The Many Meanings of Play

Born Blind

Playing in a Sighted World

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In a recent exchange of letters, Walt Stromer, a blind professor at a midwestern university, complains to Oliver Sacks (1991) that in his review of *Touching the Stone* Sacks has misunderstood how it is to become blind as an adult. Stromer (1991) writes, "I do know that the concept of darkness is not an appropriate metaphor for blindness. Those who are born blind have no first-hand experience as to light or dark. On the other hand, I don't know any person blinded later in life who would accept darkness as an accurate comparison."

In the exchange between Stromer and Sacks there are references to the inner eye, how it does or does not vanish with blindness. As Sacks puts it, "The particular point at issue is the extent to which loss of eyesight in adult life leads to a loss of visual imagery, visual conceptions of 'inner eye.' It is possible that this varies a good deal—as seems to be the case with auditory imagery, and auditory thinking, the 'inner ear' in those who have been deafened in adult life."

Keeping in mind auditory and visual factors, we are addressing the play activities of blind children—those born blind or who become blind soon after birth—in a sighted world. As sighted adults we try to traverse both the blind experience (much of which we have learned from adults who became blind after childhood) and the experience of childhood (much of which we have learned from sighted children).

With these disadvantages, we also keep in mind that as the child begins to speak at about twelve months of age, visual, auditory, olfactory, kinesthetic, and tactile perceptions are involved in the formation of language competence.

> During the first year an internal map of the world is constructed from a mass of incoming sensory data. Once a certain degree of thought, based on this experience, is achieved, the child goes on to acquire a range of communication skills of which language is the most important. Cognitive development therefore depends on

> the evolution of thought processes that are themselves dependent on normal brain function. It follows that either damage to the neuronal substrate underlying the evolution of thought or environmental deficiencies that limit sensory experience will lead to cognitive deficits that present clinically as disorders of communication.[1]

In a significant sense the blind child's approach to socializing and play in a sighted world is handicapped by the absence of part of the brain's capacity, the visual function. The eye is a vital elaboration of the brain's structure and function.

Psychoanalytic Theories of Play

Play as a means of better understanding the inner world of the young child was of great interest to Freud, who, in an important sense, mapped out for future theoreticians certain areas to be examined. He characterized children's play as essentially "serious." At the same time, he indicated that, in accord with the child's developing sense of reality, play was not "real." It seemed to have a quality midway between fantasy and reality and to represent the child's attempts to assimilate or integrate reality according to his or her own developmental stage with the cognitive awareness appropriate to it. Freud's perception of the importance of play seems to have represented a mixture of his imaginative creativity and his rigorous attempts to explore the meaning of this phenomenon of early life as he observed its manifestations in adult patients and as he learned about children, perhaps from his daughter Anna, who was in direct contact with children.

Freud's book on jokes contains important insights into the role of play in childhood, for in a sense he viewed play as a precursor to jokes. He stated:

> Before there is such a thing as a joke, there is something that we may describe as play or as a jest.
>
> Play—let us keep to that name—appears in children while they are learning to make use of words and to put thoughts together. This probably obeys one of the instincts which compel children to practise their capacities (Groos [1899]). In doing so they come across pleasurable effects, which arise from repetition of what is similar, a rediscovery of what is familiar, similarity of sound, etc., and which are to be explained as unsuspected economies in psychical expenditure. It is not to be wondered at that these pleasurable effects encourage children in the pursuit of play and cause them to continue it without regard for the meaning of words or the coherence of sentences. *Play* with words and thoughts, motivated by certain pleasurable effects of economy, would thus be the first stage of jokes.
>
> This play is brought to an end by the strengthening of a factor that deserves to be described as the critical faculty or reasonableness. The play is now rejected as being meaningless or actually absurd; as a result of criticism it becomes impossible. Now, too, there is no longer any question of deriving pleasure, except accidentally, from the sources of rediscovery of what is familiar, etc., unless it happens that the growing

> individual is overtaken by a pleasurable mood which, like the child's cheerfulness, lifts the critical inhibition. Only in such a case does the old game of getting pleasure become possible once more; but the individual does not want to wait for this to happen nor to renounce the pleasure that is familiar to him. He thus looks about for means of making himself independent of the pleasurable mood, and the further development towards jokes is governed by the two endeavours: to avoid criticism and to find a substitute for the mood.
>
> And with this the second preliminary stage of jokes sets in—the *jest*. It is now a question of prolonging the yield of pleasure from play, but at the same time of silencing the objections raised by criticism which would not allow the pleasurable feeling to emerge. There is only one way of reaching this end: the meaningless combination of words or the absurd putting together of thoughts must nevertheless have a meaning. The whole ingenuity of the joke-work is summoned up in order to find words and aggregations of thoughts in which this condition is fulfilled. (1905, pp. 128-129)

Among child analysts there is a consensus that play is an important feature of childhood and that the lack of it represents an impoverishment of the personality. Child's play is therefore one feature taken into account in assessment. Anna Freud (1965) viewed play as one of several major sources of knowledge about the child and his or her inner life, along with information from parents and the child's verbalizations and drawings. Absence of play was not, in her view, a symptom in itself, for she considered the major criterion for health to be the child's capacity to maintain progressive development.

Play, in terms of "pretend" or "imagination," is probably at its peak during the oedipal period when it can be observed easily and demonstrates directly the way in which children view themselves, with some emerging sense of past and future. In this period they maintain an unselfconscious attitude to play that is no longer in evidence in the later periods. During latency, play is associated with games; that is, delay, practice, and objective rules take over. In the group setting or in analytic work oedipal children are open in showing the ambiguities, contradictions, and conflicts that they will soon criticize in themselves as their defenses develop and as they attempt repression, reaction formations, and putting down earlier, now ego-alien, wishes and longings.

Freud noted the interesting connection between play and humor, linking play to the capacity for symbolization and playing with words. Ambiguities and contradictions become the focus for jokes shared between mature individuals; and the shared pleasure in using such incongruities as inappropriate words or unexpected outcomes becomes the focus as "wit" develops.

Imaginative play involves the creation of mental images dramatized in behavior. To a

considerable extent, children in their play reflect the way adults around them relate and use language. Much of what we learn from play is the way in which it relates to scenes and events taken out of context, often being concerned specifically with play roles—make-believe or pretend activities.

Psychoanalysts are concerned with how far play in childhood remains an important feature of life in adulthood as well as in what way and to what degree it is altered and incorporated into the capacity to work as the individual gradually moves from the pleasure to the reality principle.

The Relation between Vision and Play in Infancy

At the Anna Freud Centre, observations of blind infants and toddlers under the leadership of Dorothy Burlingham from 1958 into the 1970s led to a sustained interest in the role of vision in various areas of early development, including the early interaction and playful behavior between mother (or other care-giver) and child.[2] In these studies, looking seemed to stimulate the infant's curiosity and desire to reach out to the outside world. Along with touch and the feeling of comfort or discomfort, hunger or satiation, it played a role in the establishment of the differentiation between self and other. It was noted that blind infants could be outgoing, active, and in good contact with the outside world through stimulation of sound and touch in the context of and proportionate to the intensity of interactions with the care-giver. It was clear that with these early foundations the blind toddler and preschooler appeared much more like normal sighted children than those whose care-givers had, through their depression or withdrawal, been unable to relate closely to the sighted young child, to enjoy the infant and his or her progress. In some of the blind children we have known, the mother's pride in the child's achievements became an important element in the confidence and persistence of the children. What has been especially noted in the early observation of blind infants has been the way in which they are alerted to the tone of voice and the touch of the care-giver. (Olfactory experiences have been less well studied.) Tone of voice conveyed much of the pleasure or displeasure, praise or blame, that served as a main focus for the blind infant. This provided the baby with clues both to the mother's affect and to what she admired and encouraged—ways for the infant to please her. Thus, the child became sensitized and focused upon one person who was experienced as the source for all feelings of safety and well-being. Noted among the blind children in this group was their frequently asking, "Are you watching me?" This showed how

important the adult's attention was, just as there were many examples of the insistence on being the only occupant of the lap of the care-giver (similar to the behavior of sighted toddlers).

In a sense when we considered play in the first year or two of life (before language), it was usually in the context of a care-giver-infant unit and much of the child's activity was in response to and interaction with the mother's interest, encouragement, and pleasure. In this respect the blind child seemed to focus in an intuitive fashion and "glued" himself to the care-giver with whatever perceptual tools were available to him.

We were able to note which of those children who became blind before or soon after birth and who underwent hospitalization in the presence of the mother could maintain this close bond (which has been described as the toddler's clinging to the mother like a rhesus monkey—in other words with a primitive grasp). This contrasted with those who were alone in the hospital with the confusion and fear of the unknown, the inability to be aware of pending interventions of feeding, bathing, and the routines and procedures that take place in the hospital. Since not all interaction is comfort-giving or pleasurable, the question of anticipation is important. Vision is especially important in this respect partly because it gives an early warning signal; there is time to perceive and react according to the distance involved. Visual experience transmits clues as to whether the intervention will be tension- reducing and pleasurable or unwelcome and painful.

In hospitalizations the mother serves as an auxiliary sighted ego, warning or comforting the child who awaits medical and other procedures. Many clues can help the sighted infant anticipate what might happen. The rhythm of day and night for preparation of bath or bedtime has an important visual component, whereas the blind child has to learn associated equivalents or needs to be supported by a familiar adult functioning as an auxiliary ego. For example, recently a blind child had to be hospitalized for dehydration. His mother was unable to be with him, and his therapist came in several times to help him, to explain procedures, and to permit him to verbalize his anger, expressed mainly in his trying to remove the IV, which he hated. Nurses at first were sympathetic but soon became impatient and told him if he pulled out the IV, it would only be stuck in again. He was also angry and confused over having to wear a mask and not being allowed to go near another child of the same age (five years) because of risk of infection. He needed the therapist to interpret what

was happening and to help him deal with his anger. The therapist thought that her being with him at a crucial time when the mother could not was a turning point in her long-term work with him.

In the absence of sight, the mother provides direct physical contact as support and reassurance as well as verbal interaction with her infant. Later as the infant begins to crawl and walk, the mother elaborates her support with more specific physical and verbal guidelines. Warnings of danger along with encouragement and preparation of the environment become important in enabling the blind toddler to feel competent and to persist in expressing and pursuing what curiosity suggests. As independence develops, the mother serves as the child's eyes in development-promoting ways.

Those blind children who have been able to maintain an active stance have done so through an almost continual interaction with one or usually more than one consistent care-giver (such as a grandmother or aunt). The "others" in their lives have become known through voice, touch, smell, and the feel of the part of the body they come in contact with. The need for what might be called "visual interpretation" or "lending one's eyes" has an exclusive quality and does not easily generalize into the child feeling intensely involved with and yet separate from the family as a group. Direct individual attention is required, and the infant or toddler is alert to which person is interacting with her. There is more of a sense of being *in* or *out* of contact rather than feeling (socially and securely) satisfied in the presence of others. This would complicate the conditions necessary to achieve the capacity of being "alone in the presence of others" as described by Winnicott (1958).

The Anna Freud Centre was begun in 1947 for the purpose of training specialists in the study and practice of child psychoanalysis. In association with this center, community services were established where observations were made in a well-baby clinic and two nursery schools, one of which was for children blind from birth. This filled important clinical needs, since the United Kingdom was offering only residential settings for preschool blind children. One of the authors of this chapter functioned initially as a teacher and later as therapist for one of the children in this group.

In their preschool years when they were with other blind children either in their group environment at the nursery school for blind children or in analytic treatment at the Anna Freud

Centre, it was noted that the children made a complete distinction between the present and the absent care-givers. The absent person was rarely mentioned, and it was difficult to know how far she was a psychological presence for the blind child as an extension of being a concrete physical presence. Our children were always attentive to the telephone, which served as a link to reach the important persons in their lives. The doorbell, signaling the arrival of a longed-for or unexpected person with the connotation of separation, was important. On other levels, to a significant degree, blind children appeared to have object-constancy capacities and to maintain a positive feeling about the therapist whether they were frustrated or gratified. If sight were miraculously restored, would the "all-or-none" quality described become replaced by a fuller, more subtle object-constancy capacity?

Object relationships have an important place in play, as does the complex aspect of vision and other perceptual experiences in terms of the child's sense of safety and knowledge of and orientation in space. Blindness not only interferes with ordinary play and sharing with others to reach a common goal but also appears to inhibit fantasy formation, since the visual props are missing. In the therapy, there was evidence that play did not reveal the child's concerns, conflicts, and fears in the way that usually takes place with sighted children. The blind child was very absorbed in finding areas of safety in which he could experience pleasure. This was very different from the way in which sighted children try out various alternatives and demonstrate their anxieties, defenses, and fantasies. (Systematic studies in this area are yet to be conducted.) For these reasons, it is useful to describe the way in which blind children learn to function both in the group and in the psychoanalytic setting. These observations will further highlight how the blind differ from sighted children of the same age.

Analytic Treatment of a Blind Preschool Child

The treatment of young blind children is in principle the same as that of sighted children, but several features of their treatment differ greatly from the treatment of sighted peers. In particular, the therapist must be aware of activities available for blind children to elicit the knowledge of their inner lives and help them cope with problems caused by struggles of the ego in dealing with inner and outer reality. One wonders how the transference develops. How does the blind child experience

and use contact with the therapist as he or she is encouraged to play with and talk to this new adult? In the treatment, the analyst offers materials that will invite the child to verbalize and play out some of the concerns that give him difficulties. Where does the analyst begin when the child needs him as his "eyes"? What toys will stimulate his imagination and help him understand his fantasies? Since the blind child is very dependent upon the verbalizations of the sighted care-givers and must trust them to help him avoid dangers, how will he understand interpretations and to what extent will he accept them as useful? Will the child take interpretation literally and concretely? What is his perception of an adult who "plays" when the adult is perceived as a voice, an arm, a hand, or a lap?

Another important area relates to the parental perception of the therapy. The parents of the patient we are about to describe were rightly proud of their son and confident they could help him. They participated in and supported his verbal abilities and active attitudes. Having played a positive and successful role in his life, how did his mother feel about turning him over to a therapist who hoped to learn about his inner life and feelings? How would this be affected by the child's need to turn significantly from her to the therapist, a new "care-giver"?

Richard was the second of three children in an intact young family. The youngest was a girl twelve months old when Richard came to the nursery at age three about a year before beginning therapy. His blindness was not discovered until he was fourteen months of age, at which time, under examination urged by his grandmother, retinoblastoma was diagnosed. One eye was removed immediately, and the other received radium therapy necessitating several hospitalizations. Richard had had a little sight in the first months of life, and his parents denied any visual problem, though his grandmother commented frequently that the eye looked peculiar. He was treated as a sighted child for the first year and was thus stimulated and involved in active ways, which he experienced positively. After his sister's birth, he was encouraged to touch her, help in some of her care, and assist in her toilet-training by informing his mother when she was ready to leave the pot, needed a change, and so on.

Richard's father and an eight-year-old brother were very much involved in sports and spoke of them often. They tried to include Richard and played games with him. This promoted his identification with males and their activities. At times his brother took on the father role, especially

in regard to sports. Richard had his own toy cars, which actively provided for play with his older brother.

Richard also had a teddy bear, which he took everywhere with him. He often played hospital, with the bear being Richard and he being the care- giving mother. Richard was afraid of the wind (a not uncommon fear among blind children) and disliked sand (which he was familiar with through seaside holidays). He was friendly and talkative with the home visitor, but his speech was often babyish and not easy to understand. Richard's mother seemed tense and standoffish. The parents had not visited much during the hospitalizations, saying that the hospitals were well set up and the personnel better trained to help him than they.

Although Richard compared well with other children in the nursery group for blind children in that he was active, curious, friendly, verbal, and competent, his language difficulty and his hesitations and anxieties seemed directly related to blindness (fear of loud noises, lack of pleasure in task competition), which, it was felt, could be better addressed if more were known and understood about his inner life. Although all the children had a "special time" with a therapist, Richard's parents initially found the notion of psychological intervention puzzling and felt threatened by it. But in time, and with the help of Richard's grandmother who was very positive and undertook to bring him every day, Richard's parents came to see our involvement as a positive feature and were supportive. The fact that, like the other children, Richard made such an all-or-none kind of relationship with whichever adult he was with complicated our efforts to maintain a sense of his affective life. Other adults seemed not to exist for Richard. This existential kind of dependency relationship with its internal narcissistic satisfactions affected all those who worked with him. Adults helping Richard felt both stimulated and drained.

Richard used toys relatively well. He efficiently operated an electric car at home and built towers, garages, and railways in the nursery school, doing so very carefully, even standing on a chair to make them higher. He loved knocking them down and worried that the teacher or another child might do this.

From my first meeting with Richard I was aware of the impact of his need for an adult as

continual translator of visual reality; it was powerful in making the sighted adult feel needed and narcissistically satisfied. This was accompanied by an awareness of the continual anxiety to which he was subjected and his tendency to underemphasize his inner difficulties because of the dangers from outside.

When I came to collect Richard from the nursery school for the first time, many questions arose in my mind as to how he would understand and respond to meeting with me—a new person. Since I was neither a familiar teacher nor a parent, I wondered how he would think of our work together. Prior to this time, I had been a group teacher and was familiar with many of the special needs of blind children. For a long time, each of two teachers had at times gone on excursions with one or another child since it was clear that each child enjoyed and benefited from the one-to-one contact (lending one's eyes). It was subsequent to this observation that the second part of Dorothy Burlingham and Anna Freud's program to learn more about the inner life of the blind child—namely, treatment—was added to the educational work of the nursery for blind children. Child analysts working with the children could bring to bear new views and understandings different from those that had been explored in the educational setting.

Richard, on my first visit, was polite, but seemed apprehensive, as though he would have preferred to dismiss my presence. Fie found it difficult to leave the teachers and the nursery, employing what seemed like delaying tactics. Later it emerged that this was probably his way of attempting to assess a new situation, revealing his method of making transitions and dealing with separations. He encountered a telephone as we left and lingered with it. Obviously, it was a tool he had used in talking to his parents, other relatives, and friends to cope with separation and enhance his ability to communicate with absent persons. (Thirty years later the telephone continues to provide the possibility of instant contact, under their control, for these children.) On the way out, Richard stopped to ring the doorbell, a way of gaining the attention of teachers and peers as well as signifying to them his departure and separation. As we walked out of the front gardens, Richard bumped his head on the gate, an immediate sign of his vulnerability and his need to be helped in striving for independence while feeling safe and protected. After the bump, he cried briefly, with some anger and indignation. We climbed the steps of the building across the road, and he commented as someone left, "While we are going up the stairs, somebody is coming down." Richard

had unusually good hearing. Encountering the waiting room indoors, he examined it with his hands, at first asking repeatedly, "What is this?" He seemed pleased to try to answer his own questions by touch when the question was reflected back to him. He spoke in these terms as he spent the hour exploring the waiting room and hallway.

The next day he seemed more definite in his reluctance to leave the familiar surroundings of the nursery, showing me how he could build with blocks and how much pleasure he gained from knocking the building down. This was a little puzzling in that though he enjoyed the attention and praise given him and realized how much the teachers would have liked to preserve what he built for a time, he also enjoyed provoking a mildly negative reaction as he became restless and aggressively destructive and not nearly as pleasant for the other children in the nursery. When I insisted that we leave the group, his anger accelerated, and with a gesture of annoyance, he pushed bricks and toys from shelf to floor. Getting his coat, he threw the hanger on the floor, too, demanding that I put it back. I verbalized his sense of frustration at his lack of control of the situation and his anxiety about what going with me entailed.

Once outside the door, he ran along the way and across the street, pulling me by the hand. He felt a car parked on the street and asked where my car was, requesting that I take him to it, which I did. We spent the hour in my car, which intrigued him. Once helped inside, Richard took over, sitting in the driver's seat exploring the various switches and buttons. Fascination with mechanical devices is characteristic of the behavior of many children, blind and sighted. This behavior dramatizes how many children transform a passive longing and position into an active one as they take control of a situation. He wanted to start the engine and was elated when I did so; he demanded to use the horn, the windshield wipers, and the heater. Being in command of the sudden blast of the horn excited him. After a time, I decided the neighbors might object, so we moved a few blocks away. He was pleased and continued exploring. He wanted to master the hand brake and gears and asked about the headlights, commenting that they did not work. As I tried to think out a response, he continued his exploration of the dashboard, finding it difficult to leave when it was time to return to the nursery.

Richard was eager to come the third day and more exuberant in pulling me across the street.

Although he asked to revisit the car, he seemed very willing to come to the "new" treatment room. It seemed that familiarity with surroundings and trust in me went together. The initial reluctance was apparently based on the fear of the unknown; for the blind child transitions are difficult and not as available to them as they are to sighted children. Often they are experienced as sudden, dangerous, and fraught with unknown hazards. Richard clung to my hand. In the clinic building he asked for a telephone and called the receptionist across the street. In the treatment room for the first time he instructed me to close the door (a clear- cut separation or to keep frightening thoughts out?) and began a systematic tour of the room. This slow, laborious tactile journey taught him what a sighted person learns with a glance upon entering an unfamiliar place.

One characteristic deficit of blind children in a sighted world is the incompleteness of their composite "radar system"—the component sensory capacities for responding in a coordinated manner to the multiple stimuli, challenges, and demands of the external world. At a glance, the sighted child sees the larger picture of the external reality and what may be expected. Within this gestalt, the sighted child orients and chooses how and where to take the next step or how to respond and adapt to both external environmental demands and the desire or task that motivates the child from inside. It is very different for the blind child, who is oriented in the world by smell, sound, and touch, but lacks the visual component, a capacity essential to the well-functioning sensory "radar" in a sighted world. One child, when asked what sight might mean, thought it was like having very long arms. As I noted in these early sessions with Richard, it was as though he had in mind what he came upon through touch and what he could do with it. By using touch to make a first contact in outlining place and contents and uses, he dealt with whatever came his way. It was accordingly whatever came his way first that directed what he would do or what fantasy would be evoked. In contrast, the sighted child sees, chooses, touches, and brings to bear his own fantasies to express his intentionality and to mold his inner ideas to the overall picture.

On encountering lockers, Richard asked about them. I informed him that other children kept their private belongings under lock and key. He chose a space for his things. Much later in the treatment, Richard liked to crawl into his locker and close the door, begging me to lock it. In crawling around outside the locker, he found a doll in a doll bed and picked it up and squeezed it. When the doll's head fell off, Richard showed some concern and spoke to the doll soothingly, showing that he

had been acquainted with dolls and was perhaps reenacting a situation with his younger sister. He blew a kiss on the doll's leg and returned the doll to its bed. When questioned about his little sister at home, he acknowledged her existence but did not speak of her further. He asked me to help him play with a car and to show him how to play with some blocks, and then he was ready to leave. It seemed that he was accustomed to being "shown" how to play.

It again became clear how much blind children need to use the adult as a part of themselves in order to function adaptively in a sighted world. Richard demonstrated the need to replace vision in order to complete, in an essential way, the composite of perceptions so necessary to differentiate, clarify, organize, and focus on those aspects that provide efficient warnings of danger, conflict, and pleasure in the outer world. Without the visual component the blind individual needs to find a compensatory way of organizing multiple stimuli and demands in order to use the focusing, suppressing, and repressing ego functions in an adaptive and development- promoting manner. Richard demonstrated how he warded off a discussion of his sister in order to concentrate on the puzzling, demanding, and threatening "here and now."

There was also a frequently expressed fear that he might cause damage, breaking or destroying something or injuring someone. Richard eventually spoke of how worrisome his sister was for him, in the "messes" she made, and how disgusted he felt. When he was encouraged to elaborate these concerns, he often would say, "Be quiet. ... I told you to be quiet." In moments of distress he expressed his anger by the desire to hurl objects. On occasion he said, "I don't want to talk about all kinds of things that are horrid." His modes of responding to anxiety were associated with all-or-none reactions, which were closer to what could be thought of as primary process thinking. For example, the meaning of broken and his fear of the omnipotence of his angry feelings were confusing and difficult to discuss as treatment progressed. He might say, "Shall we talk about broken windows?" or "Can I break one?" or "I'm going to break a window; it goes smash, smash, smash." He wanted to throw the ball out of the window and said, "What will it sound like? What if it is a hard ball?" Rolling a ball down the stairs and listening to it bounce, he might say, "I better hold the bannister. Otherwise I might roll down the stairs like a ball."

As a sighted person, I always found it difficult to understand his view of the world and to try to

help him clarify it through words that might have meanings different from those in ordinary discourse. Blind children have to depend on the words of sighted adults to piece together their knowledge of reality. When I tried to explain that my lateness for a session was due to the fact that a car had been parked across my driveway and I had to find the owner in order to move it, he asked, "Why didn't you tell the car to go away?" Other confusions came up about the car. When I had dented a fender and had to take the car to the garage, he was anxious about it and too frightened to touch the dent. There were smells, such as tar on the road or paper paste, that he disliked and recoiled at touching or approaching.

Many words had frightening connotations, too. Years later I was puzzled when Richard as an adult told of a terrible nightmare he had had repeatedly, though only when he was sleeping alone. He dreamed of string. He conveyed his fear that string, perhaps like clay, might engulf and swallow the body altogether, like quicksand, so that one would be totally imprisoned by it.

In following Richard's curiosity and independent strivings, I offered him the opportunity to explore and use mechanical devices such as the typewriter, which he heard upon leaving or arriving. Trying it out, he would become frustrated and bang it angrily, disappointed that his efforts to imitate the sighted adults brought no satisfaction beyond the tactile-auditory experience.

Richard would "play at" using forbidden anal language, adding, "I am leaving you," and slamming the door as he went out to the hall. Once he sat sadly sucking his thumb, and when asked about it, he replied, "I 'spect it's 'cause I'm blind." This followed a weekend when his brother had been out with a sports group and Richard remained at home.

Richard was very frightened at any reference to the rag-and-bone man who went about with his horse and cart purchasing old items. Richard, talking about this, said he took old things such as shirts, shoes, and other articles. He volunteered that he was not frightened by the horse, but he did seem frightened by what he produced as the curious cry of the horse, imitating a somewhat unintelligible eerie noise. It never became entirely clear what had been so terrifying, but several times in this context the active Richard appeared to be totally paralyzed, needing to be picked up for reassurance.

Much of this emerged as the time for an impending hospitalization drew near. Many instances of fear and panic occurred in the context of his inability to anticipate and prepare for danger. The panic caused by the rag-and-bone man seemed associated with hospitalization and the sound of a gurney being wheeled into a ward to carry the patient to the surgical theater. On this occasion Richard demanded that I close the door to keep out flies that buzzed outside. He tried to barricade the door to keep the pediatrician out, fearing she would take him to the hospital. The anticipatory anxiety made orientation more difficult for him. Attempting to reassure himself about permanence, he asked the teacher to leave his sand castle for the next day. She agreed, while pointing out that if it rained it would wash away. He was worried about this and said if it rained, he would wave his shovel (like a wand) and make it stop.

Discussion

Much of the work with Richard focused on helping him verbalize inner and outer reality, sort it out, and integrate and comprehend his various perceptions and clarify his idiosyncratic interpretations of what he felt, heard, smelled, and sensed without the executive visual organizing capacity. At times Richard felt that his behavior caused great damage to others, to the world, and to himself. There were repeated efforts to ascertain how adults would react to his beliefs. Evidently a great deal that is communicated by the adult's facial and postural expression is profoundly reassuring to sighted children but not available to blind children. The lack of visual experience leaves the blind child in a state of uncertainty and apprehension. Safety is in the hands or eyes of the companion. The fear of regression looms as very threatening to blind children in treatment, just as in our group when the blind children stimulated each other's regressive wishes and loss of control as expressed in their shouting, throwing, and kicking. The notion they loved to share of "throwing the teacher into the dustbin" contained many exploratory speculations, including efforts taken for granted by sighted children in learning the differences in size and shape among people. They gain a sense of the whole physical person, whereas blind children depend on voice, touch, and smell to gain such comprehension.

It is very difficult for sighted adults to understand the world of the blind child. To provide "new" or learning tactile and auditory experiences for Richard provoked complex reactions and

anxieties. At times they could be overcome, but at other times the fear and negative reactions were relatively resistant to reduction and mastery. This was the case with working with clay, which was offered and encouraged in the program. A blind adult recalled how intensely he had hated clay and the experience of the sticky material covering his hands, preventing him from using his hands in other ways. Conversely, this same man recalled many scenes vividly, often those when he apparently enjoyed the feeling of "naughtiness," as had Richard in playing with clay. He needed to know and try out what limits there were. At the same time he worried about consequent damage.

It would appear, therefore, that the experience of play is bound up with that aspect of ego functioning that differentiates the inner and outer worlds. It is difficult to know how far blind preschool children are able to develop imagination, to put themselves in the role of another, even though they often reverse roles in their play with care-givers in what appears to be a form of imitative behavior. Imagining, as sighted people conceptualize it, requires the capacity to form the visual aspect of mental representations as a primary component of such psychic functioning. This probably cannot take place without a relatively stable concept of spatial orientation, which is established much later and in a different fashion in the blind child. The route the blind child takes is difficult to follow, partly because our understanding has to depend largely on verbalizations, and these come to the blind through the sighted adult labeling and demonstrating. If we follow in the *Oxford English Dictionary*, some of the many definitions of the verb *look*, we find many meanings besides "use one's sight," namely, "to contemplate, examine, make mental search, inquire, aim one's attention, observe"—all of which suggest figuratively many mental functions that help take distance from, gain perspective on, and integrate the stimuli we refer to as the impact and demands of reality.

The move into latency generally implies a resolution of oedipal wishes and confidence in the child's ability to acquire skills and envision a future in which he or she will competently take the adult's place. In the observations and psychoanalytic treatment of blind children, it is clear that the broader psychological configurations of the blind oedipal child are fundamentally the same as for the sighted child. The differences have not been systematically studied, but it is not a theoretical leap to assume that the blind child's continuing needs for the auxiliary ego visual functions of sighted, closely related persons (especially parents, siblings, teachers) have a modifying impact on the formation and resolution of the oedipal conflicts and on the continuing residual expression of

oedipal wishes.

Blind children use a variety of ways in which to adapt physically and mentally to a sighted world as they become aware of themselves. In this connection, Freud's formulation of the ego as a body ego is useful. Freud stated, "The ego is first and foremost a bodily ego; it is not merely a surface entity, but is itself the projection of a surface" (1923, p. 26). In a footnote that first appeared in the English translation in 1927, he added, "I.e., the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body, besides, as we have seen above, representing the superficies of the mental apparatus."

Human blindness reminds us that body and brain are intimately interwoven in the functions of the mind, as they are in the child's play. Thus we conclude:

1. Blind children have an ego deficit that requires that they have more care and guidance in order to be safe and oriented spatially and socially, and to enable them to sort out and organize the many nonvisual stimuli that impinge upon them.

2. Blind children with the assistance of sighted persons gradually develop special physical and psychological mechanisms to compensate for their visual deficit. Systematic psychoanalytic and nonpsychoanalytic studies of blind children at play will enable us better to understand ego capacities and reparative potentials as well as bringing improved relief to blind children and adults.

3. Central to this line of thinking is our need to acquire a better understanding of why blind children have difficulty playing in a sighted world. It is all the more important for blind children to be enabled to play, to pretend, to explore, to express, and to practice physically and mentally those functions of play and playfulness so essential to their achieving the fullness of the human experience and the capacity to reflect upon the human condition.

References

Burlingham, D. (1972). *Psychoanalytic Studies of the Sighted and the Blind*. New York: Int. Univ. Press.

___. (1979). To be blind in a sighted world. *Psychoanal. Study Child*, 34:5-31.

Colonna, A. (1968). A blind child goes to the hospital. *Psychoanal. Study Child*, 23:391-422.

___. (1981). Success through their own efforts. *Psychoanal. Study Child*, 36.

Curson, A. (1979). The blind nursery school child. *Psychoanal. Study Child*, 34:51-85.

Fraiberg, S., and Freedman, D. (1964). Studies in the ego development of the congenitally blind child. *Psychoanal. Study Child*, 19:113-169.

Freud, A. (1965). *Normality and Pathology in Childhood*. New York: Int. Univ. Press.

Freud, S. (1905). Jokes and their relation to the unconscious. *S.E.*, 8.

___. (1923). The ego and the id. *S.E.*, 19:3-66.

Greenacre, P. (1959). Play and the creative process. *Psychoanal. Study Child*, 14:61-80.

Nagera, H., and Colonna, A. B. (1965). Aspects of the contribution of sight to ego and drive development. *Psychoanal. Study Child*, 20:267-278.

Peller, L. (1954). Libidinal phase, ego development, and play. *Psychoanal. Study Child*, 4:61-80.

Sacks, O. (1991). Letter to editor. *N.Y. Rev. Books*, April 11.

Sandler, A.-M. (1963). Aspects of passivity and ego development in the blind infant. *Psychoanal. Study Child*, 18:344-360.

Sandler, A.-M., and Wills, D. (1965). Some notes on play and mastery in the blind child. *J. Child Psychotherapy*, 1:7-19.

Stromer, W. (1991). Letter to editor. *N. Y. Rev. Books*, June 13.

Wills, D. M. (1965). Some observations on blind nursery school children's understanding of their world. *Psychoanal. Study Child*, 20:344-365.

Winnicott, D. W. (1958). The capacity to be alone. In *The Maturational Processes and the Facilitating Environment*. New York: Int. Univ. Press, 1965, pp. 29-36.

Notes

1 From a commentary on the autistic child in *Lancet* (May 18, 1991), 332:1191-1192.

2 Observers made home visits and also observed mother-infant and mother-toddler pairs in hospitals and during planned excursions.