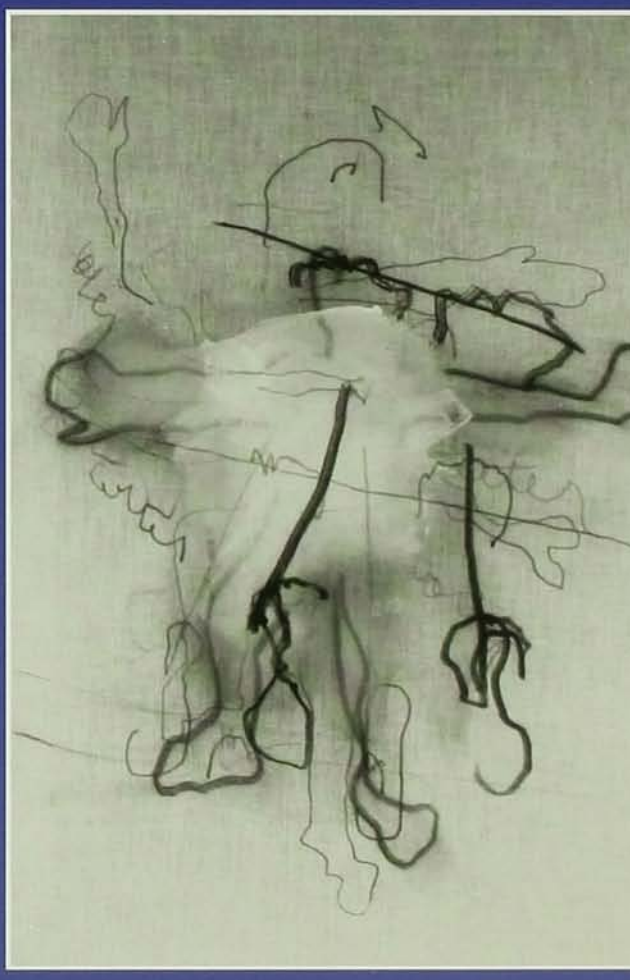
Etty Cohen

Playing Hard at Life

A Relational Approach To Treating Multiply Traumatized Adolescents



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Playing Hard at Life brings contemporary relational thinking to bear on the psychodynamic treatment of a notably difficult group of young patients: multiply traumatized adolescents, whose understandable hostility, resistance, even obstructiveness, render them poor candidates for treatment of any kind. Working with New York City teenagers who have survived the wars of inner-city life and Israeli teenage soldiers who have survived the wars of the Middle East, author Etty Cohen documents the extraordinary challenges of forming a treatment alliance with these shattered youngsters, of engaging them psychodynamically, and of working toward a viable termination. The result is not only a poignant record of courage and commitment (on the part of patient and therapist alike), but also a valuable extension of modern trauma theory to adolescence as a developmental stage with its own challenges and requirements.

The heart and strength of Cohen's book is her vivid documentation of hands-on encounters with her adolescent patients, seen both individually and in group. Cohen makes plain that, with young people so horrendously traumatized, treatment assumes a necessarily improvisational character. And yet, she argues, even in the type of pragmatic encounters dictated by massive and repeated trauma, contemporary relational theory provides a compass with which to navigate through the rocky shoals of the clinical work. Whether juxtaposing

(continued on back flap)

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Analysis should be regarded as a process of fluid development unfolding itself before our eyes rather than as a structure with a design pre-imposed upon it by an architect.

—Sándor Ferenczi

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Dedicated to the memory of my parents, Sally and Isaac Cohen.
Mom and Dad, it was too soon to lose both of you.

Contents

Acknowledgments

I wish to express deep gratitude to my patients—the subjects of this book—whose resilience and hope, despite multiple traumas and chaos in their lives, have been its source and inspiration. Their struggles affected me emotionally, and their unique participation in treatment led me to a new understanding of the psychoanalytic process in treating traumatized adolescents.

I am grateful to The Analytic Press, whose high standards every step of the way earned my appreciation and respect. I especially thank John Kerr, my extraordinary editor, whose compassionate comments on my book proposal moved me deeply. "Working with these kids is valuable simply as a human endeavor," he said. John validated my belief that the book is exploratory, experimental, and tentative since there are no definitive answers, as yet, to how to work with patients such as these, who often disrupt attempts at an orderly treatment. John's editorial suggestions deepened my thinking and writing.

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I feel privileged to be a training and supervising analyst at The American Institute of Psychoanalysis of the Karen Horney Psychoanalytic Center. I am deeply indebted to my colleagues and the candidates at this institute for stimulating my curiosity, which led to new ways of understanding the therapeutic process.

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Finally, I turn to my family: my brothers-in-law, Dani and Boaz, and my nephews, Asi and Avi. Though many miles separate us, they have always been an important source of support and joy. Above all, my deepest love is reserved for my three sisters, Rachel, Ronit, and Orna, whose unconditional caring was with me through all the pages of this book.

Prologue

It is not within the capacity of
psycho-analysis entirely to spare the
patient pain; indeed, one of the chief gains
from psycho-analysis is the capacity to bear pain.
—Ferenczi

Finding ways to treat patients with multiple traumas touches on profound issues in human experience. My choosing to work with such patients was strongly influenced by my own experience with grief and loss. As an Israeli citizen, I grew up in a society in mourning in which repeated traumas were a familiar part of the landscape. I was raised on war. I was barely in school when my uncles fought in the war of 1967. Six years later, three good friends and two close neighbors fought and died in the Yom Kippur war. I was called up from the reserves during the fighting and was stationed near the front line. After college I joined the Israeli Defense Forces (IDF) as a major in the Mental Health Corps and served for 13 years. I counseled young men and women who had been deeply scarred by the Intifada's activities in Lebanon and Gaza. Through two more wars—the Lebanon War of 1982 and the Gulf War of 1991—I continued my work with traumatized patients and shared their grief over the loss of friends, family, and fellow officers.

My therapeutic approach took shape after more than 25 years of clinical work and entailed long struggles to develop a theoretical orientation consonant with my experience. My introduction to psychoanalytic theory came during my work as a mental health officer with vulnerable soldiers in the Israeli army. The problem was that initially I had been trained in classical techniques, which neither suited my temperament nor were appropriate for the needs of my patients. I was unaware of other clinical approaches. I had struggled over the years to reconcile the discrepancies between my own values (I felt more comfortable with mutuality) and the

professional training I had received in the Israeli army, which was based on a hierarchical model of the doctor–patient relationship.

After I came to the United States, I found myself drawn to the battlefields of New York. The victims of the inner city are veterans and survivors of an urban war. They struggle to endure the violence that they witness in their families and on the streets. They grow up impoverished, abandoned, or neglected by their parents, surrounded by the temptations of substance abuse and criminal activity. As I had with the traumatized soldiers I worked with in the Israeli Defense Forces, I came to discover that little information was available to guide a clinician in treating traumatized inner-city adolescents. This book, based on more than 25 years of experience, is written to meet that important need.

After I became acquainted in New York with Ferenczi's theory and techniques, the paradigm I used was distinctly more intersubjective. The remote officer in me became an equal partner with my patients, and this kind of partnership suited me intellectually and emotionally. Ferenczi's writings became the main source for the theoretical framework of my doctoral dissertation, which was on the application of Ferenczi's theory and techniques to group psychotherapy with fragile, traumatized adolescents facing the loss of parents to AIDS (Cohen, 1997a).

Ferenczi inspired me. I read his works as though they were novels. The quality of Ferenczi's writing and the vitality of his engagement with his patients impressed me equally. I could not put the books down until I got to the last page. I was fascinated by the rationales for therapeutic approaches that fit my personality, my personal values, and my professional beliefs. Ferenczi's emphasis on mutuality informed my approach to my psychoanalytic control case (Cohen, 1997b). In this work I described in detail both the transference and the countertransference enactments that occurred in the treatment of a troubled youngster.

In recent years there has been a concerted effort to explore the impact of trauma on children (Green, 1983; Horovitz, 1985; James, 1989; Terr, 1990; Herman, 1992; Scharff and Scharff, 1994; Gil, 1996; Prior, 1996; Pearce and Pezzot-Pearce, 1997; Wolfe, McMahon, and Peters, 1997). The reaction of adolescents to trauma (Sugar, 1999; Anastasopulos, Laylou-Lignos, and Waddell, 1999), however, has received less attention, and adolescence as a distinct developmental stage has been largely ignored in trauma theory. A special issue of *The American Journal of Psychoanalysis* sets out to address the theoretical and clinical questions surrounding the ways adolescents deal with trauma and the ways trauma affects adolescent

development. This special issue includes papers by Giovacchini, Cohen, the Novicks, Mishne, and Frankel (Cohen, 2001).

In *Playing Hard at Life* I seek to demonstrate how a relational approach can be applied to treating these fragile adolescents. Although this book illustrates theoretical concepts that I found useful in working in all modalities with boys and girls, the focus is on a group of six female adolescents who were facing parental loss through AIDS. Some of them had been sexually abused. I also focus on two soldiers suffering from war trauma who were seen in a military mental health clinic and a female patient I saw in an inpatient unit; she had been emotionally abused and suffered from an eating disorder. I chose to focus particularly on these traumatized adolescents because they had the most powerful effect on me with regard to my countertransference feelings—and because of my often painful experience as a failed therapist. My therapeutic experiences with these patients were instrumental in leading me to develop the orientation I use in working with other vulnerable youngsters. It was from these patients that I learned to tolerate the chaos and ambiguity of beginning treatment without a theoretical agenda. They fight against attachment and are difficult to engage, but I believe that each can be understood in a way that fits each of them uniquely.

Their particularity notwithstanding, I believe that the cases described in this book represent a wide variety of traumatized adolescents and the general issues that occupied them and me. The names, identifying characteristics, and other details about the patients presented in this book have been changed to protect their privacy and preserve their confidence and that of their families.

Part I of the book extends the context of trauma from relational theory to its clinical application in treating traumatized adolescents. Part I explores issues in therapeutic relationships. This section focuses on clinical examples; secrets and self-disclosure, enactments, dreams, and dissociation and cultural difference. Part II highlights the evolution of the transference–countertransference matrix and includes the engagement phase—resistance and antitherapeutic alliance; the safety-phase—mutual tenderness; and the erotic phase—the confusion between tenderness and passion. Part III focuses on treatment plans; gender in the dyad; individual, group, and family therapy; contact with parents; and termination.

1

ON THE ROAD TO SURVIVAL

1

Secrets and Self-Disclosure In The Therapeutic Relationship

Felicia [singer]

She's blind.
There are no colors in her world.
Only black always black.
She's beautiful and scared.[1]

This chapter illustrates how a relational-constructivist approach can be applied to the treatment of multiply traumatized adolescents. Let me begin with a proposition from Hoffman (1998), namely, that the patient's and the analyst's experience and understanding of each other are, in the first instance, constructions. These constructions are based on the individual histories and personalities of the two parties and their interpretations of their participation with the other.

Within the constructivist approach, such as Hoffman's, it is axiomatic that analysts cannot know the full meaning of their own or their patients' behavior. As a result, constructivists argue for a heightened sensitivity to, and a tolerance for, uncertainty and spontaneity. Such contemporary psychoanalytic theorists as Mitchell (1993) have attempted to integrate constructivism and hermeneutic principles into a relational model. Mitchell clearly stakes out the constructivist position on knowing:

> It is impossible to envision a singular correct and complete understanding of any piece of human experience even as an ideal, because experience is fundamentally ambiguous . . . To say that experience is fundamentally ambiguous is to say that its meaning is not inherent or apparent in it but that it lends itself to multiple understandings, multiple interpretations [pp. 57–58].

[1] The poems at the beginnings of chapters were written by an adolescent patient and were published in her school newspaper. To ensure confidentiality, the name of her school is excluded.

From Mitchell's point of view, the construction of meanings in treatment necessarily occurs de nouveau and in an atmosphere of uncertainty. The analyst and the analysand are engaged in a continuous dance in which multiple meanings arise and are explored. Both parties in the dyad are capable of making correct interpretations: the rightness of fit of the therapist's view, when it occurs, corresponds to its match with the patient's core of experience. Balint (1968) referred to the usual disjunctions between the expectations of analysts and those of their patients:

> We analysts are often faced with the same experience. We give our patient an interpretation, clear, concise, well-founded, well-timed, and to the point, which—often to our surprise, dismay, irritation, and disappointment—either has no effect on the patient or has an effect quite different from that intended [p. 13].

Balint considered treatment failures to be the result of a "lack of fit between the analyst's otherwise correct technique and a particular patient's needs" (p. 22). He emphasized that a bad "fit" in treatment emerges out of an earlier relationship between the child and his or her caretakers.

Hoffman (1998) argues that the search for a rightness of fit and the making of good interpretations is a dialectical process. This dialectical process is, in his view, facilitated by maintaining an experiential openness to the tension between views that comprises a dynamic interplay between seemingly unrelated, opposing polarities, such as between discipline and personal responsiveness or between repetition and new experience.

To illustrate the application of the dialectical-constructivist view of the psychoanalytic process in treating a traumatized female adolescent, let us take the case of Keisha.

Keisha, an African American girl, was 14 years old at the time of referral to individual therapy. Her mother was concerned about her daughter's acting-out behavior, which literally risked her life. Keisha had lived with relatives since birth, because her mother was drug addicted and homeless and her father was in prison on robbery charges. She was an only child. After the mother discovered that she was HIV positive, she decided to raise her child before she died. Keisha, who did not know about her mother's illness, felt resentful toward her mother for taking her back. She felt a sense of loss over leaving her relatives. In the process, she also had to move to another neighborhood, which meant transfer to another school and separation from her friends. After the abrupt move, Keisha repeatedly

ran away until she realized that, if she continued doing this, she would be placed in a group home.

The mother asked for help in finding the "right" timing to disclose to her daughter the news of her terminal illness. At the time of the referral, two of my other adolescent patients had recently lost their parents to AIDS without being able to say goodbye. I was worried that Keisha would have the same experience. I felt that it was important, before meeting Keisha, to help the mother disclose her HIV status as soon as possible. In the first session with Keisha, I found myself struggling with my presumptions about the goals of treatment. I felt that the only thing that mattered was for Keisha to learn about her mother's HIV-positive status and then work through the feelings of both of them about that information. I soon realized, however, that there were other issues to deal with.

Keisha: I don't want to live with my mother. For 14 years she forgot about me and suddenly she remembers me. I am not a toy.

Etty: You express your anger now, but maybe you feel very upset inside.

Keisha: Did I say that I am upset? I don't even know her. I don't care about her.

Etty: I said that you are upset. But after your response I realize that I am the one who is upset that you could not live with your own mother as a child.

Keisha: But I like my grandparents [that is how she identified her close relatives who acted like her grandparents].

Etty: I understand that your experience is different from what I thought. You feel very close to your grandparents and you miss them. Tell me, how was it to live with them?
[Keisha described in detail how caring her grandparents were toward her.]

Etty: Since you did not live with your mother, I am wondering how it is now living with her.

Keisha: How can I know?

Etty: Yes, maybe you can't know.

Keisha: She is the one who needs therapy, not me.

Etty: Why do you believe that she needs therapy?

Keisha: She always yells at me and is angry.

Etty: What is she yelling at you about?

Another therapist might well have made other choices in conversation with Keisha about secrets and traumas. I expressed empathy with Keisha's pain at the loss of her relatives. I felt ethically conflicted, however, since I had information about her mother that was not disclosed and it affected my feelings toward Keisha. I was caught in a devastating loyalty-bind: whether to betray either Keisha or her mother. I could have been silent in the hope of getting more orienting information so as to develop an understanding of what was going on. I could have offered to meet her mother so I could understand the "reality" of what was going on between them. At this point, I chose to learn only from Keisha about her experience.

Classical psychoanalytic theory holds that transference is a distortion in the mind of the analysand. Past experiences are displaced onto the analyst, who then develops countertransference feelings in reaction to the patient. The classical position presupposed a well-analyzed analyst who maintains an autonomous observing ego and who can monitor his or her countertransference feelings through self-analysis. One element that distinguishes the relational-constructivist from classical approaches is that, in the former, the therapist relies more on his or her own subjective responses as a creative source of information about the patient and the interaction. In this approach, instead of neutrality, the analyst's mood, feelings, fantasies, and thoughts are seen as the path to the patient's issues. Instead of analyzing the transference as a guide to unconscious truth, the analyst works to understand why the patient constructs an experience in such and such a way.

Relational analysts assume that in spite of having been analyzed intensively, analysts are unable to detach themselves from the therapeutic interaction with their patients so that perforce they must be able to observe and work through their own unconscious participation on the fly, as it were. The relational orientation has both the patient and the analyst mutually participating in the therapeutic process and therefore affecting each other. The goal of the collaboration, again, is to achieve a rightness of fit of interpretations and mutual understandings. Ferenczi (1932) discussed this mutual collaboration in terms that explicitly subverted the old approach, which left correcting the countertransference to the analyst's self-analysis: "We gladly allow the patients to have the pleasure of being able to help us, to become for a brief period our analyst, as it were, something that justifiably raises their self-esteem" (p. 65).

I feel that such an approach is necessary in working with traumatized adolescents. Listening to Keisha's life history provoked sadness in me. My "expressive participation" (as Hoffman, 1998, calls it) in my interaction with Keisha can be described by four factors: (1) my participation included

an *affective connection, sadness, and tenderness,* in this case; (2) my participation was *immediate* and *unanticipated* rather than deliberate; (3) my experience came more from *within myself* than as a response to pressure from Keisha; (4) my participation offered Keisha a relatively new experience in the present rather than simply a repetition of something from her past.

I find a measure of relief in the constructivist approach in cases like Keisha's, since questions about reality versus fantasy are not focal issues. Instead, I could savor the ambiguities as emerging aspects of our coparticipation. This tolerance for ambiguity in the "truth" is significant in treating adolescents and even more so in treating traumatized adolescents. It enables one to find a measure of freedom from being ruled by a concern with what really happened.

Spence (1988) argues from a hermeneutic view that "narrative truth" is more central than "historical truth." Therefore, he sees truth in the analytic process as a matter of creation or construction rather than the slow accreation of "objective" data. Donnel Stern (1985), who has championed a constructivist approach to interpersonal psychoanalysis, argues that the epistemological questions in psychoanalysis have moved "from what we know to how and why we have the experience of knowing. The process of knowing is assuming as much importance as the content of knowledge" (p. 203). Mitchell (1993) notes that "psychoanalysis can no longer be a science in the way Freud thought about science. It is now a science that yields multiple truths, changing truths, truths that are embedded in particular interactive context of the analytic relationship" (p. 50).

These larger philosophical questions connect in many ways with current treatment issues. Writers who are part of "The False Memory Syndrome Movement" (e.g., Kihlstrom, Gliski, and Angiulo, 1994; Rauschenberger and Lynn, 1995; Brenneis, 1996) have suggested that certain traumatized patients are highly suggestive as well as fantasy prone. These writers believe that reports of events can result from a vivid imagination that is closely attuned to the implicit expectations of the analyst.

But Davies (1996), a leading spokesperson for the treatment of traumatized patients within the framework of relational theory, argues that what matters most is the pursuit of our patients' narrative truth. She questions the value of historical/objective truth.

> If we believe that there is, indeed, a newly emerging relational paradigm within psychoanalysis, a paradigm that stresses the multiple realities of each unique analytic pairing, as well as the multiple interpretive potentialities embodied in an essentially hermeneutic approach to analytic discourse, we