INNOVATIONS IN TECHNIQUE

Working with "Out-of-Control" Children—A Two-Systems Approach

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The authors apply a two-systems approach to demonstrate improved treatment possibilities and outcomes in this group of children and suggest that psychoanalysis can be defined as a multimodal strengths-based learning experience. Using clinical material from the analysis of an aggressive, "out-of-control" child, they discuss how these behaviors and symptoms are better understood as an actively constructed effort at self-regulation than as a deficiency in capacity or primitive, lagging development. They illustrate how a two-systems framework can allow for an expanded repertoire of techniques and reclaim psychoanalytic concepts that have fallen into disuse.

Eight-year-old Rachel had terrifying rages, threatened her mother with a knife, and locked her out of the house. Once the treatment began, Rachel entered each session determined to wreck the office; she flung everything she could get her hands on through the air, overturned furniture, ripped papers, and knocked holes in the walls.

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The Psychoanalytic Study of the Child 69, ed. Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight (Yale University Press, copyright © 2016 by Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight).

Initially none of my interventions seemed to have any effect.[1] If anything, Rachel's attacks escalated, and I had to clear my office of all hard objects or toys. Rachel thumped her chest, strutted, yelled, and pumped her fist in my face. She danced sexually and sang violent rap songs.

The Challenge of Out-of-Control Children

There is an exponential increase in the number of children who are described by parents, teachers, and therapists as out of control. How are we to understand this kind of behavior, and how as therapists are we able to intervene and help restore these children to a path of progressive development? Currently the tendency is to diagnose these children as having neurological difficulties characterized as Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), Oppositional Defiant Disorder (ODD), Executive Function Disorder (EFD), Pervasive Developmental Disorder (PDD), or, increasingly, Bipolar Disorder (BPD). It was hard to resist the mother's and teacher's insistence that Rachel be medicated, since none of their behavioral methods or Cognitive Behavioral Therapy (CBT) had any effect.

These children now seldom come for psychotherapy, but instead are treated by their desperate parents and teachers with reactive, repressive models of external behavioral controls, almost a reversion to nineteenth-century modes of authoritarian domination. More perniciously, there is an explosive increase in the prescription of stimulant, anti-anxiety, and antidepressant medications, as well as widespread off-label use of antipsychotic or blood-pressure drugs, without regard to side effects, long-term sequelae, or the impact on a child's self-image. The assumption seems to be that there is a one-to-one relationship between atypical behavior and some specific brain disorder, reachable by a specific medication. This of course is the age-old dream of finding a single cause in the body or the mind, a resurgent variant of the nature-nurture debate. As we and many others have noted, this is no longer a relevant dichotomy, given the constant epigenetic interaction of constitutional, physiological, and environmental influences (K. K. Novick and J. Novick, 2013a; Hyman, 2009).

1. In this paper we have chosen to use "I" when referring to the analyst in actual clinical interactions, and the collective "we/our/us" when describing our joint, general theoretical, technical, and clinical formulations. The "I" is an attempt to capture some of the immediacy of the work, and it also adds another layer of confidentiality to the reported clinical material.

Everyone is born with variety in their biological, physiological, neurological makeup; these individual differences are what psychoanalysis is uniquely suited to address. The fact that a child may have some neurological quirk or significant dysfunction does not automatically mean that a physiological treatment method is indicated. As some eminent child psychopharmacologists put it, "Biologic treatment of psychiatric illness does not imply biologic causation but it may seem so to parents. This tendency is encouraged by quasi-scientific discussion of chemical imbalances and other media and cultural forces" (Chubinsky and Hojman, 2013, p. 360). We, like everyone else, wish there were a precise magic bullet for every condition. Having grown up in the era of the eradication of smallpox, new antibiotics, polio vaccine, birth control pills, and Viagra, we know it can happen. However, in the area of psychopathology, psychiatry and psychoanalysis have succumbed to wishful thinking and to outright bribery in some cases (Whitaker, 2010; Carlat, 2010).

More subtly destructive is the crisis of confidence in our own methods, proven over one hundred years to be effective, which has led analysts to abdicate and pursue medical and scientific legitimacy by following the pyschopharmacology bandwagon. A survey published as early as 1995 revealed that over half of the patients then in psychoanalysis were also on medication (Donovan and Roose, 1995). Many therapists currently jump to referring out-of-control children and adolescents to psychiatrists when a case gets difficult, apparently doubting that their own knowledge base can usually give them adequate insight and techniques to address the child's and family's troubles and attributing superior efficacy to medical measures. Chubinsky and Hojman note that the psychiatrists themselves are not immune to such self-doubt when they remark, "Psychopharmacologists need to make sure that prescribing to patients is not seen as a prescription to their own anxiety" (2013, p. 363). Additionally, there is the strong tendency to assuage parents' anxiety and helplessness by prescribing even when fully aware that the child might be able to manage without medication. Art Farley, an eminent child psychoanalyst and psychiatrist, often remarked that "Kids' medications are for parents" (personal communication). The same holds true for the labeling function of the *DSM* categories. Full dynamic diagnosis and judicious temporary use of medication play legitimate roles in the provision of care. But both are too easily misused to palliate therapists' or parents' helplessness and guilt.

At the turn of the twentieth century, there was great optimism about medical and drug treatments for psychological and psychiatric troubles;

this intersected with the rise of managed care and so-called evidence-based treatments, but recent important reevaluation of that evidence (Hinshaw and Scheffler, 2014; Carlat, 2010) and disappointing practical results have led to a comprehensive sense that "Despite decades of costly research, experts have learned virtually nothing about the cause of psychiatric disorders and have developed no truly novel drug treatments in more than a quarter century" (Zimmer and Carey, 2014, p. 1).

Nevertheless, pediatricians, psychiatrists, and other clinicians continue to prescribe at ever-growing rates, as if children's troubles have purely physiological bases and can be addressed solely by such means. ADHD and bipolar diagnoses and their accompanying prescriptions have increased drastically in the past twenty years. Some 6.4 million American children are medicated for ADHD (1 in 5 of *all* boys, and 1 in 10 girls); ADHD diagnoses are up 40 percent since 2004 and 200 percent since 1990 (Hinshaw and Scheffler, 2014); between 1994 and 2003 the proportion of children diagnosed with bipolar disorder increased fortyfold (Carlat, 2010). Medication of active preschoolers has shown a sharp rise, with an estimated 14,000 three-year-olds and younger medicated for "bi-polar disorder" and ADHD (Visser et al., 2014). The proportion of underprivileged and minority children sedated for life is a blot on our health system, a social and political disgrace, and a permanent drain on our economy. Despite all the millions spent by pharmaceutical companies in marketing these drugs, the percentage of children struggling with conduct troubles continues to rise. Were it not for the substantive damage to several generations, it would be tempting to dismiss these phenomena as just another instance of the historical boom-and-bust cycle in the American infatuation with quick, psychotropic medication solutions (Wylie, 2014).

The Failure of Psychoanalysis

This state of affairs is not only the result of concentrated biased research and marketing by drug companies but also represents a failure of psychoanalysis to develop and promulgate effective, accessible developmental models and alternatives to the suppression of children's behavior. Despite the fact that these children are seldom now referred directly for psychotherapy or psychoanalysis, out-of-control aggressive behavior has been described by child analysts and psychologists for many years (for instance, J. Novick and K. K. Novick, 2007 [1996]; Brinich, 1984; Willock, 1986, 1987; Daldin, 1992; Mann, 2011; Slater, 2014). In reanalysis in adulthood of people who had child analyses, it is not uncommon for the adult patients to describe their past selves as inhibited, passive

school-aged victims, seeming to forget that the treating child analyst had described them as totally out of control (Ritvo, 1966; Ritvo and Rosenbaum, 1983). In fact, those adults spent their school years with periods of wild, uncontrolled behavior alternating with inhibition and obsessional defenses (J. Novick and K. K. Novick 2007 [1996]).

Psychoanalysts have tried to meet the clinical challenge of out-of-control children in the context of our theories of development. Freud actually described various developmental models, but the one that is most used, even clung to, by modern psychoanalysts of all schools is what we have termed a "single-track" model. In a *single-track model* normal children are routinely described as "autistic," "omnipotent," "paranoid-schizoid," "depressive," "polymorphously perverse," "anal-sadistic," "narcissistic," and so forth, all examples of descriptors of severe pathology in adults. Adult pathology is explained as fixation or regression to, or persistence or arrest of, what was normal in childhood. Adult normality and even creativity are explained as sublimations or compromise formations on the basis of infantile "perverse" impulses.

Many have criticized this single-track model. Frances Tustin, an eminent Kleinian pioneer in the field of autism, wrote a moving paper called "The Perpetuation of an Error" in an effort to correct what she saw as an untenable clinging to single-track theory. She noted that "this flawed hypothesis, based on faulty premises, has been like an invasive virus in that it has permeated and distorted clinical and theoretical formulations" (1994, p. 3). Many others (Peterfreund, 1978; Silverman, 1981; Gillette, 1992; K. K. Novick and J. Novick, 1994; Galatzer-Levy, 2004; Abrams, 2011; inter alia) have made similar critiques of single-track, linear developmental theory. Their cogent arguments tend to be ignored, however, and there seems to be a perennial pull, both theoretically and clinically, for psychoanalysts to stress a unitary developmental continuum. A single-track theory tends to neglect the individual's strengths, capacities, and push toward progressive development, with underestimation of the opportunities provided by reality experience, including that of the treatment situation and relationship.

Freud explicitly delineated an "original reality ego" (1915, p. 136) that preceded the "purified pleasure ego" (ibid., p. 136). There have been psychoanalytic thinkers who followed Freud's lead in using the *dual-track model of development* implied by Freud's emphasis on the presence of the reality ego, but there seems to be resistance to maintaining such a model, as evinced by the eclipse of the work of Hartmann with his formulation of a conflict-free sphere (1939), Erikson's describing life-cycle alternatives (1950), Anna Freud's developmental lines (1965), and White on effectance (1959), among others.

Our Two-Systems Model

From our clinical work on sadomasochistic power relationships and the defensive omnipotent beliefs and fantasies that organize them, we have built on the dual-track model to postulate two systems of self-regulation and conflict resolution. One system, the open system, is attuned to reality and characterized by joy, competence, and creativity. The other, the closed system, avoids reality and is characterized by power dynamics, omnipotence and stasis.

> In closed-system functioning, relationships have a perverse, sadomasochistic pattern; the psyche is organized according to magical, omnipotent beliefs; hostile, painful feelings and aggressive, self-destructive behavior cycle repeatedly with no real change or growth. Omnipotent beliefs are invoked as the main defensive self-protection. Externalization, denial and avoidance are used to support those beliefs. The aim is to control the other, rather than change the self. Reality-based pleasure is experienced as a threat to omnipotent beliefs, since the closed system depends on feeling victimized. Pain is central to the closed system, as a means for attachment, defense and gratification. Ego functions are co-opted in the service of maintaining omnipotent defenses and beliefs. Executive functions of the ego are stunted or resisted to preserve the conviction that achievements are quick, easy and result from forcing, rather than work. Rules of any sort, from the laws of physics to the conventions of society and the patterns of games, are undermined and denied. Children operating in the closed system feel like entitled exceptions to the parameters of reality. (K. K. Novick and J. Novick, 2012, p. 52)

Both systems aim for self-regulation. In the open system the mastery of inner and outer forces is accomplished via the maximum use of one's genuine mental and physical capacities. In the closed system, the illusion of mastery is achieved by a magical, omnipotent belief in the power and necessity of being a perpetrator or victim in order to survive.

The closed and open systems do not differentiate people, that is, they are not diagnostic categories. Rather, the constructs describe potential choices of adaptation *within each individual at any challenging point in development* and allow for a metapsychological or multidimensional description of the components of the individual's relation to himself and others.

Labeling children as out-of-control or lacking in self-regulation implies a deficiency, as if some development has not occurred or the person is stuck in a primitive place along a linear developmental trajectory. This appears to be the prevailing assumption, not only in pharmaceutical rationales but also in the developmental psychology and child

psychiatry research literatures. For instance, Greene and Ablon's rich descriptions of "explosive children" and sensitive, sensible prescriptions for addressing such behaviors nevertheless are predicated on the idea of "lagging skills" (2006).

We think psychoanalysis can have a different conceptualization to offer. Rather than seeing out-of-control behavior as stemming from a deficiency, we, with an increasing number of colleagues and students, recognize this behavior as an active, substantive solution to an experienced or anticipated sense of feeling overwhelmed. It is a mode of self-regulation that is the best the child can come up with at the time. As I recognized how effectively Rachel was making me feel helpless, I began to understand that I was dealing with an externalizing transference, in which I was carrying the overwhelmed and traumatized aspects of her experience. This formulation illustrates how my two-systems understanding of Rachel's desperate need to protect herself against trauma provided me with a crucial perspective that facilitated our analytic work.

The idea that pathology represents a solution is part of our two-systems model of self-regulation (J. Novick and K. K. Novick, 2002). To us, the troubles of these children reside in the territory of pathological power relationships, springing from complex, disturbed parent-child interactions that have traumatic impact. We have been studying this for many years in an ever-expanding theory of sadomasochism (J. Novick and K. K. Novick, 2007 [1996]), which has evolved into our model of two systems of self-regulation: the closed, omnipotent system and the open, reality-oriented system.

Two Systems Generate Two Techniques

The idea of two systems of conflict resolution and self-regulation can lead to a conceptualization of two kinds of technique, one that elucidates closed-system functioning, another that enhances open-system functioning (J. Novick and K. Novick, 2003). There are many basic psychoanalytic concepts and techniques that are extruded and then get defined as nonanalytic because they cannot be integrated in a single-track model. The most significant casualty has been the early psychoanalytic concept of the therapeutic alliance, which research demonstrates is the most robust predictor of therapeutic effectiveness (Gelso and Carter, 1985; Karon, 1989; Heinssen, Levendusky, and Hunter, 1995). A dual-track model can encompass the importance and presence of the therapeutic alliance along with the other components of the treatment relationship.

Technical interventions have differing impacts on phenomena relating to the two systems. Here we will first focus on techniques relevant

to closed-system functioning, which are much more discussed by most analysts, in an effort to contribute further understanding and fruitful suggestions. These fall under several broad headings that constitute a therapeutic stance or approach when dealing with persistent, refractory, and frustrating patterns of functioning.

WORKING WITH CLOSED-SYSTEM FUNCTIONING

It is important throughout the treatment to respect the patient's closed system as a creative solution to a problem, and not only as a problem to be eradicated. Verbalizing this often produces a profound feeling of being understood and a feeling of relief. As defensive omnipotent beliefs emerge, we can then connect them to the underlying experience of helplessness. This points the way to finding alternative solutions.

We look together with the patient at what needs are being met—what problem is being solved by the closed-system response? This includes discovering the various functions of attachment, protection, and gratification being served by closed-system, hostile, or submissive relationships; how the sadomasochism replaces superego controls of feelings and behavior; and the sources of instinctual gratification that are implicated. I regularly commented on the defensive function of Rachel's getting herself "all worked up" and acting out of control to keep her mind off painful feelings, to protect herself and feel strong. I noted that Rachel seemed to feel good for a while at those moments. She said, "Of course I do, stupid, because then no one can stop me. Those feelings don't just happen to me, you retard. They make me feel good and I choose to have them."

Then we address the omnipotent beliefs, which can come in many forms and may or may not be conscious. Often the omnipotent belief that the patient's sadomasochism controls other people is conscious. Severe guilt or inhibition of action is often connected with a conscious belief in the omnipotent power to hurt and destroy others. In Rachel's case, the out-of-control behavior represented a panic-driven need to prove that she was not helpless, as well as a plea to be stopped and punished for her terrible deeds. Over many weeks I could get across that she wasn't really out of control. She had cleverly found a way of making herself feel very powerful instead of helpless.

I said to Rachel that no one wants to feel helpless—I don't and all the other kids I've seen hated being helpless. It's the worst feeling in the world. I said that Rachel had found a way that works and I wouldn't take it away from her. Our job in treatment is to find *more* ways to protect herself, ways that would work but would also make her feel good

about herself. "I don't need you," she shouted, "I'll find my own ways." And indeed she did. She began calling her mother on the phone and telling her that I was a bad therapist, that I wanted to kill her and I should be sent to jail. I said, "I think you really believe that you can be in charge of what happens to me. When you call your mother and complain about me as you did about your father, you think that you can make me disappear, too."

Rachel's father had been physically abusive with everyone, including Rachel. Rachel told her mother about his hurting her and threatening to kill her. Mother had said she would call the police, but had not followed through. However, soon after, when Rachel was four, her father was arrested and jailed for drug dealing. At eight, Rachel remained convinced that she was responsible for his being sent to jail. This was not a childish "false belief," one that a course of CBT or I could just correct.

We make a crucial distinction between infantile theories that children formulate on the basis of their developmentally appropriate cognitive capacities and constructed beliefs that become part of character or personality in an organized effort to protect the psyche from further or potential trauma. Rachel held on to her magical omnipotent belief that she had sent her father away because it protected her from feeling that she could be at the mercy of powerful, abusive grown-ups. With repeated shared experiences that magical beliefs don't change anything or anybody, especially the analyst, the focus can shift to exploring their sources and the unconscious and dynamic motivations for holding on to them, then seeking alternatives. Much of the work with Rachel involved testing these issues over and over, titrating her disappointment and terror over the failure of her omnipotence and providing repeated reassurance that I could withstand the attacks and still be there for her.

An omnipotent belief cannot be maintained, however, without validation of some kind from the environment. In this case, and in most that we have seen, a mother's repeated failure to protect a child from abuse, or parental inability to protect a child from chronic pain, for instance, leaves the child helpless and throws her back on her own resources. Recent research on post-traumatic recovery emphasizes the role of the environment, particularly parents, in mitigating or consolidating the impact of traumatic experiences (Dobbs, 2012).

There is a vicious cycle created in the experience of the children who end up out of control. The original trigger may come from inside the child, in the form of medical problems, hypersensitivities, neurological vulnerabilities, unaddressed mismatches with parental personalities, or from outside circumstances of adversity, trauma, pathology, physical or

mental illness, and so forth. Whatever the source of the helplessness, the child has to find a solution in order to survive. When the environment does not offer children realistic, age-appropriate opportunities for genuine mastery, the child is thrown back on her own resources to create psychological protections against trauma. One way to feel powerful is to rage, be unmanageable, and make others helpless. The need to believe that they can control others also makes them feel omnipotently responsible and then guilty for whatever happens to others. Rachel's ongoing guilt that she was responsible for her father's imprisonment carried her omnipotent belief into each level of development and maintained her sense of power.

This is an example of what we have called a closed-system superego (J. Novick and K. K. Novick, 2004); it operates to justify sadomasochistic and cruel functioning, shore up omnipotent delusional beliefs, and keep the child safe from even more toxic internalizations and identifications. It feeds into the repetitive, static, vicious cycle of closed-system functioning, as it does not offer benign reassurance, internal sources of authentic self-esteem, fuel for a changing ego ideal, or realistic aspirations. The operation of a closed-system superego is one factor that contributes to intractability and treatment failure in various diagnostic groups that share this core dynamic.

Parents faced with an inconsolable, uncontrollable child really can feel helpless. Parents with sturdy internal resources and outside support systems can be helped to counteract the experience, but many flounder. Their helplessness is traumatic in itself to children, who need adults to keep the world safe and predictable, setting realistic limits that can be internalized. Parental weakness also validates the child's belief that she can rely only on her own omnipotent functioning, reinforcing the wild, cruel, or violent behavior as the solution (Shengold, 1991). Once established, closed-system functioning becomes an addiction, both psychologically and physiologically, with involvement of the endogenous opioids (Rathbone, 2001).

Lastly, and very importantly, we look at the operation of externalization in all family members. Externalization is a central mechanism in closed-system functioning. It represents a way of relating that is in itself abusive, as it violates the reality of the other (J. Novick and K. K. Novick, 1994). We describe this as based on "soul blindness," a defensive refusal to see others as they really are (Wurmser, 1994; J. Novick and K. K. Novick, 2005). This is the antithesis of attunement. Externalization is a broad category encompassing all the mental mechanisms of attributing the inside to the outside. We have distinguished among various forms of externalization, since they each respond to different interventions

(J. Novick and K. K. Novick, 2007 [1996]). Such mechanisms appear outside treatment, and, within the treatment relationship, in the form of an externalizing transference. Positive aspects of the patient's self, as well as negative ones, can be externalized onto the analyst.

In Rachel's case the first type of externalization involved aspects of the self of infancy. Rachel's analysis was filled with externalizations of her own neediness, sense of inferiority, shame, deprivation, and experiences of assault. The most powerful and effective externalization was of her helplessness; in a passive-to-active maneuver, her out-of-control behavior rendered me as helpless as she had always felt. She often called me "stupid," made up games, then changed the rules and laughed at me for not understanding anything. At holiday time she told me about all the wonderful gifts she would be getting. She sarcastically playacted feeling sad because I had no family, then gloated, "You'll be sitting all alone in your freezing apartment, nothing to eat and no one to love you." Her meanness often left me feeling abandoned and useless.

I used these feelings as an initial signal and then wondered with her where such feelings could come from, to find out together if this was an externalization of an earlier self-experience. Gradually Rachel and I were able to reconstruct how she had felt as a baby and toddler, when her abused mother had effectively disappeared emotionally and Rachel had to do something with the feelings. In the concurrent work with Rachel's mother, she recalled her post-partum depression with intense guilt and the realization that both her depression and her experience of being mistreated had been too much for her and she had just "checked out."

Next to appear in Rachel's material was the form of externalization we call "generalization," where the person assumes that others are like her. Rachel thought that I was as competitive, hostile, critical, and vulnerable as she was. So she had to strike preemptively to protect herself, for fear I would retaliate in kind. Repeated interpretations and explanations of these protective efforts gradually led to increased capacity to explore together where this type of shared hostility had actually occurred; this led us to the history of hostile and violent arguments between her parents and the way Rachel had drawn their joint fire by provocative behavior. Concurrent work with her mother confirmed this reconstruction.

Rachel tried to damage toys and furniture in the office, but she also often ended up hurting herself at home, school, and in treatment. I understood this in part as her turning aggression against herself, as a form of torturous superego self-punishment. We see this as not only an instinctual vicissitude but stress also the technical implications of the

sequence of defenses it contains. Mothers and fathers of suicidal and self-injurious patients have often externalized hated aspects of themselves onto their children. The children feel rage at the psychic assaults, then defensively internalize the attributes, first in the service of holding on to a tie with their parents, but subsequently as an active means to maintain the image of a loving, perfect mother or father, safe from the child's destructive rage. A child who harms herself may be attacking her own body as a representative of the hated aspects of the mother. Each step in this sequence has to be addressed. It is slow, hard work.

Projection and externalization became characteristic defenses employed to support Rachel's precarious self-esteem. "You forgot to say what a nerd you are and how stupid you are and how pathetic your whole family is," Rachel insisted in sessions. She repeatedly ate snacks in front of me, taunting me with how good the food was and how she had no intention of sharing it. Rachel emphasized how deprived I was: "You're so poor you don't even have any grass in your front yard. You don't have anything. Your parents and sisters are dead. There is no one to give you anything for Chanukah. The temple is going to have to have a food drive so you will at least get something to eat. They'll bring it to you in the cardboard box you live in next to the supermarket," she said, laughing. She was voraciously curious about every detail of my personal life.

What comes through is Rachel's sense of deprivation and the intense need to deprive the other. As her attachment to me grew, her attacks and infliction of pain increased as well. Her mother effectively left her in infancy, losing her investment and attentiveness. Through what researchers describe as contingent learning or stimulus-response (S-R) association, Rachel began to connect her mother with emotional pain (Demos, 1985; J. Novick and K. K. Novick, 2007 [1996]). All that was left to Rachel was to attach through her intense feelings of deprivation, her pain and rage over having and not having. This is the first strand in the development of a sadomasochistic, omnipotent, closed-system pattern of relating. This marks the beginning of a closed-system defense against traumatic helplessness, through the belief that pain omnipotently attaches the other and keeps the other person under the child's control.

Our own researches, starting with the study of beating fantasies in children (J. Novick and K. K. Novick, 2007 [1996]), see the origins of the closed system in the pleasure and pain economy of the parent-infant relationship. To us this early and persistent link between attachment and pain leads to an addiction to pain. But it takes more than a painful parent-child relationship in infancy or a disorganized attachment

to maintain and consolidate the brain trap of pain and attachment (Doidge, 2007). The preponderance of pain relative to pleasure continues through all the later phases of development.

Over the summer break Rachel had worked on her soccer shots. She felt good about her increased competence. But very quickly her competence was swamped by destructive wishes, as she again lost the distinction I had often drawn between assertion and aggression. After assigning me the position of goalie, she wondered whether she could kick hard enough to break my bones, and she worked to perfect a new shot, called the "nuclear missile." Her mother's continuing fragility validated Rachel's omnipotent belief and fear that she could truly damage others. Concurrent work with Rachel's mother addressed the importance of her building her own emotional muscle to feel sturdier in herself and also convey to her daughter that Rachel's impulses could neither drive her away nor destroy her.

Rachel elaborated further externalizations, often of her positive ego capacities and executive functions, attributing competence, resilience, and strength to me. In this realm we can see how complex these matters become, since her externalizations meshed with some of my real capacities. This became an element in Rachel's intense loyalty conflicts, first as she perceived the real differences between her mother and me, and then with the exacerbation of her defensive externalizations, designed in part to protect her mother from Rachel surpassing her in any way. Rachel's attacks on me accelerated during this period, as she desperately denied that I could have anything good about me, much less anything better than her mother. Gradually we were able to approach the pain she felt at the idea that she herself could be better than her mother, and we could link this to Rachel's belief that her assertion and selfhood could destroy others. These were important developments in Rachel's treatment, but we think they also illustrate the significance of considering the role of a child's real experience of the analyst and all the other people in her life and the ways in which only the time and space of psychoanalysis, including concurrent parent work, can address the complex detail and interactions of the real, the transference, and the developmental in the therapeutic relationship.

The form of externalization described by Freud in the Schreber case, paranoid projection, where the aggression is repressed and experienced as coming from the outside, is what we call "projection proper" (S. Freud, 1911; J. Novick and K. K. Novick 2007 [1996]). In our experience this has to be approached later in the treatment when there is a strong positive alliance. Near the end of Rachel's second year of treatment, after we had established the extent to which she had been

abused emotionally and physically by her father and let down by her mother, I could look with her at projection proper as a clever way of protecting her mother from her own rageful aggression by provoking and turning her mother into the aggressor. Rachel could then figure as the innocent victim and feel justified in retaliating without guilt and with sadistic glee. This first had to be taken up in material about her schoolmates, outside the treatment relationship. Later I could bring it into explicit description of our interactions to make sense of Rachel's complaints about how I was mistreating her and being so cruel.

Omnipotence of thought or deed is a potential fantasy response in any of us to any experienced helplessness and can be a pleasurable accompaniment to daydreams. But as a *fixed* delusional conviction in an older child, omnipotence is usually embedded in a lifelong interaction with parents who deal with their own anxieties by the imposition of their omnipotent defenses in enactments with their children. In most of these families, we find a reflection of a broader cultural confusion, in which no distinction is made between assertion and aggression. Even in the best of circumstances, many parents confuse the two; the child's independence, exploration, and curiosity may feel like too much for parents and they can respond as if the child were doing something assaultive. This then defines assertion as hostile and skews the child's own judgment about her autonomous actions. It made sense to Rachel to believe in her omnipotent power to nuke me with her capable and assertive soccer shots.

Therefore, with children who present with out-of-control behavior, which so often is evidence of closed-system functioning, we look at the operation of externalization in all family members. Mutual externalizations and internalizations create a complex family system that requires careful analysis, with the interpersonal psychological exchanges detailed. Each step in the sequence carries and evokes different emotions.

In all our clinical activities with children and adolescents, we find parent work crucial to understanding the child's psyche and addressing ongoing pathology in the family. Rachel's parents were "soul blind" to her needs as an infant and then failed to protect her as she grew. Rachel's own functioning began to demonstrate in a defensive passive-to-active externalization the assaults she had experienced.

Instead of turning to reality gratifications and internalizing positive, realistic sources of self-esteem, Rachel spent her early school years persisting in a sadomasochistic, omnipotent organization of phallic-oedipal issues. At this time, early connections to others through pain, the use of pain and externalization as defenses, and the confusion of assertion and aggression became sexualized and took on a true sadomasochistic

character. Her parents' dramatic fights and the father's abusive interactions with everyone, including Rachel, created an atmosphere of triumphant excitement. Her closed-system oedipal phase did not issue in the formation of a kind, dependable superego and a reliable, open-system self-regulation. Rachel's early school years were marked by intense competitive strivings to control others, expressed alternately in wild, bullying behavior and extreme inhibition, victimization, and panic.

Rachel is similar to the very disturbed children we have written about, who in middle childhood don't play games according to the rules, use a beating fantasy in lieu of a superego, have no pleasure in real achievements and competence, have no realistic ambitions, and whose self-esteem derives from a delusional self-image as an entitled exception to reality rules (J. Novick and K. K. Novick, 2007 [1996]. Self-regulation is through maladaptive, magical, omnipotent means, in a closed feedback loop.

The nonstop rivalrous activities that Rachel made mainstays of her treatment did not reflect ordinary school-aged competitive strivings but rather conveyed her intensely driven needs to triumph, dominate, torture, and humiliate me. She laughed and sneered with excitement as she named a game of ball "Win, or Lose Your Life and Dignity," demonstrating the ongoing sexualization of her interactions.

Analytic practitioners may differ in the details of how they would understand and address Rachel's conflicts, but all would see her out-of-control behavior as having meaning, as stemming from multiple causative factors, like her traumatic early life, her parents' pathology, the intensification of rage both as reaction and defense, and Rachel's closed-system responses to the challenges of each stage of development. Most children like Rachel are currently placed into the diagnostic niche of pediatric bipolar disorder. But what does that label tell us or offer for treatment and intervention? It is striking that, in a review of the voluminous psychiatric literature on that diagnosis, Parry (2012) found no mention of family dynamics, trauma, maltreatment, or modes of attachment. This is another reason why it is so important for psychoanalysts to formulate a useful model of understanding and treating out-of-control children.

WORKING WITH THE OPEN SYSTEM

So far we have been describing one aspect of Rachel's treatment, that is, the work on her closed-system defenses and her sadomasochistic relationships. But these technical stances and interventions will only take the treatment of troubled patients like Rachel a certain distance.

Rachel is not such an unusual kind of case. There are many published accounts of work with out-of-control children in the child analytic literature, and most of them describe disappointing results if the work stays only within the arena of the closed-system functioning. Many children improve somewhat, but repeated enactment of an unchanging closed-system dynamic remains likely, as the issues outlined above are addressed again and again and the patient still does not progress age-appropriately (J. Novick and K. K. Novick, 2007 [1996]). It can seem impossible to both the patient and analyst to break out of the vicious cycle of closed-system functioning (Wurmser, 1996).

We can use the approaches described above to make significant inroads, but such efforts may not achieve full effectiveness in restoring patients' capacities to choose alternative solutions. We have found that it is crucial to work *simultaneously* with open-system concepts and techniques in order to promote growth. Thus we include in our conceptualization of psychoanalytic technique many that have been extruded from establishment psychoanalysis in the long American controversy over what constitutes "psychoanalysis proper" and what is relegated to psychoanalytic therapy (Kubie, 1943; Knight, 1949; Stone, 1951; Gill, 1951). An unfortunate side effect of these distinctions has been the growth of myriad rival therapies, each claiming its difference from and superiority to psychoanalysis, while psychoanalysis has retreated ever further into narrow exclusivity or orthodoxy. Historically and currently, perhaps in response to the challenges, analysts are prone to define what we do negatively, for example, Freud saying analysis was *not* suggestion, or more modern assertions that there is no place in analysis for CBT, education, support. Our view is that only psychoanalytic metapsychology offers a complex-enough theoretical structure to encompass both normality and pathology and should include the broadest possible range of concepts and techniques, functioning as an umbrella for what can and should be a multimodal, strength-based learning experience for everyone involved in a treatment. This broad umbrella, with at least six points of view, allows for the creative flexibility to take from multiple schools of thought, whether Anna Freudian, Kleinian, Bionian, relational, CBT, MBT, DBT, and so forth. We have found support for this position in the work of Pinchas Noy, who elaborates the benefits of metapsychology, based on "a multi-modal theoretical system, i.e., a system composed of several theoretical models" (1977, p. 1). Solomon is another commentator who stresses the utility of this position (1992).

We will turn in the next section to the open-system interventions that are central to developing alternatives for helping children and their parents return to a path of progressive development.

Rachel clung desperately to the closed-system methods of self-protection, gratification, and self-regulation that she had generated in response to the reality traumas of her life. It was clear that we needed additional tools to offer her a different pathway. What is the alternative for a child like Rachel? She feared that the only alternative was the primitive states of helplessness, rage, or traumatic guilt that originally gave rise to her defensive, hostile, omnipotent closed-system functioning.

To think about an alternative and techniques to support it, which provide hope to both patient and therapist, we have to consider and reconsider some of our basic psychoanalytic assumptions. In a single-track model, normality is described as issuing from pathological infantile functioning. A major aspect of our developmental model is to go beyond the linear, single-track schema held by most psychoanalysts of all theoretical schools,[2] to elaborate an epigenetic, dual-track conceptualization of development, which leads to our two-systems model (J. Novick and K. K. Novick, 2002).

There is a fundamental need in everyone for homeostasis and mastery, which underlie a sense of self and self-esteem. Each person needs to feel safe (Sandler, 1960), that his world is predictable, that his experience is encompassable, that obstacles can be overcome, problems can be solved, and conflicts resolved. From infancy on, individuals can feel pleasure when such conditions can be assumed. In the closed system the basis for mastery and self-regulation is omnipotent belief in the power and necessity to be a perpetrator or victim in order to survive. In the open system the method of mastering inner and outer forces is the maximum use of one's genuine mental and physical capacities to be realistically effective and competent.

One way to characterize the goal of treatment is in terms of movement out of characteristic closed-system self-regulation to a greater proportion of open-system functioning (J. Novick and K. K. Novick, 2002, 2006). Psychoanalysis has traditionally elaborated substantive understanding and treatment of closed-system pathology, as we discussed earlier, but there has been insufficient attention to the co-existing operation of open-system capacities. We feel this is particularly important in work with children, as they are building the psychological skills they will need to move with strength into adolescence and beyond.

The closed and open systems represent two possible ways of responding to feelings of helplessness. In our model, the open system

2. Some child psychoanalysts have begun to explore the limitations of the linear, single-track theory, notably K. K. Novick and J. Novick (1994), Galatzer-Levy (2004), Tustin (1994), Abrams (2011), Lament (2011), and Knight (2011).

of self-regulation is attuned to inner and outer reality, has access to the full range of feelings, and is characterized by competence, love, creativity, and mutuality. Through the longitudinal development of the open and closed systems, respectively, with potential choices available at each phase throughout life, we may see the open-system effort to *transform the self*, in contrast to the closed-system aim to *control, force, and change others*.

With Rachel, work on illuminating, supporting, strengthening, and developing open-system functioning proceeded simultaneously with the efforts to address her closed-system functioning. Rather than addressing only closed-system material and functioning, as has generally been taught, we are suggesting that therapists have the additional tool, from the beginning, of also pointing out and supporting open-system aspects of the same behaviors and feelings. In this section, we will describe the work with Rachel through the lens of the open system, elucidating also additional techniques to address closed-system omnipotent functioning. We think of this as a step-by-step construction of a viable alternative through competent, open-system self-regulation. This is not an easy task for analyst or patient. Each step brings its own anxieties, resistances, conflicts, and defenses, the meanings and mechanisms of which need elucidation and working through. Once there are alternative possibilities, a child and her parents have a genuine choice in how to live their lives. When we can provide a platform of open-system strengths for both parent and child, then we can more safely explore the continuing pull of omnipotent closed-system solutions.

OPEN-SYSTEM TECHNIQUES

Verbalizing Positive Affect

We discern and name the positive affect contained in the moment. For instance, when Rachel snapped at me about her out-of-control "hyper" feelings—"They don't just happen to me, stupid. They make me feel good and I choose to have them"—I noted to myself the sadomasochistic gratification she was expressing. But I commented first on the protective function of getting herself "all worked up" to keep her mind off painful feelings. I underscored what an important solution that represented for Rachel, who had found a way to feel safe and strong. With repeated validation of her legitimate wish to feel powerful, strong, and in control, she was no longer too humiliated to take ownership and examine the utility or not of her defensive stance.

We then generalize this experience by characterizing these as important feelings that everyone wants to have. Displacement and general-

ization are centrally useful techniques with children and adolescents, as their self-esteem is very vulnerable. Children easily feel accused of having feelings and impulses that they have just worked hard to leave behind; they are insulted to be told they are afraid or insecure or too angry. I said to Rachel that everyone wants to feel strong and powerful, because feeling helpless feels so awful.

Next the omnipotent action can be described, first in general terms—"A person probably doesn't feel helpless when they are throwing things around." And then the link can be made between her actions and the need to defend against helplessness. I said, "Oh, so when you are throwing things around, you're making very sure that you don't feel helpless."

Central Role of the Therapeutic Alliance and Real Pleasure

A major manifestation of open-system functioning in treatment is in the patient's and therapist's joint creation of a therapeutic alliance. The therapeutic alliance and mastery of its collaborative tasks offers an alternative to closed-system functioning (K. K. Novick and J. Novick, 1998; J. Novick and K. K. Novick, 2000). Achievement of therapeutic-alliance tasks throughout treatment promotes attunement in the relationship and offers a model for partnerships beyond the therapy. A delusional belief in total self-sufficiency is characteristic of the closed system. As we saw earlier, Rachel initially warded off the idea that we could work together, calling her mother instead, or running out of the office into the waiting room to hand her notes about my villainy.

The therapeutic alliance creates a context that offers a contrasting alternative and makes manifest the gratifications of mutuality and cooperative, mature interdependence. With children, we talk about the good feelings that come when we work and play together, notice when we figure out something together that we could not have understood without each person's contribution, and enjoy the feelings of reunion when we have missed each other during a vacation. The therapeutic alliance allows for the emergence of the analyst in the patient's mind as a new object, a real object, a developmental object, and so forth. The tension between the analyst as transference object and as a new, real object can provide therapeutic leverage.

A first context for addressing Rachel's anxiety about working together was in soccer games, where I was the goalie and she was the kicker. Repeatedly, Rachel was threatened by the pleasure of playing together and her kicks became "nuclear missiles." While verbalizing her excited feeling of power from the idea of hurting me, the simultaneous open-system intervention at such times was to note the gain in her skills, the

good feelings that came from that mastery, and the knowledge of current events contained in her naming her shots "missiles."

From the beginning of treatment, we focus on the patient's experience of pleasure that comes from realistic achievements. The pervasiveness and persistence of closed-system functioning is revealed in many ways, but especially in the patient's difficulty in acknowledging, sustaining, and remembering good feelings, including love. Part of what makes these treatments long and arduous is the tenacity of sadomasochistic means of attachment, defense, and gratification, which have been the most reliable methods of self-regulation available. The example of Rachel's soccer kicks allowed for focus on the important conflict in the area of her feelings. The focus can be worked on in terms of how realistic competence makes a person feel dependably good, versus the illusory, transient excitement of magical, omnipotent gratification. I remarked explicitly on how Rachel felt about her knowledge and her new skills. There was no bad feeling connected with those to spoil her satisfaction and sense of mastery, in contrast to the potential guilt and loss involved with the idea of killing me. Rachel found it hard to believe that her assertion and enjoyment of her skills was not aggressive, that it wouldn't hurt me or her mother.

The idea of the therapeutic alliance gives us particular techniques for noticing, acknowledging, and enhancing the patient's capacities for a cooperative relationship with the analyst. There are other components of the treatment relationship, such as transference, identification, and developmental object aspects, which will also be addressed, but attention to the cooperative, collaborative alliance component and the resistances to such mutual engagement provides both participants an open-system opportunity for lasting change and growth.

The specific therapeutic-alliance tasks of any particular phase of treatment confront resistances arising from closed-system functioning, the major obstacle to developmental and therapeutic progression (K. K. Novick and J. Novick, 1998). The closed-system solution is fast, easy, exciting, familiar, effective, and therefore attractive and addictive. As part of developing shared treatment goals and a therapeutic alliance with a child, we note that there are many ways to feel good and strong, and we describe treatment as a place where she can learn a whole range of ways to feel powerful. We can invite the child to participate in the work: "You don't want to feel helpless, and I don't want you to feel helpless, either; we both know how bad that feels. This is what our work together is about, to find better ways you can feel strong, powerful, and not helpless."

Reality Matters

Realistic reassurance and hope are aspects of the open system. At the beginning of a treatment, child and parents are all usually filled with despair, helplessness, frustration, and pessimism. Psychotherapy is often a last resort, when behavioral management, punishment, waiting for the problems to be outgrown, and medication have failed. Therapists too should not undertake a treatment without a sense of hope that their methods have a good chance of effectiveness. Therefore we recommend a longer evaluation period in order to establish the baseline of realistic optimism. Then it can be sincerely conveyed to the child and the family (K. K. Novick and J. Novick, 2005).

We can, for example, truthfully say to a child like Rachel, "I've known lots of kids like you who had the same ways of feeling powerful. But these ways were usually pretend and got them into trouble. I've helped them understand the difference between pretend power and real power that comes from their real strengths. So I know that we will be able to do that, too. Let's start by you telling me the things you are really good at." In fact, despite her wild behavior at home and in the sessions, Rachel was intermittently a good student at school. She had some friendships, albeit somewhat superficial. She was intelligent, knowledgeable about music, and potentially a good athlete.

The two-systems model places the analyst and patient in their legitimate relationship to reality. It provides an historical and theoretical justification for expanding the repertoire of clinical concepts and techniques (K. K. Novick and J. Novick, 2002; J. Novick and K. K. Novick, 2009a). One of our aims in this paper is to illustrate the gains from reclaiming some discarded technical tools in order to help children often deemed unsuitable for analysis. When we work with a two-systems model in mind, there are a number of pragmatic outcomes from this reality-grounded stance. For instance, we extend evaluations long enough to engage in an authentic relationship with parents of children and adolescents. In setting the framework for a treatment, we protect the treatment and the relationship by insisting on a mutual agreement that no changes will be made by parents, child, or therapist without thirty days' notice. This simple intervention is surprisingly difficult for many therapists to implement, much to their later chagrin when cases are abruptly stopped.

When we think about the role of reality in the treatment, we include also working concurrently with the parents of child and adolescent patients. A child's reality includes his or her parents; any changes in the

child have to be reflected in parental changes for treatment to have any permanent gains. Reciprocally, children's treatments often stall until some related movement in parental personality and functioning can be generated. Parent work with Rachel's mother helped her access her own strengths, acknowledge past troubles, and perceive Rachel realistically as a separate, capable person; this in turn freed Rachel to own her own good capabilities and admire and love her mother.

We propose dual goals for any child or adolescent treatment: (1) restoration of the child to progressive development, and (2) restoration of the parent-child relationship. Stating these goals and establishing them with parents and children as shared aims from the beginning has proven to be an effective way to protect treatments from premature termination and make therapy work (K. K. Novick and J. Novick, 2005, 2013a, 2013b; J. Novick and K. K. Novick, 2009a). Progression through the phases of the child's treatment affects and is dynamically affected by interaction with the parent work. Parental consolidation in the phase of parenthood may also be profoundly impacted by the child's forward developmental movement. It follows that the establishment of a therapeutic alliance with parents is essential.

The contrast between magical ideas and real possibilities can be made from the beginning and continues throughout treatment in the work with parents and children both, since the conflict between the two systems of self-regulation is constantly active. For example, when Rachel played in the sessions on her range of soccer shots, a distinction to address was between pretend and real. But we started with the real. The aspect we would take up first was how hard she had actually been working to perfect a skill and how effective that work had been, since her shots were really improving. Work is a defining characteristic of an open-system middle childhood. The analyst can focus on and reinforce pleasure in the process as contrasted with closed-system excitement over an illusory triumphant outcome.

Elucidating Conflict

When she called one of her shots the "nuclear missile," I noted how much history Rachel knew. On this platform of realistic competence, it was then possible to interpret Rachel's continuing pressure to feel good through sadistic destruction and the omnipotent belief that she had such powers. "Wow, those shots have really gotten stronger and more accurate, and you have more than one now. I'll bet that feels really good. You called that shot a 'nuclear missile.' Sounds like you have been learning a lot about history and world affairs. Not a lot of people know about the Cold War and the missile race nowadays. You're like a

history student." Then I noted, "I see also that you are getting excited about the idea of breaking my bones. That part is magical and pretend, so you have two ways of feeling good. But they can't both operate at the same time, since you can't have me as the goalie and the person admiring the new skills you worked so hard to improve, while you are nuking me." This is an important step in the clinical work—highlighting the inherent conflict between these two systems.

The idea that closed- and open-system ways of functioning are incompatible is hard for even sophisticated grown-ups to understand and accept. Singletary creatively uses the analogy of computer operating systems to make the point (2013). He talks to patients about how one can switch between PC and Mac on the same computer, but how it is impossible to use them both at the same time.

Here is where we can see the central challenge for patient and analyst, the point at which intellectual understanding, cognitive efforts, or cognitive treatments fail to change the situation and we need a dynamic, metapsychological, psychoanalytic understanding. Only when the conflict between the different sources of good feeling in closed- and open-system functioning is experienced and made explicit can the analyst and patient begin to puzzle together over why it remains so difficult. Where did this come from? Why does the patient keep believing that her feelings and wishes control the universe? Why would she need to think that?

For example, Rachel alternated realistic accounts of her soccer league and dance concerts with pathetic, whining reproaches to me and threats to tell her mother how mean I was. I enlisted Rachel to puzzle together with me about this contrast. As the treatment developed, there were more and more instances of both high-level school-aged functioning and reversion to closed-system bullying, controlling, and torturing me.

Rachel insisted on a singing contest with me, initially to humiliate me. However, rather than just her usual crude, aggressive, in-your-face rap, she began to share some other songs she had written, including a long, tearful lament: "You've left me and I feel so bad. / Was it something that I never had? / What will I ever be able to do? / How can I go on without you?" Rachel herself noted that these were much more mature songs. I agreed, "Those songs really are more grown-up, because you're brave enough to talk in them about sad feelings. We can wonder why it's hard to stay at that mature place, since you start pretty soon to dump your sad, lonely, helpless feelings onto me, making fun of me, and calling me pathetic." Here is an opportunity to introduce an important open-system concept, which we call "emotional muscle" (K. K. Novick and J. Novick, 2010, 2011, 2012).

Emotional Muscle

The idea of emotional muscle, in analogy to physical muscle, makes sense to children, parents, teachers, and patients of all ages. This concept derives from the early analytic notion of ego strength and links to current interest in resilience and protective factors. Emotional muscle is central to the open system because it derives from courageous engagement with reality. Just as physical muscle is developed through physical effort and interaction with real forces, resistances, and concrete things, so emotional muscle grows through mastery of challenge and psychological stretch. Defenses, which are aimed at denying or avoiding reality, work against the growth of emotional muscle. Closed-system defensive constructions that invoke magical solutions to helplessness and trauma create internal structures that are static, brittle, and ultimately undermining to the personality (J. Novick and K. K. Novick, 2009b). Here we see another benefit of utilizing a two-systems model: it allows for incorporation of important and salient advances in adjoining fields, such as research in resiliency, risk and protective factors (see, for example, Cicchetti and Rogosch, 2007), and positive psychology (Seligman, 2002; Seligman et al., 2005).

In Rachel's case, her resistance to working to strengthen her emotional muscles related to her wish to retain sadistic gratification, her general fearfulness over setting aside omnipotent beliefs, her difficulty in tolerating affects of any kind, her unwillingness to regulate and modulate feelings in a socially acceptable way, to take responsibility for her wishes and actions, to stand frustration, and to consider alternatives. Verbalizing one goal of treatment as helping her develop stronger emotional muscles gave Rachel an incentive and the courage to try to face things that made her anxious.

Rachel frequently abused me with taunts, such as, "You're all alone. Your mother and your sister left you and you'll be dead soon." I said, "That sounds like such an awful feeling. I'm glad I would be able to face it and think of what to do about it now. Your song showed that you also have the emotional muscle now to face that kind of feeling and make something out of it. But if we were babies, we might not know what to do—we might feel completely helpless and have to find some magic to feel better or put these feelings out onto someone else."

OPEN-SYSTEM RECONSTRUCTION

Psychoanalytic ideas go in and out of fashion for various reasons. We suggest that reconstruction may have fallen out of favor because it was sometimes misused in an authoritarian way. Analysts sometimes either

told patients what happened in their pasts or developed images of implausible one-to-one correspondence with theorized infantile experience. We see an alternative in what we call "open-system reconstruction," where patient and analyst are developing a life narrative that makes sense to them both in the context of everything they know and experience. It has to be consistent with real knowledge from developmental research and child observation, as well as shared understanding of the complexity for the child of her experience with her own body, psyche, family, society and physical environment, as well as intergenerational effects. To us, reconstruction remains a crucial and effective technique for work with both closed- and open-system phenomena.

What do we mean by open-system reconstruction in the context of Rachel's treatment? I said, "Remember all the times we've talked about how everything comes from somewhere and means something? This is true for everybody, kids and grown-ups." Generalizing in this way eases the child's narcissistic worry that she is the only one who has had any troubles in the past or present. Then I could move to Rachel herself, saying, "We know, for instance, that your knowledge of music comes partly from all the music you've heard at home. Part of our detective work together is to figure out where all that good stuff comes from, as well as the bad stuff. So your song makes me wonder about that awful alone feeling we were also talking about."

The next crucial element in an open-system reconstruction is the fact that everyone finds some solution to the challenges of his or her experience. To a child like Rachel, one could say, "Those were such big feelings we've been talking about. Did you know that everyone, even a little baby, has to find a way to feel safe and protected when things feel too big? I'll bet you used whatever strengths you had when you were little to find a way to feel safe and strong."

We described earlier material that centered on Rachel's externalizations of everything bad, uncontrolled, smelly, and so forth, onto me. Just as she felt she did with her father, she was going to make me go away by her anger, her assaults, her calls to her mother to dismiss me. In the context now of developing an open-system reconstruction, the material can be recast as Rachel's capacity to find a way to deal with abandonment and feeling overwhelmed. Believing that she had made both her mother and father disappear protected Rachel from feeling helpless and vulnerable and established her omnipotent beliefs as a major defense. Her telephone calls and reports of my wickedness represented Rachel's efforts to be the one to actively get rid of me before I would abandon her. Here I said, "Now we can understand what you figured out to do—you made the other person the bad guy you could send away.

That was pretty smart for a preschool kid. Then you could feel like the boss who makes the others feel sad and lonely. Sometimes you do that here with me, and it makes you feel strong for the moment. The trouble is that then we wouldn't be together to play and figure things out. So we can find some better ways to protect you from feelings that are too big and keep us able to have fun and like each other."

Most patients of any age need the reassurance that their closed-system ways of coping will not be taken away; in fact they never disappear (J. Novick and K. K. Novick, 2006). I told Rachel, "Those old ways to feel safe will always be there. But we can add some new ones, so you have a choice. We'll notice the times you reach for the old ways, and we can wonder why and what made it hard to remember your new ways."

CONCURRENT PARENT WORK

The concept of the open system provides theoretical justification for substantive concurrent work with parents, which is so necessary to the maintenance and success of a child or adolescent treatment. Work with parents follows directly from the open-system focus on reality. This includes the parents' conscious and unconscious beliefs and fantasies. Anna Freud often quoted Augusta Bonnard's remark, the "psychic reality of the mother is the external reality of the child" (1970 [1966], p. 32).

Rachel used externalization as a major defense; this would alert us to look for externalizations and transferences within the family. I wondered in my work with the mother whom Rachel might represent? Did she remind Mother of anyone else—a parent or sibling and so forth? What similarities and differences with herself did her mother perceive in Rachel? What did her mother see as Rachel's strengths and vulnerabilities? How did she imagine her future? Rachel's mother talked about how much Rachel reminded her of her ex-husband, and much of the parent work involved helping her see Rachel as an individual in her own right.

Rachel and her mother experienced her early years very differently. This was an element in the pathogenesis, since they were struggling separately with different issues. The mother was dealing with her troubled marriage, post-partum depression, and her husband's abuse and deteriorating functioning, while Rachel was suffering from the unavailability of her mother, exposure to violence between the parents, abuse from her father, and then his departure. Part of the reparative work of treatment is to bring child's and parents' experiences into synchrony with each other, integrating knowledge of each other's emotional his-

tory. At this point Rachel's mother could apologize to Rachel for not realizing what she was going through, reinforce her protective function, and explicitly encourage and support the joint work of the treatment.

Parents can be introduced to the idea of "emotional muscle"; they can share with their child that they too are working on becoming strong enough to bear sadness, to accept responsibility, and to apologize. We use this to build a positive cycle of mutual support, encouragement, practice, and growth. This is set up in contrast to the family pattern of unchanging vicious sadomasochistic cycles of victimization leading to justified omnipotent rage, which in turn engenders terror and massive inhibition, leading back again to victimization. This work was crucial in helping Rachel's mother establish herself in the phase of parenthood.

Superego in the Two Systems

Rather than internalizing helpful values and benign authority in a realistic superego, children like Rachel use beating fantasies as internal controls (J. Novick and K. K. Novick, 2007 [1996]). The construction of a closed-system superego in middle childhood is a significant dynamic element in maintenance of closed-system functioning, as it supports, validates, reinforces, and legitimizes the vicious sadomasochistic cycle that appears in school-aged symptomatology. Such a superego begins by the school years to define the sort of person the child is—an out-of-control bully, a victim, or a loner, and so forth. This necessitates further ego distortion and often involves the child in isolative maneuvers or the development of a double life, with secret omnipotent gratifications masked by compliant behavior (J. Novick and K. K. Novick, 2004).

By means of a strengthened alliance with the parents, with the child, and between the child and her parents, the analyst can work more effectively on alternatives to persisting omnipotent beliefs. Middle childhood is the time when an open-system superego can be consolidated and reinforced from inside and outside.

As Rachel's treatment progressed, she became able to talk with me about the terrifying experiences of her early childhood and how much she appreciated the limits her mother and I currently set; they made her feel safe and helped her develop her own controls. In the alliance among Rachel, her mother, and me, the family pulled together. Rachel was able to integrate the different parts of her personality, and she and her mother were able to reconstruct a shared narrative of their complex family history.

In our developmental model of two systems of self-regulation, we see the years of middle childhood as a crucial opportunity to address

residual omnipotent functioning from earlier times and to prepare the child for adolescent development. Adolescence is the time when the closed system can get consolidated and define the course of adult development. Thus, intervention in latency is critical for preparation of a sturdy foundation for adolescence and adulthood.

Summary

Out-of-control children have always been with us. Indeed, in 1972 Anna Freud noted, ". . . against previous expectation, aggression looms larger than sex in child analysis, dominates the child patient's acting out and transference behavior and poses questions of technique, many of which are unanswered still" (p. 168). In this paper, we have made these suggestions:

1. The out-of-control behavior does not necessarily indicate a deficiency of capacity to self-regulate, but rather represents a mode of self-regulation in its own right.
2. It is helpful to conceptualize two systems of self-regulation, potentially invoked by anyone at challenging moments throughout life, to deal with the threat of trauma.
3. Predominant use of closed-system ways to self-regulate involves hostile, sadomasochistic, omnipotent defenses that pull development away from progressive possibilities.
4. Aggressive behavior occurs in the context of a family dynamic of externalizations and abusive psychological interactions among all members. This reality *mandates* concurrent parent work.
5. All psychoanalytic writers agree that interpretation alone does not adequately address out-of-control functioning and that additional techniques are needed. Unfortunately, these additional techniques are often described as nonanalytic and set up in opposition to dynamic work. A two-systems model allows us to integrate new techniques into a multimodal psychoanalytic technical stance.
6. This case illustrated the usefulness of many psychoanalytic concepts that have fallen into disuse, such as the therapeutic alliance, defense, superego, reconstruction, active technique, and corrective emotional experience, among others.
7. A two-systems model allows us to reclaim a wide spectrum of techniques as analytic and to generate ways to address closed-system functioning and nurture open-system strengths.
8. A two-systems approach leads to a definition of psychoanalytic treatment as a multimodal, strengths-based learning experience.
9. A two-systems model allows psychoanalytic therapists to demonstrate that a full psychodynamic assessment of a child and family can be the

> most useful *first* step in evaluation and treatment planning, rather than a last resort when all else has failed (K. K. Novick and J. Novick, 2013a).

We would like to underscore that our two-systems model builds on and elaborates the work of many psychoanalysts from Freud's dual-track model onward. It includes Freud's 1909 emphasis on cognitive beliefs in his engagement with the Rat Man's omnipotence, Ferenczi's openness to technical experimentation (1928), Aichhorn's creative ways to establish alliances with delinquent adolescents (1935), Anna Freud's emphasis on metapsychology as the "language of psychoanalysis" (1966) and her statement "There has never been anything like a classical child analysis" (quoted in Penman 2013), Stone's (1951) and Gill's (1951) reformulations of Alexander's "corrective emotional experience" (1950). We can incorporate Waelder's principle of multiple function (1936); Pine's synthesis of old, new, and reconstructed developmental factors of the personality to arrive at the idea of four psychologies within psychoanalysis (1985, 1988, 1990); and Brinich's summary of the many strands making up the fabric of child analysis (2013). We hope that we can, like them, reverse the unfortunate tendency toward a theoretical Balkanization of our field and consequent narrowing of "acceptable" analytic techniques.

As we attempt to integrate the many types of developmental models discernible through the history of psychoanalysis as a whole and of child analysis in particular, we note that closed-system functioning operates in a predominantly continuous, linear, and cyclical way, displaying unchanging and repetitive patterns, with only the content, but not the form, changing over time with growth of the child. Open-system functioning, on the other hand, engaged with reality and subject to its vagaries, can appear and arise at any time. The interaction of inner and outer experience can give rise to nonlinear, discontinuous functioning, with changes in the course of a person's development, including those triggered by the experience of treatment, possible at any point in life.

Tolstoy began *Anna Karenina* with the remark that "All happy families resemble one another, [but] each unhappy family is unhappy in its own way" (1970 [1878]). Much as we admire the author, we disagree, in that closed-system functioning tends to follow similar formats and patterns. Novelty, change, creative innovation—these happen in the context of open-system possibilities.

Rachel's first effort to deal with her traumatic experiences of being overwhelmed was not evidence of deficiency: it was the best she could do at the time with what was actually available to her from inside and outside. Her maintenance of those responses, using closed-system

mechanisms to serve legitimate, basic needs for safety, attachment, self-protection, and gratification, became repetitive and continuous in her functioning. Her behavior had a visible and plausible developmental history, a clear line stretching back to her early experiences. Treatment was built on her real capacities to offer her alternative solutions, but there was no way to know ahead of time that she could and would become a good athlete, dancer and musician, a student of history, an astute observer of herself and others, and a loving, sympathetic daughter. Those new choices, those discontinuities in her life trajectory, demonstrate the need for the metapsychological complexity offered by a two-systems model.

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