NONVERBAL COMMUNICATION IN PSYCHOANALYSIS: COMMENTARY ON HARRISON AND TRONICK

In the beautiful clinical material presented in this paper, we see Alexandra Harrison create an action-dialogue with her young patient Kate, containing and thereby transforming the fear-filled consequences of her patient's trauma. Harrison and her coauthor, Edward Tronick, use the material to illustrate their "dyadic expansion of consciousness model," a model for understanding the cognitive and emotional growth and understanding that can develop when a child's inner world becomes altered and meaning gets made, not just uncovered, through the interaction with a sensitive, empathically attuned other.

The session presented here has significance as a model for understanding what can transpire, nonverbally, in analytic treatment, not only with children but also with adults. Harrison demonstrates how what is communicated implicitly by our words and actions, as the communication takes shape in the back-and-forth movement between patient and analyst, may have more mutative power than an explicit communication. What I would add is that in some instances such implicit communications lose their power to alter a patient's inner world if they are made explicit.

Harrison's first moves were directed toward engaging her patient, Kate, who had begun treatment for panic attacks, stammering, significant separation anxiety, and a sleep disturbance, all of which developed after she witnessed the televised attack on the World Trade Center. Her mother was not available during this frightening event because she had

Training and Supervising Analyst, Washington Psychoanalytic Institute; Supervising Child and Adolescent Analyst, Cleveland and Seattle Psychoanalytic Institutes; Clinical Professor of Psychiatry and Behavioral Sciences and Clinical Professor of Pediatrics, George Washington University School of Medicine.

gone to the hospital for a minor medical emergency. Thus it is probable that even prior to witnessing the attack, Kate was aware of an atmosphere of anxiety in the household.

Harrison had a toy airplane and a dollhouse ready in her office; she knew of Kate's history, and of her cries, "Get those planes out of my head!" She was prepared to explore Kate's fears through play therapy, and she explains in the paper that she turned to play because Kate was so young. However, with older children (or adults who are phobic), even if an analyst is alerted to the content of the fears before meeting the patient, she generally does not approach the feared subject head-on. Instead, as Harrison did with Kate, analysts try to establish a relationship with the patient. Presenting oneself as curious, interested in connecting, without an agenda, without intrusion, is how we try to approach every patient, regardless of age. Though words are exchanged with adults, our implicit message is the same as Harrison's to Kate—that is, "I'm interested in you, I have some knowledge of how people feel (Harrison's pretend crying sound for the car that lost the race), I'd like to connect with you." None of this is said explicitly, neither with Kate nor with our adult patients, but it is the message we hope is received. Words can be ignored; to say to a patient, "I know what it is like to be sad," is usually much less effective than demonstrating such understanding.

Gradually Kate includes Harrison in her play world (by inviting her to go to the circus), and soon they have an arena in which Harrison can begin, tentatively, to work with Kate on the painful associations she has made between the vision of the World Trade Center disaster and her mother's absence. I say "tentatively," for again it is how Harrison presents herself to Kate that permits the engagement; it is the implicit, largely nonverbal component of her approach—her lack of intrusion, her gentleness, her careful attention to Kate's responses—that keeps Kate engaged.

Harrison then does something very important—something from which we can all learn. As Kate sets up a play scene that can be related to the frightening vision of people jumping from the World Trade Towers, Harrison introduces three options for jumping so that jumping no longer is an either/or proposition of survival or death, of hurt or not, of being safe or not. Her aim is to eventually alter Kate's vision of safety and danger so that Kate will no longer believe that either you are with your mother (all the time) or you are alone (forever) and in danger. As Kate and Harrison play with the idea of jumping, with a doll

getting hurt because she "took too big a jump" and dolls jumping safely (and softly) by making littler jumps in the safe space of the playground, Kate's fears seem to diminish, including, as Harrison suggests, her fear of what happens when girls are separated from their mothers.

Following the presentation of clinical material, the paper moves to a discussion of the "dyadic expansion of consciousness model," of the growth that occurs in normal development as well as in psychotherapy "when two individuals interact in a way that results in the disorganization of old meaning and the emergence of new meaning." In their discussion, Harrison and Tronick focus on dynamic systems theory to explain the process of change. I would like to examine another aspect of their work, that of implicit communication, an aspect they refer to often, but perhaps do not emphasize as much as they might. What they call messy, I call ambiguous, but I think we refer to the same quality. In the exchange between patient and analyst, where meaning is not fixed, the implicit communication of availability, containment, accompaniment, and tolerance allows for both the emergence of unconscious fears, conflicts, and wishes and their eventual transformation.

Harrison's nonverbal engagement and increasing incorporation into Kate's world of play, her nonanxious availability and willingness to follow Kate, gave her the tools, through play, to alter the meaning Kate had made of her experience. She moved her to a state of "criticality" that I translate (I hope not too inaccurately) as "receptivity." Play is a perfect medium in which to develop a state of receptivity. When a child is in the "pretend" mode, the defensive hypervigilance and guardedness felt to be necessary in the "real world" relax, and the child is much more available for a meaningful interaction.

However, as Kate's overwhelmed state abates, other defenses will be called into play, and the issues that lead her to be so profoundly affected by the television viewing will have to be addressed. So with Kate, as with all patients, the analyst, like a mother, must curb her tendency to regard the child's progress as a reflection of her own skill, and must instead tolerate the movement back and forth between regression and progression, between Kate being available for work and Kate pulling back, even becoming rejecting, as she struggles to make the new understandings and growth her own. Essentially, what I am suggesting is that while there may be a dynamic expansion of a child's (or an adult's) consciousness through the shared exploration of experiences, another important aspect of early development, and the

development that resumes with analytic treatment, is that space be made available for the child or adult to incorporate and claim the growth as his or her own. We can see the result of Harrison's providing Kate with this space when Kate takes over the exchange with the cars and initiates their interaction with her question, "Do you want some gas?"

How an analyst or parent makes available the possibility of autonomous functioning is important. For adults whose self-representation of helpless dependency serves multiple psychic functions, autonomous functioning may not be unambivalently desired. Many patients, regardless of their difficulties, develop, in response to the genuine help they receive, a powerful connection to the comfort-providing figure of the analyst, leading to an attachment that can be hard to give up. One can address this directly, but in traumatized individuals for whom protection and help were not available when needed, such attachment often becomes rigidly fixed, and cannot readily be modified. As with the initial trauma, words alone rarely help; rather, it is the nonverbal implicit communication that has the most power. For the analyst's behavior contributes to a patient's giving up (or holding on to) the idea of an idealized care-provider; that is, whether or not the analyst accepts the role of all-important other has a significant impact on patients. Mothers have the same task; they, too, must allow the child's world to expand beyond the dyad of mother and child and accept the pleasure in activities the child finds for himself with peers and others.

Harrison and Tronick suggest that it is mostly the child who communicates nonverbally. "Adolescents and adults," they say, "communicate primarily in language with abstract symbols." With this I disagree. Although there is much "talk" in the analyses of older individuals, much is also communicated implicitly, nonverbally, in all analyses. And it is in the exploration of what can be communicated nonverbally that this paper has much to offer for analytic work with adults, as well as with children and adolescents.

At some point in every analysis, verbal interventions, be they interpretations, clarifications, or "simple" comments about the ongoing interaction between analyst and patient, will lose their power to modify the patient. Whether the patient actively disagrees or superficially complies with what has been said, the words will be heard through a transference veil so thick that any impact is blocked. Young Kate could not use words to lessen her distress, both because of her age and because she had walled off the association between her current dis-

tress and her prior life experiences. However, older individuals, who may understand, intellectually, the origin of their difficulties, and may even "see" them played out in their life both inside and outside the analysis, may be unable to use their "understanding" to modify their internal object world because it too, like Kate's, has been walled off, leaving that world out of reach of the analyst's words.

In child analysis, even with a child who has not been traumatized as Kate was, but is "simply" dealing with neurotic conflicts, words can be "too much." Without the defenses necessary to protect her from their impact, words themselves can be traumatizing to a child, leading her to regress and remove herself from any engagement. This is why so much of child analysis, initially, occurs in displacement through the use of play. I believe that similar techniques are often necessary with adults, particularly when words cannot be tolerated or when perceptions are so fixed that words cannot touch the patient's internal object world. In these moments, the nonverbal behavior of the analyst, the "action" that accompanies the words, may be all that will influence the movement of the work. An analyst's failure to be defensive when attacked or accused of some impulse or wish (an openness to "wearing the attributes" so described, accepting the patient's fantasy), an analyst's tolerance of a patient's provocation or seduction without reaction or withdrawal (as opposed to saying to the patient that he wishes to provoke or seduce), an analyst continuing her availability in the face of a patient repeatedly inviting rejection—all communicate in a manner beyond words and may lead to an increased ability to self-observe, as well as to an expansion of consciousness, much as the authors have described with Kate. Our continuing availability, our honesty, our failure to retaliate, as well as our willingness to self-examine when we have retaliated or been mistaken or defensive—at times these are the only sort of communications that can be received, even if they are never acknowledged. These nonverbal implicit communications in adult analysis are similar to the moment-to-moment meaning-making that Harrison and Tronick describe. It is not that the information they contain cannot be verbalized, only that sometimes only a nonverbal approach can deliver the information in a way it can be used, particularly when there is no conscious awareness of the underlying concerns involved.

I suspect our field has not yet fully appreciated the importance of this implicit communication; we acknowledge the need for tact, acceptance, a nonjudgmental attitude, but I don't think we yet understand

fully what it contributes. Many of our colleagues in England speak of containment, the analyst's transformation of projections by understanding and implicitly tolerating them, which allows the content of the projections to lose its forbidden, dangerous quality. But, of course, understanding is never fixed; not only does it change in the back-and-forth between patient and analyst, it also changes over time, from one session to another, from inside sessions to outside, as a consequence of both intrapsychic and interpersonal experiences. And this changeable quality of perception, of self- and other understanding, must also be tolerated, implicitly, by the analyst.

Harrison has presented us with one session, but I suspect the work with Kate continued beyond that session—such fear of loss, of hurt, usually is multiply determined and requires more than just one session to be resolved. The analyst's attitude, her behavior and nonverbalized reaction to the patient's progressive and regressive movement, will be an important part of the work. For example, in the one session presented, Kate became a caretaker, telling the doll who said "Ow" that "You said 'Ow' because you took too big a jump." Being a caretaker could reflect her appreciation and identification with her therapist and/or her mother and be an important step in working through her concern about not being taken care of herself. But it can also become a fixed position (as we see with a number of older children and adults), a combination of projected need, masochistic surrender, and an attempt to control one's vulnerability. In addition, both the intensity of Kate's fear and her assumption of a caretaking role probably function as defenses against her own angry feelings—anger over the unavailability of her mother, her brother's getting to go to school while she remains behind, and myriad other factors. As the authors state, "Kate's conflicts about her hostility and aggression in the dependent relationship with her mother were catapulted into a new category of traumatic meaning when she witnessed the World Trade Tower attack on television in her mother's absence." Anger is a ubiquitous feeling in childhood (as it is throughout life), for young children's immature ego functioning and lack of experience render them susceptible to misunderstandings and frequent hurts. Their shaky reality testing often makes them fearful of these angry feelings, hence the need for projection, denial, and reversal of affect. In addition, most of the other defenses we see in adults are present in children, not so fixed, thank goodness, but called into play to prevent a child from being overwhelmed.

But Kate *was* overwhelmed by the confluence of events at the time she witnessed the destruction of the World Trade Towers, hence her profound regression and symptomatology. As the authors point out, when an individual is overwhelmed by trauma, the sense she has made of the trauma is often rigidly fixed, "closed to the meaningful input of others." Thus, attempts by parents and others to "explain" to Kate that she had nothing to fear from the towers falling, that her mother was safe, that she would not lose her, that she would be there in the morning after Kate went to sleep, had no impact; she could make no use of their words. Words could not touch her; the meaning she had attached to the destruction was rigidly fixed and could not be altered by any explanation.

Implicit communications have the ability to disrupt a previously held conviction (Chused 1996) and create a state of "criticality" or receptivity. When an analyst wears the attributes ascribed to her, she functions as a displacement object, much as the dolls functioned in Harrison's play with Kate. When patients have a "fear of dissipation of . . . psychic organization through opening it up to change," the analyst's tolerance of what is attributed to him, and his willingness to explore the patient's perception and understanding of the analyst's motivations and affects, can lead to these attributes losing their forbidden quality and make ownership of them more accessible to the patient and less frightening. And with this advance comes the receptivity or "criticality" that is necessary for change. In essence, what I am suggesting is that the expansion of consciousness that the authors describe can take place in adults as well as in children if we attend not only to the content of what we communicate, but also to our patients' receptivity to different modes of communication. When patients are unresponsive to our words, it may be only the implicit communication, the message in our nonverbal, moment-to-moment behavior, that can be received. Just as Harrison and Kate built a playground together and explored the safety of a "soft jump," so an older patient and an analyst, through elaborating and then examining the drama as projected onto the analyst, can render it less frightening and more available for exploration within the patient's internal world.

REFERENCE

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1805 Randolph Street NW
Washington, DC 20011–5339
Fax: 202–723–7896
E-mail: jchused@chused.com