

Psychotherapy with Children with Intellectual Disability

Alicia Fagliano*

Introduction

The field of application of psychoanalysis as a psychotherapy is constantly expanding, as Freud (1918), in his visionary manner, imagined it. With respect to child analysis, it was in the 1920s when the ground was laid for the treatment of very young patients, with severe developmental disorders. Were it not for the more or less significant difficulties in the relationship with their parents, these children would have attained a normal intelligence. In this way, the consideration has been given to the treatment of children with intellectual disability with a normal basic structure of the nervous system but with severe neurotic disorders or psychosis, in the absence of genetic disorders or injuries,.

The emotional difficulties in children who suffer severe developmental disorders due to intellectual disability produced by genetic syndromes or cerebral injuries, are in general perceived as a consequence of the medical condition suffered at or before birth. Even from an early age, the type of treatment they are offered is educational or medical, or of special schooling, but the inclusion of a psychotherapeutic treatment is only very rarely taken into account. There is a paucity of papers in psychoanalytic literature where the psychotherapeutic approach of this type of child is attempted.

In this paper I intend to present in greater detail the psychoanalytic understanding of the children with mental disability, and the resulting advantage in the full development of their personality, which contributes to the improvement of the quality of life of the child and his/her family.

* afagliano@gmail.com / [CV](#)

There is a widespread view within the psychotherapeutic field in general, and the psychoanalytic one in particular, that the intellectually disabled, due to genetics or injuries are not likely to benefit from an individual psychotherapeutic approach.

We know that the intellectual development of children with such difficulties does not reach the complexities of the symbolic thinking of a subject with a normal nervous system, but that at best, in mild impairments, they reach the level of concrete operational logic.

I will now clarify the terminology used, so as to place the group of children to which I will refer. These are circumscribed specifically to the field of the oligophrenia or mental retardation, as deficit disorders because of genetic or non genetic origins (malformations, chromosome abnormalities or acquired mental retardation of prenatal, perinatal or post natal cause), to differentiate them from the field of mental disabilities that are a consequence of severe developmental disorders, as for example childhood psychosis or severe neurosis.

One added factor that makes this approach difficult, is the deficiency in language development, since it is limited and appears later; in many cases riddled with dyslalias and in others not developed at all, in the latter I only discerned the appearance of a few syllables. What is usually prescribed in the case of infants or very young children, is early stimulation, more than some type of family psychological treatment or support.

Paradoxically, almost exclusively the children who presumably are normally intellectually equipped, (as there is no organic or genetic pathology causing their disorder) can have access to a psychotherapeutic treatment even though they might be severely limited in their communication, expression and thinking. This happens with psychotic children, who potentially seem to have a normal or superior intellect even though they manifest severe symbolization and communication deficits that render them mentally handicapped.

A further complexity is brought by the somewhat "practical" queries that both the parents and the medical and pedagogic community raise. That is, is it worthwhile to invest the effort involved in a long term therapy, with a child that presents from the start of his/her life potential developmental limitations, were possibly he/she will not be able to acquire the necessary autonomy to fend for himself/herself as an adult? Will there be a benefit that will alter the living conditions for these children?

Background Clinical Theories. Reflections

It is probable that the idea of excluding the mentally disabled children from a psychotherapeutic approach, is based on some of Freud's statements about the psychoanalytic method and the type of patients to whom it could be successfully applied.

In "Sexuality in the Aetiology of the Neuroses" (1898): *"Psycho-analytic therapy is not at present applicable to all cases. It has, to my knowledge, the following limitations. It demands a certain degree of maturity and understanding in the patient and is therefore not suited for the young or for adults who are feeble-minded or uneducated."* (Pg.282, Vol.3). Later he adds: *"I think it very probable that supplementary methods may be devised for treating children and the public who go for assistance to hospitals."*

In "Freud's Psycho-Analytic Procedure" (1904) *Various qualifications are required of anyone who is to be beneficially affected by psycho-analysis (...) Furthermore, a certain measure of natural intelligence and ethical development are to be required of him; if the physician has to deal with a worthless character, he soon loses the interest which makes it possible for him to enter profoundly into the patient's mental life."* (pg 254, Vol 7)

In "On Psychotherapy" (1905): *"Now analytic psychotherapy is not a process suited to the treatment of neuropathic degeneracy; on the contrary, degeneracy is a barrier to its effectiveness. (...)I do not regard it as by any means impossible that by suitable changes in the method we may succeed in overcoming this contra indication—and so be able to initiate a psychotherapy of the psychoses."* (pgs 263-264 Vol 7)

These statements, I believe, discourage the possibility of imagining a psychotherapy for the mentally disabled child or young person, since intelligence and language are indispensable factors when considering a psychotherapeutic approach in general and in particular a psychoanalytic one.

But let us not forget that despite these assertions, Freud himself optimistically considered that in the future the application of his method could be expanded to other types of pathologies. Experience and further knowledge would lead to the establishment of the necessary technical changes to widen the scope of work.

In Lecture XXVIII Analytic Therapy (1916) *"Analytic therapy, as you know, is in its youth; it has taken a long time to establish its technique, and that could only be done*

in the course of working and under the influence of increasing experience.” (Pg. 458, Vol.16)

In *“Lines of Advance in Psycho-Analytic Therapy”* (1918) *“On the other hand, it is possible to foresee that at some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery; and that the neuroses threaten public health no less than tuberculosis, and can be left as little as the latter to the impotent care of individual members of the community. When this happens, institutions or out-patient clinics will be started, to which analytically-trained physicians will be appointed, so that men who would otherwise give way to drink, women who have nearly succumbed under their burden of privations, children for whom there is no choice but between running wild or neurosis, may be made capable, by analysis, of resistance and of efficient work.”* (Pg. 167, Vol.17)

In the same paper Freud concludes by saying: *“It is very probable, too, that the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion (...)But, whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psycho-analysis.* (Pg. 168, Vol 17)

The task that I propose, as difficult as it may be, is the avoidance of further affective and mental deterioration, and permanent committal to an institution of mentally disabled young people or adults. To prevent this happening, the person needs to have the opportunity to develop a consistent self, insofar as his/her own circumstances permit.

One can observe in the history of the development of psychoanalytic theories, how Freud’s statements on the progress and broadening of psychoanalytic psychotherapy has been happening thanks to the fundamental theoretical and clinical contributions of the French and English schools. This allowed for the work with psychotic patients, with young children and with severely disturbed patients.

Already in her first papers, Melanie Klein deals with the problem of intellectual inhibitions. In an article dedicated to the study of neurotic inhibitions of talent, *“Infant Analysis”*(1923) she states that *“...the absence or presence of capacities (or even the degree in which they are present), though it appears to be determined simply by constitutional factors and to be part of the development of the ego-instincts, proves to be further determined by other, libidinal, factors and to be susceptible of change through analysis.”*

Within psychoanalysis it was Maud Mannoni, who, in her book : *"The Backward Child and His Mother: A Psychoanalytic Study"* introduces in the clinical the emotional issues of retarded children and social prejudices (including those of the psychotherapists) that deny the emergence of their own subjectivity.

Anne Alvarez, in her book *Live Company* (2001) when reviewing the expansion of the scope of application of the psychoanalytic method, emphasizes Donald Winnicott's influence and the new treatment areas that have been explored lately.

"There have been further developments, many in the area of preventive psychiatry. The teaching of Donald Winnicott, the great paediatrician and child analyst, has inspired child therapists, already trained in infant observation, to begin working in baby clinics and obstetric and paediatric units in general hospitals to help mothers of distressed infants with feeding or sleeping problems (Daws 1989). Some are being asked to help mothers with babies who seem too withdrawn for their own good. Some are consulting to day care centres for babies and under fives, some to residential children's homes and some to units for premature babies. Others are working with the emotional suffering of physically handicapped or terminally ill children and of the parents and nurses who care for them (Sinason 1986; Judd 1989). Although this work is not in every case always straightforward psychoanalytic therapy, it involves the use of many of its skills, especially sensitivity to and familiarity with primitive, nearly unbearably painful states of mind."

Starting points for psychotherapy

J. de Ajuriaguerra (1975) in his *Handbook of Child Psychiatry and Psychology* states: *"From this point of view, it can be accepted (...) that the mental deficit depends on the association of two criteria (each in isolation is not sufficient). A general inferiority of intellectual development that starts at the developmental stage and a poor quality of response to the social and natural environmental stimuli. (deterioration of the adaptive behaviour)"*

My reflections in this paper are around the phenomena of this second criteria. To what point is this quality of response determined by the severe disturbance of the early relationship with the parents, who themselves are burdened with a profound ambivalence and sometimes open rejection of this baby that is born different and with a poor prognosis of the development of her/his mind and personality? The birth of a handicapped child creates an intense traumatic situation in the family. The working through of this, will depend on the parents personality, on the situation the family is in,

and on a whole range of factors that will have to be considered case by case. But essentially, this birth has an effect on everyone's narcissistic equilibrium and this will decisively determine the upbringing of each particular child.

In this sense, as psychoanalysts we are studying with increasing interest, how the emotional ambivalence of the parents modifies the primary links that are the psychic foundation and in consequence up to what point these relationships lead to severe distortions in the development of the self and the mental world.

In any neurotic patient, the infantile aspects of their personality are modified by the ambivalent attitude of the primary objects. This becomes more pronounced in the disabled child.

Inhibitions caused by anxiety when faced with intellectual knowledge are understandable in the neurotic child. We can also understand the lack of development and deficiencies in the mental apparatus of a psychotic child, who is severely emotionally disturbed. But with a child with a diagnosis of mental disability, the expectations remain uncertain. The family and the environment believe that he/she will not achieve a development of his/her subjectivity that will underpin an original, productive personal identity, capable of integration into his/her family and the different groups into which he/she might have the opportunity to be included.

Many of the difficulties that Ajuriaguerra calls "deterioration of the adaptive behaviour" are the result of emotional problems caused by disturbances of their early relationships. These disturbances are perpetuated and they condition and increase the deficiencies in their intellectual development.

Since Freud we are aware that the development of intelligence depends, not only on the endowment of the central nervous system itself, but on the emotional development. In psychoanalysis the intelligence capability is directly related to the capacity to deal with inner anxieties, to the possibility of feeling safe within themselves and the environment, so as to go through those experiences that will progressively lead to the discrimination between me and the not-me.

The theoretical and clinical contributions that unfolded based on Winnicott and Bolwby's work, focus on the development of self awareness and the acquisition of identity and how they are affected by the early relationships. Theories on transitional space, play, real and false self, attachment, together with the fruitful research that is ongoing, stemming from their work, give us insight into the mentalization processes of children and the construction of their inner world from the establishment of their object relations and their internalizations. Both authors bring to the fore the deficiencies in the environment that determine either feelings of security or vulnerability resulting from the primary relationships that generate pathology.

These perspectives lead to understand with more precision the vicissitudes and risks of pathological developments in the constitution of the self. The mental endowment of mentally disabled children will be undermined to a large extent because the optimal path of development (Bowlby) will be hindered by the constitution of a fragile and debilitated self. In many cases it is hidden behind the armour of a rigid false self and in more severe cases, the impossibility of integration leads to the appearance of psychotic features.

One might think that the treatment of this type of child would need significant modifications of the therapeutic technique. Certainly, modifications of the technique will need to be implemented, but in my experience, the analytic stance of keeping the setting, involving that fundamentally the analyst keeps a balanced, receptive and observing emotional attitude, make the necessary modifications quite unimportant, and these depend more on the individual case than on pre-established rules. The therapeutic endeavour also requires work with the family. These families need constant containment and therapeutic guidelines, so as to work through the traumatic situation and to expand their horizon, in such a way that they can harbour hope and an understanding as realistically as possible of the limitations of the affected child.

It is my understanding that the psychotherapeutic approach needs to be held in the theoretical and clinical framework of psychoanalysis. The theoretical framework is based on the studies about early development and establishment of the self. The clinical framework is working with the transference and countertransference. I believe that in no other way would it be possible to uphold these treatments, which usually are long term, and often continue through all the development until adulthood.

Our objective is to attempt to understand what is happening in each session. "*First of all to understand*" (Valeros, 1997). Attempting to achieve this, without theoretical prejudices that could contaminate the spontaneous relationship with the patient, keeping alive the ability to observe and detect small changes and new details in the therapeutic relationship. From this perspective, not one session is the same as the other, and this prevents the loss of interest mentioned by Freud. Understanding the situation of the family, which can be concretely understood in the countertransference which often is very intense and disturbing.

The fundamentals of this type of therapy continue to be, like Freud requested with the "*most effective and important ingredients of a rigorous psychoanalysis*": the hypothesis of the unconscious, infantile sexuality and the use of transference and countertransference to conduct the treatment. Important also is the understanding and

sensitive attitude of the analyst, and the way each patient is understood, a result of their own analysis, their clinical experience and their theoretical training.

Clinical example

Cecilia was 4 years old when she was brought for psychological consultation. She was referred by her neurologist and her physiotherapist because of her state of isolation and the despairing family situation which made it impossible to start any type of physiotherapeutic treatment or re-education or attendance at a special school. According to her parents, only at that stage had the neurologist given them the diagnosis of autism caused probably by an organic problem. They agreed to bring her to the consultation, hoping she would improve.

The neurological report stated: "...she suffers from severe mental retardation due to genetic causes. She presents mental retardation and atypical behaviours. From her first year she has developed symptomatic epilepsy..."

Her parents realised she had problems when she was six months old, and at nine months the diagnosis of developmental delay due to organic causes was made. They have another daughter who was 11 months old at the time of the psychological consultation.

During the first interviews they presented as overwhelmed, the mother could not stop crying and said: "If at least she would show in some way that she recognizes us, but she does not..." She said that she felt asphyxiated by her daughter's state and felt that she was not a master of her own life. This got worse since the nanny that helped her had to leave the family. The father tried to be contained and to keep his balance, although he recognized that sometimes he also felt suffocated. "When one does a lot and achieves very little it is exhausting".

The mother was constantly afraid that the seizures would repeat. Her emotional state was getting worse, she felt more demanded, trying to be all right and not look depressed.

When they brought Cecilia for the first time, they carried her, she did neither walk, nor talk and she had a vacant look. She did not show any type of reaction to the new situation. She looked like a rag doll, very thin and hypotonic. She seemed very fragile. At home, she either was in bed or on an armchair or she stayed the whole day lying on the floor. She did not sit up without support or stand up.

At the beginning I did not know if I would be able to help the little girl. Because of this, in the course of many months I worked with the mother in the session, talking with her and making small approaches to contact the girl. As the sessions progressed I

realised, based on very subtle changes in her responses, that Cecilia perceived me and would be able to stay on her own with me. Trying to work with her might make sense. From then on her mother waited in the waiting room.

I started trying to get closer to Cecilia. I would go down on the floor, next to her, at the beginning with no eye contact, but touching her hands and talking to her briefly. Cecilia, lying on the floor, was not interested by nearly any thing in the room, and apparently was not interested in me either. I insisted in spending some time close to her, but she did not give any sign of noticing me or responding, even if I called her name. She started vocalizing while shaking her head from one side to the other, self-stimulating.

At other times I would sit far from her, observing her from my armchair. Slowly I began to realise that she was observing me when she thought I was not looking. If I looked at her directly, she would turn her head or look away. Slowly these exchanges became a kind of game of meeting and escaping of looks. But they did not last long. After some of these exchanges she would stop responding and would retreat into self-stimulation moving her head rhythmically.

In one of the session she started to be attracted by the telephone cable which she would extend, shake, let lose and pick up again. One of those days I observed that while she was lying on the floor and holding on to the cable she extended it and let it go. She repeated this action again and again observing with attention how the spiral of the cable moved, extending and retracting according to her movements. She seemed to be exploring something.

In a following session, while Cecilia was concentrated in this activity, and because I feared that the telephone could fall on top of her, I told her to let it go. She stopped moving and she was still for a while holding the cable, finally she turned her head so as not to look at me and she let it go. I considered that this response was not a random, but that it seemed deferred in time. I realized that she was aware of me, and this fact allowed me to continue with the game of looks and with hand contact, knowing that I needed to be alert for longer to capture that offered responses in the interaction. That offered I started to notice in the interaction: she looked at me for a second, and then very quickly she lowered her eyes and looked sideways. I then would place myself in the direction she was looking. She would escape again and this started to become pleasurable, since I did not detect tension or rejection and she would smile faintly. Slowly I started to place her on a settee in order for her to be upright and I could watch her, facing her.

One day, while I was watching her, I was resting my feet on the settee she was sitting on, and accidentally I abruptly pushed the settee. It scared me, but for the first time she smiled openly and with pleasure. I moved her seat again and that made her

laugh again. This started a game that lasted a long time: I would hold her by the waist on the settee and I would move it, sometimes rhythmically, singing a song to her, at other times suddenly, which made her laugh even more.

One day, after the start of the session (she was brought in twice a week) I started to feel at a loss. She was kneeling on the floor, close to the couch moving her head without looking at me. By then she had been able to sit up and stay like that for five to ten minutes sitting on her legs. It was one of those days when I wondered what I was doing and if there was any point to it.

I took out a recorder that I kept in a drawer of my desk. In actual fact I was feeling paralyzed and with a heaviness in my heart that hindered my creativity. To attempt relief I started to play a simple melody, without giving a thought to what might happen. Cecilia got up immediately, she came towards me and crawled into my lap, took the recorder and looked at it. Then she looked at me and threw the recorder to the side with a pleased expression. In this way she demonstrated her curiosity and the need to participate, asserting herself in the act of tossing the recorder.

I picked up the recorder and played again. This time she did not pull away, she stayed close with her hands on my lap. She observed me closely, moving her head from one side to the other, smiling. Every now and then she would interrupt me taking the recorder in her hands and looking at it. By this she demonstrated her choreographic memory of the sequence of the game.

From that day onwards we started a period of games with music, singing and repeating every now and then, the game of moving the settee. Later on, while waiting for me with her mother in the waiting room, she no longer kept lying on the floor. She generally knelt, looking through the window. I would greet both of them and then go back to my office and play a melody she knew. I stood behind the door. When hearing the music she would get up and she came on her own, crawling into the office. She usually stopped at the door looking for me. When she saw me, she would come in. After a while, when stopping by me she would push the door to close it.

Once more I will quote Anne Alvarez (2001) who talking of the importance of focusing on the here and now of the transference phenomena states: *"In some ways, this attention to the present makes the work for the psychoanalytical therapist much harder and more demanding, but it also makes it much more interesting and infinitely more lively. The popular image of the zipper-mouthed, detached and frosty analyst-scientist really no longer applies. The comparison, instead, should perhaps be with a trained and skilled but constantly improvising musician who, like the patient, has to live and learn from felt experience and - not surprisingly - also from practice."*

This treatment continued for four years. It was interrupted by the need of the family to move to a different city because of work. In the meantime Cecilia was able to be integrated in a special school.

She was much more lively and connected, interested in exploring the environment, the relationship with her family and with me. Her mother reported that she was much more active around the house, that she would get into the kitchen and empty the drawers, taking out pots and anything else she would find. Although she did not walk, her crawling was very fast and she would stand supporting herself on the furniture. If she was called, she responded with a gesture or with a look. At times I heard her clearly saying "no". But she also would pronounce some other syllables, with the intention of communicating something. Her parents were much more relieved: they felt that even with her severe limitations, Cecilia was a child that now could affectively relate to them. The change in her mother was striking, especially when she was with her. She would talk and look at her differently, with the trust that her daughter could understand her, and in her own way also make herself understood.

Conclusion

To conclude I will transcribe a quote of Enrico Montobbio and Patricia Mainardi (1995) who worked for many years in Genoa, with mentally disabled children (Down syndrome) with a Bionian framework. They express a point of view that I share with them, and in my opinion it is the basis of the necessity of psychotherapy for this type of case: *"We start with an apparently obvious and sharable premise: every child with a disability always holds inside of him/herself a healthy child, that has the affective and educational demands as befit all human beings. Thus every person has a basic need, that we will call a need of normality. This need for normality is, from our point of view, something easy to understand, but hard to satisfy. It is interfered with by problems related to the biological conditions of the child and difficulties within the family, in particular within the mother-child relationship."* Certainly, through the early mother child relationship key aspects of the personal full fledged development of the mentally handicapped child are at stake. In the clinical case I brought, I did not describe this aspect in detail, but this girl had not been sufficiently touched, rocked, watched or lulled to sleep. Her birth brought about an intensely traumatic situation (maternal depression, over-adjustment of the father) which in the long term also affected her sister, who also developed over-adjustment and the attempt

by intense self-expectations to alleviate the distress that her parents suffered with Cecilia.

In a case like this, the hardest part for the therapist is to be able to be committed to observe avoiding pessimistic forecasts. The purpose of the therapeutic treatment was that of connecting with each other, within the limits of her possibilities and the hope that this would lead her getting in touch with the human environment and awaken her interest, not only of exploring her surroundings, but also being able to discriminate her inner and her outer world. And moreover, for me to have access to an experiential understanding of the parental struggle, and to help them in the working through of their own feeling of impotence, desolation, guilt, pain and rejection of their daughter.

The parental circumstances improved, because they observed and became aware that I would dwell on every detail of the communication with their child, which helped them to learn with me to watch attentively, and this in turn helped them to extricate themselves from their guilt. The relief this brought, allowed a much more fluid and affectionate relationship between all the members of the family.

There are numerous issues that arise that need thoughts and study. The traumatic impact of the birth of a disabled child, the study of the relationship with parents when they become depressed or they move away denying the existence of this child. In what way is the constitution of the self interwoven with possible pathologies in their later development. The prevention of these, treating the situation from the beginning and following it throughout the growth of the child.

From a more theoretical standpoint: how does the mental apparatus develop in children suffering pathologies that lead to mental disability? Does it follow the vicissitudes of normal development but protracted in time? Does an 'unconscious' agency develop, like in a normal child?

Finally I want to underline the importance of providing information and awareness to neonatology, paediatrics and specialists transmitting the knowledge that is being reached on this issue. And beyond the specifically therapeutic, the need to work and reflect about the educational and social integration of these children and young people. It happens frequently, for example, that in a manic reparative attempt these children are placed in normal school classes which often increases the drama of segregation and isolation of the child.

References

Ajuriaguerra, J. De (1980) *Handbook of child psychiatry and psychology*. Masson Pub. USA

Alvarez, Ann (2001) *Live company*. Tavistock- Routledge. London and New York.

Bowlby, John. (1988) *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Basic Books. Reprint.

Fonagy, Peter & Target, Mary. (1996) Playing with Reality: I. Theory of Mind and The Normal Development of Psychic Reality. *Int. J. Psycho-Anal.*, 77:217-23

Freud, Sigmund. (1994) *The Standard Edition*. Hogarth Press. London

Klein, Melanie. (1997) *The Psychoanalysis of Children*. Vintage. New Ed edition. London

Mannoni, Maud (1972) *The Backward Child and his Mother*. Pantheon Books. New York

Marrone, Mario (2001) *La teoría del apego. Un enfoque actual*. Madrid, Ed. Prismática.

Misès, Roger. (1977). *El niño deficiente mental*. Buenos Aires, Amorrortu editores.

Montobbio, Enrico y Mainardi, Patricia. (1995) "La normalidad negada". En *La identidad difícil. El falso yo en la persona con discapacidad psíquica*. Barcelona, Ed. Masson.

Pérez de Plá, Esperanza y Carrizosa Silvia. Comp. (2000). *Sujeto, inclusión y diferencia*. Méjico, DF, Universidad Autónoma Metropolitana, Unidad Xochimilco.

Stern, Daniel (1985) *The Interpersonal World of the Infant*. Karnac. London

Tustin, Frances (1995) *Autism and Childhood Psychosis*. Karnac. London

Tustin, Frances (1996). *Estados autísticos en los niños*. 2ª. Edición. Barcelona, Paidós.

Valeros, José (1997) *El jugar del analista*. Buenos Aires, Fondo de Cultura Económica.

Winnicott, Donald (2000) *Realidad y Juego*. 7ª edición. Barcelona, Ed. Gedisa.

Submission ID: 2162

Submission title: Psicoterapia Psicoanalítica en deficientes mentales