



INTERNATIONAL ASSOCIATION OF COUPLE AND FAMILY PSYCHOANALYSIS
 ASOCIACIÓN INTERNACIONAL DE PSICOANÁLISIS DE PAREJA Y FAMILIA
 ASSOCIATION INTERNATIONALE DE PSYCHANALYSE DE COUPLE ET DE FAMILLE

Revista internacional de psicoanálisis de pareja y familia

ISSN 2105-1038

Nº 11-2012/1

El psicoanalista ante las familias y las parejas del Siglo XXI: nuevos desafíos técnicos

**FAMILY PSYCHOANALYTICAL PSYCHOTHERAPY:
 CLINICAL MATERIAL REGARDING SIMULTANEOUS
 PSYCHOANALYTICAL THERAPY OF PARENTS AND
 MINOR**

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More and more are coming to the practice presenting emotional impasse, with more or less fully declared symptoms on the part of family members and very often the disturbances in question are presented by the children. This paper will show the application of

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psychoanalytic psychotherapy in which family groups are treated using parallel parent-child settings with different therapists: co-therapy with the parent couple, and a single therapist working with the child.

The case we present here highlights how, through the psychotherapeutic and psychoanalytical treatment used in the two distinct settings, the parents' therapy led to a rediscovery of the patients' inner world and how confrontation with their partner stimulated a reactivation of phantasies for the spouses as individuals and as a couple, with a positive outcome for the family dynamic as a whole. The child's therapy led to not only a more natural growth and mobility of his inner world but also to greater breadth and definition of his emotional sphere. External supervision of the group of therapists guaranteed integration of the unconscious family dynamics, reducing the chances that fragmentation or splitting could compromise or damage the therapy.

A family comes for a consultation. They have been referred by the seven-year-old son's pediatrician because the boy presents persistent constipation described as a will at all costs to retain feces, including through somatic contortions. The main concern, especially for the mother, is for the boy's extremely hostile behaviour, for the aggression shown toward his mother, the jealousy of his little sister and of the tantrums where he throws himself upon the floor, shouting and crying desperately as a result of even minor failures at school or corrections or when losing a game or object. It is this desperation at losing something that also leads the boy to accept the help of a psychologist and later he will tell his psychotherapist that this is the main cause of his malaise.

The mother works as a learning support teacher and at the time of the consultation she is supporting an autistic child. She is worried that her own son may be autistic. She frequently compares her son with her student and complains of the same sense of frustration and desperation.

The parents agree to enter therapy with a pair of therapists separately from their son's therapy. The therapy will not be easy. The few interpretations offered will be denied or rejected and at a certain point the pair will also ask for the pace of sessions to slow down. The child's therapy will also be questioned just as the boy presents the most significant changes and the child shows great pleasure at the idea of going to see his therapist.

In the first sessions, the mother seems frightened and incapable of dealing with her son's outbursts; at home he often says: "I hate you and when I grow up I'll kill you". This triggers angry behaviour on the part of the mother because her son does not correspond to her expectations, making her feel unfit as a mother, which in turn aggravates her expressed, indeed, declared, depression.

The therapist who met the couple for the first time in our waiting room recalls the strong impression she had of this brooding woman who looked angry and standoffish, hunched over herself, perceived as particularly "dark, black" (physically and psychologically), which also gave an impression of dirtiness. The therapist also recalls her initial desire not to meet the mother, to not take care of her; the impression changes, however, from the first meeting where there is evidence of positive transference and an implicit request for help from the woman. Looking back, the

impression of dark and black seems linked with the image of a grieving woman, and at the same time the sense of dirtiness is linked with the feces retained by her son which often soiled the boy's underwear. The image the therapist had of her corresponds exactly to the way the woman will describe her son: always brooding, angry at the whole world, hunched over himself, never happy with himself or life, considering himself incapable of anything, which is why he hates homework, corrections, school and doesn't want to go there. This is just what the mother also feels and this attitude often caused her not to take on certain jobs because she felt she wasn't up to doing them. She reports that she always feels anxious and expresses worry that her son may be just like her. During the sessions, it emerges that the mother is concerned her son may make some rash gesture because the boy says and writes (in notes he hides in his room) things like: I'm so unlucky, life stinks, I want to die, I'll kill myself, I'll throw myself off the balcony.

The mother's story of how things are going, of her experience, together with the therapist's counter-transferential experience, give the impression of a considerably insufficient mother-son relationship. The mother is affected by her own dirtiness and darkness so that she may take in her son's dirtiness and darkness. In terms of the maternal function, what seems saturated is her ability to function as, in Meltzer's expression, "toilet-breast"; that is, the child's need to have, in the outside world, an object that is able to contain projections (Meltzer 1967). Projections which circulate freely uncontrolled within the family and at once invade therapy, searching for a suitable and transformational container.

The father is good-looking, apparently of a sunny disposition, with a ready smile, but somewhat taciturn. One is struck by the light-hearted way he talks about even his most terrible life experiences, laughing openly and unrestrainedly. He also compares himself to his son: like the boy, he was afraid of things when he was young, of the dark, for example, and had terrible nightmares in which ferocious animals attacked him. He was terrified because he felt the real presence of those animals in the dark, to the point where he was convinced he could touch them and so up until the age of 11 he would run into his parents' room and get into their bed. The father goes on to describe his very unconventional and spiteful behaviour towards his two sisters, one older and one younger than him. He would cut the heads off their dolls, or cut the hair of the dolls which his sisters so carefully combed; he urinated off the balcony onto passers-by below; studied very little, what was strictly necessary to get by because he learned easily and quickly; then he would spend his days in the countryside, stealing fruit, deviating irrigation channels to flood fields; he joined opposing gangs that used to fight each other, and so on. His parents worked away from home all day and he was "out of control, crazy. Compared to me, P. is a little lamb! My grandmother and sisters had to tie me to a chair sometimes, but I always managed to get away. In the evening, my mother always defended me and justified what I did". He would have calmed down only later, as a teenager, including in his attitude to schoolwork.

This seemingly maniacal attitude reveals dissimulation and restrained handling of the man's aggressivity and violence. The father here seems more or less consciously to want to find an affinity with his own violence in that of his son, considering, again, more or less unconsciously, it to be in some way virile or manly. Nevertheless, he is able neither to see his spouse's

inability to deal with this violence, unlike the women in his own family, nor to understand how his son's violence has certain sadistic and at times masochistic traits.

The couple met at university: The wife had for some time been thinking of going off to live on her own but couldn't do it because she was afraid to live alone. She decides to live with her boyfriend (today, her husband) only after the sudden death of her brother which is particularly traumatic for her. He was found dead one morning in bed. She feels an uncontrollable desire to flee, to escape from that house where she can no longer sleep. Her brother's death leaves an unfillable hole in that house to the point that his bedroom is still exactly as it was when he died, and her son P. often goes there when he stays with his grandmother. The mother describes her childhood relationship with her brother as conflictual. She felt he was very envious of her and that she was considered, and felt herself to be, the good child. The association with what P. says of his sister – "I'm the bad child and C. is the good one!" – is particularly revealing in this sense.

Both spouses will report that P. was born two years after the death of the woman's brother, and that P. came to bring joy to them all, especially to his grandmother. Both partners will also report that they placed a great many expectations on this ideal child who was going to have to be the best, who was supposed to grow up quickly and make his way through life just as fast. And that was how P. behaved for the first year and a half of his life. An ideal child, clever, an early learner, well-behaved, sunny, a source of joy for them all. Then C. arrived, and her arrival also interrupted breastfeeding for P. which was still ongoing at that time. It was from that time that P.'s behaviour completely changed.

We will also learn that two months before she came in for consultation, the woman's father had died. "During my father's illness, I was calm and then after I reproached myself for not doing enough, because I had abandoned myself to ["lain down upon"] what the doctors were telling me ... when he got sick and we discovered the prostate cancer was quite far gone and the doctors said they had to remove the organ ..."

These two episodes of unresolved grief give us the key to understanding the complex mesh of this family's projective identifications (those "crossed projective identifications" referred to by Norsa and Zavattini, 1997), in which aggression cannot be spoken of, or thought of, but only acted out or placed in the other. The child retains violence in the coils of his colon or in behavioral acts, the father transforms his into mirth and pride, the mother experiences it as depression and persecution.

At his first encounter with the therapist, the boy goes straight to the toilet: he has to poop. The boy says he is angry with his sister who steals his toys. He can't stay still. He picks up a train and makes it derail violently. He chooses felt-tip markers and discards wax crayons. During the second meeting, the boy takes the train and arranges a race among the wagons. In the end "the winner is the one who has always been last". Then he goes to the toilet and tells the therapist, "You don't need to come". He does drawings, which he describes as "messes".

At the same time in the parents' therapy, this first stage brings to light the mother's difficulty in accepting the boy as a male bearing a penis not connected with an unmanageable violence. In her own family, she had "lain down" when the doctors had told her about

her father's prostate cancer. When her father's urogenital apparatus was seriously compromised and could be removed, she was finally able to "lie down" serenely with her father. At the same time, her brother's sudden death, experienced, as was her father's death, with a strong sense of guilt, is the uncontrollable effect of envious retaliation. In other words, the penis is violence, and trying to deal with it can be fatal. The son is autistic in that there has been no valid way to relate with him since the arrival of his sister, since, that is, the child has been unequivocally differentiated as a male child. Meltzer (ibid.) affirms that when the mother's breast disappears or is no longer available, the child substitutes buttocks for breast.

The father is indifferent. In his own family history, he has learned that this virile violence, of which he is the transgenerational bearer, is managed by women, that is, it is free to act sadistically without any paternal check/opposition.

Right away, the boy shows what his problem is: the management of his aggressive anal impulses. The difficulty to manifest them properly, to find an external container able to handle them, elaborate, neutralize and perhaps transform them. With its fecal mass, the train goes off the rails. At the first meeting, the boy goes straight to the toilet, needing to void his bowels. Once unencumbered, he rejects the wax crayons (fecal rods) in favour of felt-tip markers because he is now able to produce and draw contents less disturbed by the excessive violence of before. At the second meeting, the need to go to the toilet is deferred. And when it does arise, that phrase, "There's no need for you to come", with its negative verb, hints at a voyeuristic oedipal desire which, in terms of prognosis, is an encouraging sign.

Therapy proceeds simultaneously. With the parent couple, therapy focuses on restoring the mother-son relationship, leading the mother, who cannot see herself in her full maternal role but only as a supporting player, to abandon her *autistic* mental position, as well as involving the father with his own family, unfettering him from his experience of himself as a violent child in a patriarchal world.

It has already been demonstrated (Fraiberg, 1975) how unconscious transgenerational phantasms intrude upon the mind of the other, engendering phenomena of "psychic contagion" (Cramer, 1974), impacting the psychopathology of the child and the whole relational structure of the family (Dicks, 1967; Giannakoulas, Giannotti, 1985; Bonaminio, 1991). It is as though each member of the family cannot be themselves because someone else is acting in their stead and the borders of each one's Self are not respected but rather invaded by the others' unconscious phantasies.

Here is an excerpt from a session towards the end of the first year of therapy. The therapy almost immediately caused the boy's constipation to recede and considerably reduced the outbursts of anger. The boy begins the session playing with a ball and demonstrates some exercises his father has taught him to help him improve in goal. He has already worn on the football pitch the goalkeeper's outfit his father gave him. He says he no longer needs to come [to the practice] and asks the therapists if she would come [to his] home. He asks the therapist if she remembers how he used to get really angry when he lost something like when his school teacher gave him a mark like 7 and scolded him saying: "My goodness, P., you got everything

wrong. You're such a good student. How can you make all these mistakes?" Now he doesn't get angry. "This teacher is crazy! She gives us so much homework!" He does some drawings. He draws a goalkeeper and then a whale.

The child has clearly improved. In terms of therapy, an interesting note is raised by the crazy teacher who gives too much homework associated with his improvement and the invitation for the therapist to go to his home. The boy seems to have overheard his mother, or perhaps both parents, wonder, given the improvement, whether it was not appropriate to stop therapy; and he takes counter-measures. The crazy teacher who gives too much homework is a good definition for a mother who expects her son to resolve a lot of issues on his own, especially, in our case, issues linked to violence. And of a mother who demands that her son always gets top marks so she, the mother, won't be embarrassed. It is also noteworthy that at this stage of therapy, her mind at rest concerning her alarm about autism, the mother now asks the therapist if her son might not suffer instead from dysgraphia or dyslexia.

The boy is nine years old during the second year of therapy. Here is an excerpt from the last session before the Christmas break, as reported by the therapist. 'He runs up to the door and hides to one side. The mother says jokingly, "P. isn't here today". The boy smiles. The woman adds, "He's desperate, doctor. He's been doing this all day". I look at P. who looks at me and snorts. "Well, come in then, and tell me about your desperation". The boy says how "all his classmates are desperate because the teacher gives too much homework, 'not just him, you know'" [...] He says, "I think of this great game to play and start getting things ready and then along comes my mother and says, 'Get a move on, P.! Your

homework! And I have to drop everything". He adds that he told his mother that if she sent him to school the next day he would throw himself off the balcony. I instinctively reply that I would feel very badly if anything happened to him. He turns to look at me and says with a very affectionate tone: 'Why, how could I feel if something happened to you?'"

This is a rather heartbreaking exchange between P./Romeo and Juliet/therapist on the eve of their Christmas separation. The session continues with a game suggested by the boy in which child and therapist toss a ball of play dough against a little house that represents the school (let's get away like Bonnie and Clyde?). Finally he picks up some toy animals, dinosaurs, sorts them into teams, has them fight each other and kills them all off. "I remark that no one survives," reports the therapist, "he replies that he didn't know who to have win so he 'killed them all'." Therapist and boy say their goodbyes until the following January. "Well, okay. It's only for 15 days. What's that, anyway?" remarks the boy.

The dynamics related to separation and the intensity of transference and counter-transference are quite clear. What is more interesting is what happens with regard to the supervision of the work with the couple and the child, in which the couple's therapist and the child's therapist enter into a lively discussion. The couple's therapist claims that P.'s therapist avoids engaging with and interpreting the boy's aggression, while P.'s therapist claims that the boy's mother wants to see him as a pathological case when it is she who needs firmer handling. From crazy teacher-mother, there has been a shift to good mother/bad mother, good therapist/bad therapist, with all the possible variations, bad mother/good therapist, bad teacher/good teacher and so on, as well as inner conflict.

For our purpose, which is to demonstrate the complexity and interplay of projections in this technique, we see here how the force of projective identifications, in this case of the mother-child relationship, goes beyond the specific setting, which seems to have calmed down, and invades the other. Violence, destructiveness, the tendency for acting out, are represented in a more concealed way. Splitting and projective identification are their weapons, emerging in the lively confrontation between therapists. We believe that the restraining function of the therapist group, and the identification of pervasive dynamics through external supervision, are of fundamental importance.

Concluding observations

The work with P. based on the written sign and the spoken word in therapy give meaning to what is happening inside P., including within his body, as well as outside him, while helping to establish the limits and confines of his Self as distinguished from those of his parents. P., who at the beginning of therapy did not want to draw because he thought he was incapable or he would only draw "messes", gradually succeeds in transforming those "messes" into animals and figures: one of the first "messes" transformed will be a whale with its young inside. He is very envious of the other children seen by the therapist but one day he will tell her that she can use his transformed "messes" with the other children because they (the drawings) might be useful to them, too. At the beginning of therapy he is able to deposit his feces, concretely, in the therapist's toilet. Two years later, he is symbolically able to transform those feces into something useful and meaningful for others. Just two years after starting therapy, P. has become an excellent drawer. He was able to tell his therapist that not only is he no longer afraid when he loses something, but the problem of

retaining his pooh no longer existed. He was able to talk about his anger and his fears and give them meaning. It is worth noting how, in the course of therapy, the boy's "language" changed, as did his mother's way of reading that language. P., who from the earliest age had a very sophisticated vocabulary (and this was one of the signs that made his mother worry he was autistic), was incapable of talking about his emotions which could only express themselves through acting out or bodily functions. He gradually became able to talk to his mother about his emotions and what he feels. And gradually his mother began to think of him no longer as autistic but rather first as dyslexic, then as suffering from dysgraphia and then dyslalia. Now mother and son, who before could only say "I'm going to kill you!", are able to express their positive feelings for each other as well. The mother is very gratified by the affection P. shows her and is grateful to the pair of therapists for her inner change towards her son and for her new ability to read and understand P.'s "language". The boy has become an accomplished reader, inventor and writer of "stories" and lately his matricidal-suicidal threats have given way to a desire to talk with his mother and his therapist about death and about what one feels when one dies, with questions and answers closer to philosophical reflection than to a child's thinking.

We would like to emphasize the fact that, in our view, progress in therapy would not have been as rapid if the boy's therapy had not been flanked by his parents' therapy, by the therapists' teamwork and by external supervision. The mother intuitively right away perceives the richness of our approach to teamwork and will express her satisfaction for the benefits to herself, perceiving not only the improvement in her relationship with her son but also greater serenity and significant reduction in her sense of anxiety about her work at school.

It is worth remembering that the simultaneous psychoanalytical therapy of parents and child, organized as set out above, presents, in our experience, a number of specific features which we wish to highlight and to pool with other therapists. There are, of course, difficulties involved in implementing the two therapies simultaneously. We will deal here with technical issues, without considering for now the issues raised by the socio-cultural context. In our view, external supervision is necessary; it is an effective tool to gather, compare, identify, contain and process the dynamics that involve all therapists.

The parents' therapy, co-conducted, helped contain each partner's anxieties, put phantasies in their proper place, and allowed them to re-appropriate their respective unconscious contents, thus delineating the confines of their respective Self. "Parents can acknowledge and re-appropriate their anxiety and what they project onto their child as well as feeling supported in their ability to contribute to his growth" (Ricciardi and Sapio, 1982). The group of therapists acts as a container, making the whole family feel welcome, avoiding the laying of blame or the connotation of illness for this or that member and making it possible to intervene not only in the individual unconscious but also in the unconscious inter-psychic dynamics and the pathology of the bond itself.

Another necessary feature is the degree of therapists' adaptability. The technique is, of course, psychoanalytic, which means that the therapists have to be capable of evaluating technically, that is, deontologically, how far to push and when to stop. For example, the case we present here is quite classical, with the child presenting both symptom and pathology. As regards the parents, once we had established where the

deficiency lay, that is, with the maternal function, and in particular with what Meltzer calls the toilet-breast function, we were able to intervene in a carefully targeted way. The innovation, not to say heterodoxy, in our technique lies not in an exclusive mother-therapist relationship based on transference and counter-transference. Rather, we intervened putting the parents at the heart of a different context, one in which the mother's experience of virility as synonymous with homicidal/suicidal violence, the father's delegation of violence to female figures that was a hallmark of his own matriarchal context, are here identified, clarified and restored to their original contexts. This allowed the family unit to be identified as a unique whole, neither deriving from nor contaminated by their respective original families and further led to the recovery of acceptable levels of parental skills which, apart from being worthwhile in themselves, ensure that the child's therapy is not compromised but rather reinforced. Of course, and this is what we mean by the therapists' adaptability, the intervention will be more, or less, profound from case to case.

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