the mother-child attitudes to bodily pain are carried over to the development of other feelings.

After an earlier history of either not protesting pain at all or, helplessly overwhelmed, burying herself in mother's lap and arms, Barbara showed a similar all-or-none response with embarrassment and anger. At 2½ years, she appeared quite unconcerned over wetting and soiling, which mother attributed to her "not being ready." But when Barbara spilled a little juice while pouring it from the pitcher into her cup, she felt mortified, cried helplessly, climbed into Mom's lap, and buried herself in mother's enveloping arms, as the mother kindly reassured her. When angry at Mom, Barbara at times disintegrated into a temper tantrum, again pushing into mother who containedher in her arms, often telling Barbara and us that the child was just tired or had a bit of a cold. But for the most part, Barbara did not show anger at all. When peers took her toys, she did not protest; and when they intruded on her play, she let them. Initially the mother was pleased that Barbara "shared so well" and was "kind to others," but she came to appreciate our concern with Barbara's lack of self-defense. She related it to her own trouble with saying "no," taking on tasks that overburdened her, and ending up in uncontrollable situations with much mutual anger. Not wanting to pass on her difficulty to her child made her want to work on this. She acknowledged to Barbara her own trouble with anger and promised to help her so Barbara could do better. And Barbara soon did. She began to stand up for herself and even took the lead with mother. One day, when the mother disapproved of Barbara's good painting of angry monsters, Barbara said, "But, Mommy, it's only a picture." Another day, when the mother again suggested that Barbara's angry defiance of a request was due to fatigue, the child yelled, "No, I'm not tired, I am angry." Mother agreed. With mother's support, despite her trouble, Barbara learned to have and use her own anger.

Embarrassment was harder for Barbara. Here the mother had to help in a different way. She told Barbara that feeling ashamed for making a mess was hard for everyone, but that Barbara would feel better if she took care of the feeling and mess herself, instead of Mommy doing it for her. With the next spill, Barbara crawled under the table. The mother pointed out that hiding only made others notice it more. She would feel better if she cleaned up and were more careful next time. Barbara did so with downcast eyes. In time she mastered not only pouring juice but using the toilet.

It may seem that Chris, Kent, and Barbara had simply taken over

their mothers' feeling or lack of feelings and that this is how children develop feelings. It is not. Feeling what mother feels bypasses the development of the child's own feelings and results in a lasting inner confusion and uncertainty, covered by the adaptational use of other people's ways of showing feelings, but never enabling the child to use his feelings as a guide to action.

In an extreme example of this, a 9-year-old analytic patient told me a joke. I told her it did not sound funny to me. She repeated it, lest I had not understood. I still did not think it funny. She protested, "But at school everyone laughed at it." "Maybe they thought it funny, but I don't. Do you?" A bewildered look crossed her face and she quickly replied, "Of course. I laughed because they all laughed." Then she added very quietly, "How else would you know whether it is funny?" Although she could be helped in time to find her own feelings, she never dared to voice hers, being sure of them only when she found someone who could validate them.

When the toddler takes his cue about what to feel from his mother, she has actually failed to feel with him, has assumed that he would only feel what she feels. Truly feeling implies assisting the child in crystallizing his own feelings and coming to know them with the help of her validation and appreciation of them as his. He can then identify with her means of containing, differentiating, and using them, and verbalization is among those means. When A. Freud and D. Burlingham **(1942)** noted that during the London blitz youngsters panicked or remained calm,

depending on their mothers' frame of mind, the implication was not that they took over their mothers' fear or lack of fear, but responded to their mothers' means of coping with fear.

For these reasons I question the experiments used by some developmental psychologists to investigate the role of affects in early mother-child interaction. In one of Emde and Sorce's **(1983)** experiments, 12-month-olds approach a "visual cliff" and look at mother's face to gauge her expression. She sits in the room, but at a distance. "At this point our experimental design calls for trained mothers to pose either a happy or fearful facial expression" (p. 26), and the child responds accordingly. In another of their key experiments, the mother places her young toddler in the center of a room with toys. A strange woman reading a newspaper sits on one side. Mother sits down on the opposite side, says, "Now Mommy's going to read," and then reads her newspaper without paying attention to her child. After 6 minutes there is a knock, mother and stranger exchange seats, without a word, and continue reading. Next the stranger looks interestedly at the child and then "a remote control robot toy came out from under a table and moved toward the

infant" (p. 27) for 3 minutes. Then another knock alerts mother to stop reading and become emotionally available while still seated at a distance. The results indicate that the children then seem happier and more active, but showed neither fear nor distress before. An "in tune" mother would not expose her child to a potentially disorienting experience, would not distance herself bodily or emotionally, would not impose false affect. No child would experience feelings when decathected and shown "trained" as opposed to spontaneous affect. It seems to me that the experiments preclude normal mother-child communication to such an extent as to raise serious questions about the validity of the results.

When toddlers have not been helped to make affective mental sense of their sensations and motoric discharges to know and value their own feelings, they may persist with bodily manifestations or may adopt mother's feeling responses, but they may also use a variety of primitive defensive maneuvers, described by Fraiberg **(1982)**, or a developmental continuation of them.

Two-year-old Alan fought the world. His screaming could be heard from the hall; when he entered our room, he barged around from toy to toy, handling them roughly, snatching things from others, angrily denying every request, often hitting out or teasily running off and throwing things. He was unable to sit for his snacks and tried to grab all the food; at circle time on the rug he tried to poke into mother or at others and disrupted our songs with his noise and aggressive hyperactivity. His mother's constant verbal directions went unheeded and, as often as he could, he wrenched away from her bodily hold on him. Everyone felt intimidated, and this provided the first clue: I assured Alan this was a safe place and that neither he nor others could be hurt. And I enforced this, calmly but firmly. Although he had no understandable speech, he began to make eye contact with me and relaxed somewhat. I then noticed that, just before his sudden bouts of hollering and acting up, there would be a moment when he looked scared. I verbalized this sympathetically and encouraged him to show us what was scary. Finally one day he pointed to the ceiling. With effort, I could make out the slight noise of a toilet flushing on the second floor. He was much relieved that I understood, explained, and declared it safe. When I had initially shared my observation with his mother, she could not believe that her tough boy was ever scared, but she became more receptive and supporting of Alan as, day by day, we learned of more fears—noises, changes, visitors, fears of being sent away, of being stupid, helpless, and incompetent. Being felt with, he could increasingly feel his fears and use his feeling to help himself, sometimes

to seek explanation, sometimes to learn to master an activity, or to modify his behavior. He also became softer, could experience pleasure, and show loving feelings. He became a person.

Developmentally, Alan's fighting mechanism had been at the transition point between motoric discharge and identification with the aggressor. Unlike Alan, however, many even younger toddlers are well able to experience a variety of feelings, but they cannot trust and accept them and cannot feel they themselves are acceptable, when mother does not feel with them. Early defense mechanisms then come into play; above all, we observe poor bodily and mental self-regard, lack of trust in themselves and the world around them, and increased dependence on mother.

Two-year-old Carole clung to her mother and was standoffish with the teachers. She chose very easy activities to do privately with her mother, but never seemed pleased with her accomplishments. When a teacher approached or asked to look at her work, she crossly refused and hid it away. Yet she herself keenly observed everyone and tried to

attract admiration by wearing bows and jewelry. The mother was surprised when we pointed out Carole's evident loyalty conflict, but she considered this and assured Carole that it was alright to like the teachers and that there would still be lots of love left between Mommy and Carole. This helped the relationships but not Carole's liking of herself.

The father had left the family several months earlier after protracted severe marital discord and some abusive outbursts at the mother and Carole's older brother. Visits with the father were more or less weekly, but Carole never mentioned him, nor did the mother. When other fathers visited the toddler group, Carole was subdued and reacted with pained side-long glances at the fathers and increased closeness to her mother. We alerted the mother to this so that she could support us when, at the next opportunity, I quietly told Carole and Mom, "A girl might miss her own Daddy and wish he could be with her too, like the other Daddy. That's hard, but a Dad can still like his girl and be a very nice Dad, even if he can't come to visit." Carole's eyes filled with tears and the mother hugged her. On their way home, the dam broke. Carole was furious at Mom, blaming her for "kicking out" Daddy, whom she loved, who was so nice, and with whom she wanted to live. In her rage she even threw out her own beloved teddy which the mother retrieved. Having been prepared by the therapist and teachers, the mother could begin to feel with Carole, apologize for not having understood, and help her. The mother confessed that she had not believed us because she simply could not imagine that Carole's feelings about the father were so different from her own. Mother's new empathy

and appreciation of Carole's feelings led to much improvement in her daughter's strides in bodily self-care, zest, and pleasure in activities as well as kindness with mother, teachers, and peers. She even happily showed off gifts from her Dad.

FEELING WITH CHILDREN IN ANALYSIS

Most of our child analytic patients are not in touch with their feelings, not because they failed to develop the ability to feel, but because their feelings arouse so much unpleasure or anxiety that they defend against them. As we all know, interpretation of these defenses produces unpleasure or anxiety. It does not usually bring back the warded-off feeling, much less the ability to tolerate and use it; often enough, the mere threat of the feeling intensifies the defense or leads to instituting another defense. Without access to his feeling, the patient cannot be helped to link it meaningfully to its appropriate ideational content, nor can he use it to explore further the relevant connections in his past experiences. We are therefore faced with the task of helping the child to value, bear, and contain his feeling, and we achieve this by feeling with him, whatever route we take or words we use.

Jennifer, a smart and pretty 8-year-old, had great difficulty owning and tolerating any feelings. She used a variety of rigid defenses, and we had worked on this for a couple of years. At one point she was busy planning her birthday party, and her parents had agreed to make it quite elaborate and special, but she could not write the invitations, in spite of her happy anticipation. First she put off the task, then wrote in the wrong date, then mislaid them. My attempts to engage her in observing that something was getting in her way met with cross rebuffs. I found myself helpless, as I put it to myself, "to find a way in." This was my first feeling signal. Then came a session in which she totally ignored me. She brushed off my inquiry, saying she was concentrating on the pretty leaf patterns of the tree outside our window. I said she was giving me a very hard feeling, the feeling of being left alone and unwanted, because she was so busy with something that she liked better than me. It was a feeling I knew well because I, like everyone, sometimes had it. She turned on me brusquely, "That's just silly, I don't know what on earth you are talking about." I replied that this made the feeling even harder, because it made it seem that I was all alone in having it and that I was silly and strange to feel it. But, I added, I still thought it was an important feeling, even though it was so hard, important because it was part of me and because it could help me. Jennifer turned away and buried her head in the couch cushion. After a while I

said I was using my left-out and unloved feeling to help me understand how one would have trouble inviting people to a wonderful party. Maybe one would worry that they might say, "No, I am busy with better and more important things," and then one would feel left out, hurt, and unwanted. "Not at all, I already know three that will come." "How nice, but it would be nicer yet if one could be sure of all of them." She relaxed, her facial expression and body posture conveyed softness, and she was especially nice to me on leaving. I learned the next day that she had phoned each guest the previous night and one had refused. I said I was sorry and she replied quietly, "It's that feeling you talked about." The girl who had refused because she was doing something else was a girl Jennifer especially wanted

as a friend, but she had increasingly withdrawn from Jennifer. As she could now bear her unwanted feeling with me, I could tell her how brave she was to bear it and how it helped her to be kind, instead of having to be so scared of this feeling that she had to make others feel it, and then worry they would not like her because she was unkind.

Without helping her to bear her underlying feeling, she would have had to reject my interpretation of her widespread habitual defense of passive into active, or even of its secondary effect on her relationships and self-esteem. I knew from past material that many specific situations, including the parents' relationship and ability to make babies, had been experienced as rejections, but she could not link her defense to these contents as long as she could not own her feeling about them. I also knew that these past contents had been so unbearably painful because they were embedded in the context of the parents' inability to feel with her, the rejection she so harshly identified with in calling my feeling silly, strange, and ununderstandable. But any interpretation of this identification and of the parents' difficulty would also have been felt as a rejection of herself and of the parents. Only when she was able to feel rejected would she be able to integrate this with empathy for the parents, instead of again defensively rejecting the parents, myself, and others. She was not yet ready for this work, but there had been a beginning. Of course, I did not think through any of this until afterward. During the sessions, feeling with the patient is one's main and surest guide to interpretation.

Many of our patients have not even reached the developmental level at which feelings are warded off. Like some of our toddlers, they are arrested at earlier stages of experiencing bodily sensations or discharges which have not yet crystallized into mentally experienced feelings and need the analyst's help to achieve this.

Martha was a healthy, intelligent 10-year-old with a debilitating

learning disturbance. It soon became clear that she could neither know things nor feel. Vaguely distressed, she would curl up in the corner of the couch, twirling her hair and half hiding her thumb sucking, complaining of being cold or of one or another part of her body hurting. Her mother, feeling at a loss, would sometimes take solicitous care and keep her home from school, sometimes declare Martha was making up excuses and send her off without sympathy. I always sympathized how hard it was not to feel good, but also suggested that, by feeling cold and hurting, her body was, in its own way, saying that there were uncomfortable feelings about other things. Feeling with Martha enabled us gradually to be a bit more specific—feeling unhappy or lonely or "everyone is mean to me" or "I feel mean." As bodily symptoms subsided, the nonverbally communicated feelings became more intense and conveyed primitive terror, pain, and rage. Martha constantly tested my ability to feel, articulate, and contain these feelings with her. So, when she took to getting under the couch and signaling to me only with hand gestures, I thought it yet another test. After weeks of this, however, we were able to reconstruct an early experience of being in pain, confined in a crib, and trying to reach someone to be with her bodily and mentally. I finally wondered about a hospitalization and, much to our shared surprise, the parents confirmed what they had until then forgotten and omitted from the history: at 11 months, there was an emergency operation. Martha was hospitalized for a week and the parents complied with doctor's orders not to visit her to avoid upset. Unbeknownst to Martha, they had observed her for short periods at a distance and found her quietly sitting, sucking her thumb, and twirling her hair. On her return, she seemed alright, began to crawl, and say words, and the parents never referred to the experience again. The mother recalled missing the nursing which had stopped at the time and missing taking care of Martha, but she was unaware that she had lost being in feeling touch.

HELPING PATIENTS WITH UNCONTROLLED BEHAVIOR

It is even harder to feel with our patients and to gauge the developmental level at which they feel, when their expressions are in the form of motoric discharge, assaulting our senses and bodies, and endangering themselves or the office and materials. Such activity may be defensive (e.g., representing an identification with the aggressor or abuser, or an externalization of a harsh superego introject, or warding off helpless or even loving feelings), or it may be related to primitively unfused aggression with insufficiently available libido to tame it, or it

may show early states of being overwhelmed, with or without the use of defensive maneuvers of "fighting," as was the case with our scared toddler Alan. In each instance, it is mainly the analyst's ability to feel with the child which helps him determine what may be going on.

Some years ago, the father of a Hanna Perkins child introduced their new housekeeper to our school during the mother's hospitalization. He explained that this was a special school where kids were first helped to get in touch

with their feelings and then they could be expected to be responsible for their behavior. This summed up better than I could the teachers' educational approach and the goal we help the parents pursue. It also applies to aspects of the analyst's work, but whereas the parents' and teachers' task is to help the child know his feeling in a current situation and to use the adult, and parts of himself, to gain mastery, the analyst has to help the child to use his or her feeling to explore its history and role within the total personality. Feeling with the child's anger or angry defenses and allowing the relevant affects and contents to emerge gradually can take a long time and involve a lot of uncontrolled behavior. How can we best assure safety as well as analytic process?

Analysts vary greatly in how much physical aggression and destruction they can tolerate and contain, be it having one's space invaded by screams, pushes, and kicks, or paper airplanes; be it wasting of paper, spilling of water, or turning over of furniture; or be it unsafety of the patient himself. In 1967, R. A. Furman described the rule he made with little Billy that all messes had to be cleaned up before the end of the session, and they set aside part of each session to do so. He explained that they would work on understanding the causes of Billy's messing, and then he would not have to mess, but until then he would feel better if he left the office cleaned up. A. Freud, on reading R. A. Furman's paper, agreed completely. She said she was perhaps so definite about this because she was a teacher and regretted that many of her co-workers took a different view, fearing that such educational control would interfere with the unfolding of the analytic process. I also am a teacher, but I do not think this fact, or my personal touchiness about messes and hurts, is my main reason for taking very early and definite steps to ensure my basic analytic rule with my patients: "You, I, and everything here has to be very safe." This rule derives from learning over the years that children who are physically aggressive to the analyst, destructive with materialthings, or unsafe with themselves are the very ones who are most frightened by these impulses and by the least evidence of damage they cause. Their terror, often of an unconscious nature, stems from aspects of the etiology of their behavior,

regardless of whether it is defensive in its current form. They are either youngsters who have been the victims of aggressive-destructive behavior (whether intentional or merely perceived as such) and/or they function at very early levels in terms of feelings. In the latter case, they have not been helped with channeling sensations and motoric discharge into feelings and often had not even developed the basic protest and comfort-seeking use of bodily pain. They therefore live in a state of inner turmoil and fear of being overwhelmed. In either case, they cannot trust a differentiation between inner and outer reality, cannot trust that a contained feeling will serve as a barrier between impulse and action or serve to tame and control the action, in themselves or in others. Feeling with this anxiety helps us to appreciate how extremely vulnerable they are. Their underlying fear, often a fear of annihilation, overshadows all else to such an extent that they cannot effectively work on and integrate other psychic contents, even if they produce them as analytic material. The question is not how much anger and destruction can the analyst contain, but how much can the patient contain. With the uncontrolled child, the answer is none. The analyst's task therefore is to provide utmost safety in order to create a productive analytic milieu, one in which these basic fears can be explored and understood.

Some practical measures may help to illustrate this, but they have to be adapted and timed to serve the individual patient. The children's implied question about safety usually arises at the very start, perhaps as they carry scissors across the room, harshly bang the door shut, or take their magic marker activity to the upholstered couch instead of the table. I pick up on the first clue I notice, articulate the question, provide my overall rule reply, and usually ask them to figure out the reasons for its particular application, e.g., why would it not be safe to use the couch for work with magic markers? They tend to come up with more reasons than I would have thought of, although they may deride them at the same time and contrast them with their different home rules. As soon as possible, I point out that there is a part of them that wants everything to be safe—like the part that is so good at figuring out all the reasons for using magic markers at the table—and I want to help that part of them. It is the part that feels good when it can keep things safe, and it is also the part that can do the best work on troubles. Like R. A. Furman with Billy, we have a clean-up and fixing-things time, during or at the end of the session. I relate it not only to helping them to feel good and in control, but to their own expectation of finding everything in good repair and in its place. If I let them leave things in a mess or damaged, how could they trust that I would not allow others to

do so? If putting things right is so interfered with that it extends beyond the end of the session, we may need to arrange to take the extra minutes off their next session. Again, taking away another's time without making up would lead them to expect that I would let others infringe on their time. And if cleaning up is impossible for them—and of course I always point out that such troubles will be understood in time and will not always have to leave them

feeling badly—then the materials left in a mess or disrepair will be off limits. We then gauge together when the sensible part is strong enough to be better in control of using them. This applies also to items which are aggressively misused.

Seven-year-old Jane suddenly threw the scissors at me. Sudden brutal attacks were among her symptoms. She usually denied them or minimized their effect on others, and we had already done much work on safety. We decided to put the scissors away for now, in an accessible box, which she accepted. When we later agreed she was ready to give them a new try, her controls were still labile, so I said she would need to ask me each time she wanted them and I would sit next to her at the table while she used them. In spite of some protests, she was greatly relieved. Eventually she could safely use scissors independently and even graduated from a rounded to a pointed pair. But in the process of this progression, many of the issues related to her attacks could be worked on in regard to minor incidents. One day she tested me, surreptitiously trying to take the scissors out of the box. I was aware of it, which enabled her to put them back, and we could then wonder what had made *her* feel unsafe. At a neighborhood party the previous evening, the children had been left unsupervised and a notoriously aggressive boy had pushed her off the swing, all in the midst of excited and aggressive interplays. She felt hurt and guilty and had not reported the incident for fear of being blamed. This allowed us to help her understand that her self-blame as well as the uncontrolled behavior preceding the accident (a masturbatory derivative) had served to ward off her helpless unsafe feeling when her mother disregarded her and failed to protect her at the party from inner and outer dangers.

When Jane tried to mistreat me, even if only by aggressively getting too close, I would state my dislike of it in words and take measures to protect myself. As I discussed in greater detail in "Aggressively Abused Children" **(1986)**, I have found this especially important in tuning into these children's difficulty with effective self-defense, "If I don't stand up for myself and protect myself, how could you believe that I could help you to stand up for yourself?" With Jane, too, this proved helpful. Although she could attack viciously and even fight back, she could not

fend for herself with her unprotective parents and alert them to her needs, which often included their disregard of bodily pain and illness.

I am always amazed that the initially most uncontrolled patients later reveal themselves to be the most astutely aware of the most minor damages.

One early latency boy had to be held off bodily at times and, to avoid the stimulation of bodily contact, needed to spend times in my rather spacious and well-lit closet, where he could give himself a better chance to feel safe and to regain control of himself, while remaining in reassuring verbal touch with me. At later points in our work, he would draw my attention to such minor transgressions as using two Kleenex instead of one, which he called "wasting and spoiling" my property. It turned out to represent his helpless oral rage and fear of being overwhelmed, which he had first experienced as an unattended hungry infant and which later dogged him at every developmental level. Without the safety of our office, these terror-filled experiences could not have been tolerated, understood, or mastered.

Feeling with the child patient's earliest anxieties about safety and protecting him as well as helping him to protect himself support the analytic work. They do not interfere with it.

ROLE OF FEELINGS IN EGO GROWTH AND IN THE ANALYTIC RELATIONSHIP

Developmentally, a child is helped to know, own, and use his feelings when the parents feel with him in a contained manner and assist him with it, step by step. This achievement has wide-ranging effects on all ego functions, especially on his organizing ability, i.e., integration and differentiation. A. Katan **(1961)** and R. A. Furman **(1978)** referred to this role, and it has been implicit in this paper. Tracing these mutual ego influences in detail deserves separate discussion. At this time, I merely wish to underline an aspect I discussed in a different context (1988), namely, that an individual's independent reliable testing of outer reality grows out of knowing and trusting his inner reality, his sensations and feelings. In analysis, when we help a patient to develop, or regain, his ability to feel, this progress also needs to be assessed and compared in the other areas of ego functioning. Improvements may be limited, especially when there are developmental deficits.

Feeling and being felt with also play a special role in the patient-analyst relationship and working alliance. Some years ago, when our informal workshop discussion at the Association meetings focused on

children's motivation for analysis, we agreed that children do not primarily seek insight, and I doubt that this is the main aim with many adults. H. Kennedy **(1982)** at that time said that children want to be understood. I agree, but I would go a step further. I think that "being understood" means being felt with and helped to master. This is the most difficult aspect of our work but also the most gratifying. As child analysts, we self-select ourselves for this task. To an extent that rarely faces the analyst of adults, we bear the ego strain of tapping into our earliest, most primitive feelings in empathy and, like parents, assist our patients to bear, own, and use their feelings at the same time. It is the real gift the child analyst gives, and gives generously and unconditionally. Yet it is a gift our patients reciprocate, because feeling with them provides a deep rich satisfaction and helps us to learn more about analysis and ourselves.

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