Forum THE JOURNAL OF

THE NEW ZEALAND ASSOCIATION OF PSYCHOTHERAPISTS (INC.)

TE ROOPUU WHAKAORA HINENGARO

VOL. 8 • August 2002

THE NEW ZEALAND
ASSOCIATION OF
PSYCHOTHERAPISTS (INC.)
TE ROOPUU WHAKAORA HINENGARO

Forum

VOL. 8 • August 2002

All articles are copyright to the authors and *NZAP Forum* 2002. Their content does not necessarily reflect the views of the Association.

Editorial

In his book *The Songlines* (1988), Bruce Chatwin describes how as a young man he awoke one morning to find himself blind. Understandably he smartly sought a medical consultation. His consultant suggested that he had been engrossed in examining paintings in fine detail for too long (he was an art expert at Sotheby's), and should take time to explore long horizons. His sight had returned by the time he reached the airport.

I read about this in Australia's Northern Territory, a place of long and broad horizons. I was clearing my head, perhaps my vision, after a period of intense focus both within my practice and in our Association as a whole. Professions call for such a focus, and psychotherapy is no exception.

Without regular contact with long horizons it is easy to become 'one-eyed', 'blind to what is important' - there are many apposite metaphors. My visit to the 'Top End' fulfilled a long-held dream. It is not the only long horizon I have touched during the past year. In supervision, at the Association's Nelson Conference, with my grandchildren, I have been called away from a myopic view.

The songlines of which Bruce Chatwin writes are physical paths of communication between far flung Aboriginal Tribes, a walk in the footprints of their ancestors. They are a physical, cultural and spiritual map communicated through song, ritual, dance and story to new generations. As one character describes it, 'providing you know the song you can always find your way across country'. Individuals in different tribes hold different parts of each songline, and the knowledge each holds is respected and shared with caution. Where it seems it will not be respected it is not shared. Yet if it is not shared the culture will die.

As a trainee psychotherapist I anxiously guarded my 'song', my passion and core values, fearful that others would tell me they were 'wrong', that their version was 'right'. I did not have a sense that psychotherapists really respected each other's ideas, or that each could have a part of the whole. I am still not sure how much of my anxiety was my own, and how much an accurate perception of how psychotherapists in New Zealand really relate to each other's understandings.

It is not easy to hold one's own 'song' lightly and confidently while listening to the apparently different song of another. When asked about a part of the songline which is outside their territory an aboriginal would say 'that's their business'.

In our inclusive Association we overtly attempt to connect with each other's understandings, each other's business, yet I know some still hold the anxiety I experienced. There is still caution in discussing one's psychotherapeutic song in case it, and oneself, will not be respected. This is evident in the tension about our admission processes. I wonder if it also underlies some branch meetings' low attendance.

The papers in this issue of Forum put before us a satisfyingly diverse range of issues. It is particularly pleasing to welcome contributions presenting the challenges and rewards of working with children. My thanks to the authors who share their part of our songline with us and so lengthen our horizons.

Lesley King

Contents

Nicola Atwool

Who's listening? The voice of the traumatised child 6

Joy Haywood

Sweet Chilli in the Soup 18

Richard O'Neill-Dean

The Sussicranistic Mind: a new diagnostic category? 31

Judith Morris

Emotional ties that bind: weaving a healing tapestry for an attachment disordered child 41

Stephen Appel

Roadblocks in the way of Passion 64

Jan Currie

Problems, Pitfalls and Potentials of the Unexpected in Psychotherapy 80

Contributors 87

Guidelines for Contributors 89

Who's listening? The voice of the traumatised child

Nicola Atwool

Abstract

This paper outlines ways in which traumatised children remain invisible and argues that play is one means of giving children a voice in the therapeutic environment. It begins with a discussion of the ways in which children's trauma often remains invisible. It outlines briefly the impact of trauma and offers an alternate construction to the dominant discourse, arguing that each child's experience is unique and that his/her voice must be heard at each stage of the process if therapy is to be effective. The relevance of play in therapeutic work with children is then discussed, drawing on research and clinical experience to illustrate the significance of play in giving children a voice and achieving positive therapeutic outcomes. In the final section the implications for adults' interaction with children in other contexts is outlined and the implications for adult psychotherapy are also explored.

Definition of trauma

There are a number of definitions of what constitutes trauma and they share a common theme of trauma as an overwhelming event or series of events which renders the individual helpless. Psychodynamic definitions emphasise the overwhelming of defensive capacities (Goodwin: 1993: xxiv) while other definitions emphasise the helplessness experienced in the face of intolerable danger, anxiety and instinctual arousal (Eth & Pynoos cited in Armsworth & Holaday: 1993:49). Terr has combined these two elements in her definition: '...the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations' (Terr: 1991:11).

Children may be exposed to one or more of the following: abuse (physical, sexual, and/or emotional); neglect; parental separation; multiple changes of address, school, household structure; living with parent(s) with substance addictions or psychiatric disorders; natural disasters; accidents; serious illness in themselves, parents or siblings; death of a friend or family member; bullying; witnessing violence at home or in the community; exposure to violence through the media. There is room for a wide range of opinion as to whether one or all of

these constitute trauma. Research on stress and coping indicates that individual children will differ in the extent to which they will experience these events as traumatic (Cairns: 1996; Monahon: 1993; Rutter: 1993). I have taken a broad definition of trauma which recognises that all of the above events have the potential to have a traumatic impact on children's lives, and I argue that paying attention to the child's voice is the most appropriate way in which to address issues of individual variation.

Impact of trauma

Case studies provided by practitioners are one of the primary sources of information about childhood trauma. These come from three sources: children who present in therapy as a result of single event trauma (Terr: 1990; Monahon: 1993); children who are referred for assessment and therapy as a result of behaviour and/or past history of trauma (Terr: 1990); and retrospective accounts of childhood experience presented by adults in therapy (Briere: 1992; Herman: 1992; Miller: 1985, 1987a; Terr: 1990). Three other sources of information provide insight into childhood experience: retrospective reconstructions based on public figures (Miller: 1987b); retrospective reconstructions provided through interviews with adults who have experienced trauma (Sanford: 1991; Sereny: 1998) and autobiographical accounts (Fraser: 1987; Johnson: 1995). All of these accounts bear witness to the profound impact of trauma on children's lives. Trauma in adulthood threatens our established patterns of coping and challenges previously held beliefs, whereas trauma in childhood may become a central focus around which the child's growing takes place, shaping and possibly distorting, their perception of themselves, the significant adults in their life and their view of the world.

Given this, you would expect that there would be considerable awareness of children's need for support and therapeutic intervention. This is often not the case. It is tempting to think that we live in enlightened times in which children get the help they need. In my experience this is not the case. Only a very small percentage of traumatised children get access to appropriate services. When I worked at Child, Youth and Family all of the children in care had suffered multiple trauma. Those that were referred for therapy were most often the children whose behaviour was the most challenging.

Invisibility

How is it that so many traumatised children remain invisible? To be visible traumatised children need to be recognised by the significant adults in their lives. Because they are dependent on adults for access to resources, parental recognition of their experience is a prerequisite for obtaining support. When a

child's experience is not validated as traumatic s/he may assume personal responsibility for this event. This can occur if the parent(s) does not know what has happened to the child, if the parent(s) denies that anything happened or claims that what happened was not important. When there is a conflict of between parents, or between a parent and a child, the child's perspective may be suppressed or ignored. Even when parents recognise that the child has been exposed to trauma they may block the child from having access to support. Sometimes parents actively resist intervention, fearing that their child - and themselves - will be retraumatised in the process (Schwarz & Perry: 1994).

Sometimes overwhelming trauma is not obvious in the child's behaviour and emotional responses. The child is assumed to be coping and the trauma remains invisible. Terr (1990) provides eloquent descriptions of children who have experienced trauma who did not give these signals. She also draws attention to the resistance which parents experience in acknowledging that their child may be affected by trauma. In her work with the parents of children involved in the Chowchilla kidnapping she discovered that many did not want to think of their children as suffering any negative consequences and accentuated the evidence that their children were coping (Terr: 1990:289-290).

Herman (1992) emphasises the extent to which children's dependence on parents leads them to adapt to abuse within the home in ways that preserve the relationship with the parents in spite of the abuse. It is therefore possible for a child's exposure to trauma to remain invisible. This is the most powerful way in which the child's voice is silenced.

Even when parents recognise that something is wrong, they may not be aware that the child is reacting to trauma. When children are referred to professionals it is usually as a result of their behaviour. Sometimes the referral is the direct outcome of a traumatic experience but more often referrals are made because behaviour is causing concern. Parents seeking help are likely to be referred to a mental health service or a social work service. The range of professionals offering such services includes psychologists, psychiatrists, psychotherapists, counsellors, and social workers. Each discipline has its own system for assessing and categorising the child and/or the family and this process shapes the response of the professional. The primary source of information is usually the parent(s) or caregiver(s). Information may also be sought from the school, family doctor or other agencies that have contact with the family. The child is not necessarily consulted. Smith (1996) notes the failure of social workers to interview children during care and protection investigations. Hall (1996) outlines the way in which concerns about children's memory and suggestibility have shaped re-

sponses to children in ways which may silence their voice. Glaser (1996) documents the vulnerability of the child in mental health settings and points out that there may be a lot of conversation about the child without considering either the child's view or the impact of being talked about. In these ways the child becomes invisible, or at best is seen indistinctly through a series of adult filters, despite being the focus for concern.

I have explored the reasons behind these reactions in another paper (Atwool: 2000). What I wish to explore here is that even when help is obtained the child's voice may not be heard. The children I work with rarely deal with specific incidents in an overt manner. Rather they bring issues, themes and concerns that recur in their play, their drawings and in their talking. This material relates to broad issues such as trust, conflict, self-esteem and self-perception. I have come to the conclusion that trauma is not experienced by children as a stand-alone incident or series of incidents. All that children experience becomes interwoven and underpins their self-concept, their worldview, their feelings and their behaviour. What children bring to therapy is the sum total of their lives, not discrete issues or problems.

Furthermore they bring their unique subjective experience which may or may not coincide with the perception of the significant adults in their lives. Not only is the child acted upon by external events, they are also engaged in the process of interpreting these events and incorporating them into their worldview. Current intervention strategies are primarily based on single event trauma within the context of otherwise satisfactory lives. This creates a gap between theoretical formulations about the impact of trauma on children's lives and the lived experience of the children. This model is not applicable to those who experience single event trauma against a background of less than satisfactory experience, or those children who experience multiple and on-going trauma and fails to address the barriers which may prevent disclosure of trauma.

Importance of Play

Most of the children I work with have not experienced single event trauma. Many have experienced ongoing neglect, physical and/or sexual abuse, emotional abuse, changes in family structure and placement outside their family. In some situations detailed information about the child's experience during their early life is not available but their behaviour and emotional reactions are consistent with the experience of multiple trauma. It is not surprising that they do not present specific trauma related issues in their therapy. For these reasons I find play to be invaluable in working with children.

Significance of play for children

Childhood has been constructed as a preparatory stage for adulthood (Prout & James:1990; Stainton Rogers & Stainton Rogers: 1992; Mayall: 1996) and play is often dismissed as frivolous activity, something that we grow out of (Cattanach: 1992; Strom & Ray: 1971). It is seen to be a luxury and increasingly we are seeing children's lives organised into busy schedules of structured activity. However, an alternative view suggests that play is an intrinsic part of development and that adults might benefit from retaining aspects of play in our lives.

The role of play in child therapy

Play has been recognised as part of work with children as far back as Freud and the now legendary "Little Hans". It was first used in a systematic way by Hermine Hug-Hellmuth in 1920 and some ten years later Anna Freud and Melanie Klein both used play in their formulations of the theory and practice of psychoanalytic play therapy (Gil: 1991; Schaefer & O'Connor: 1983). It is important to note that they each used play in different ways, Anna Freud regarding play as important in building the relationship between therapist and child while Melanie Klein regarded play as the child's equivalent of free association. Since that time many different forms of play therapy have emerged including Virginia Axline's non-directive play therapy, David Levy's structured play therapy, gestalt play therapy, behaviour therapies, group therapy, and the incorporation of play in family therapy (Henderson: 2000; Gil: 1991; Cattanach: 1992).

Although there is considerable variation in the way play is used in different forms of therapy there appears to be agreement that play is the child's primary medium of communication and allows greater flexibility than reliance on verbal communication (Henderson: 2000).

> Nickerson (1973) views play activities as the main therapeutic approach for children because it is a natural medium for self-expression, facilitates a child's communication, allows for a cathartic release of feelings, can be renewing and constructive, and allows the adult a window to observe the child's world. (as cited in Gil: 1991:27)

Winnicott maintains that it is important to remember that playing is itself a therapy. He argues that "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self "(1971: 54). Winnicott believes that play occurs in the space between the internal world and the external world. If we view childhood as socially constructed with the child being both active (operating from the subjective inner world) and acted upon

by the external world then it makes sense that play provides the medium through which these processes are managed. Play serves the same function for children as language serves adults in a postmodern analysis. Meaning and social relations are constructed through the process of language for the adult and cannot exist outside of language (Lyotard: 1984). Play serves the same function for the child. In other words play and language provide the mediums through which children and adults participate in, and construct the social processes that we call reality.

Winnicott (1971:38) states that "Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist". This is perhaps the closest description I have found of my experience with children in the playroom. I know that I am least effective when adult preoccupations prevent me from entering into the child's world. I also know that what children achieve in the playroom is the result of their own efforts. The therapist's role is to provide the environment and the safety within which the work can take place. However, play has been so trivialised that it would be dangerous to assume that *all* the therapist does is play with the child. Knowledge and skill are required.

Children referred to therapy bring their own subjective understanding of reality (Atwool: 2000) and may be unable to comprehend even the simple rules put in place. Children behave toward the therapist in ways designed to evoke the responses with which they are familiar. Children who have experienced abuse may test the relationship repeatedly, unable to believe that the therapist will not hurt them or reject them. Children may feel helpless when the therapist does not conform to their expectations of adult behaviour and with this comes anxiety. One way to manage that anxiety is to attempt to regain control of the situation by provoking the responses that are familiar (Gil: 1991). Those of us who work with children are motivated by the desire to make their lives better and it can be very disconcerting when we find ourselves experiencing negative emotions. The work is often frustrating, as change may be a long slow process.

Trauma may inhibit play and sometimes the work is about helping the child rediscover the world of play (Winnicott: 1971; Gil: 1991). This can be a slow and confusing process as it feels as though nothing is happening. I have played endless board games with some children only to realise that these have provided a vehicle for the child to begin the work they need to do. Some of the greatest challenges for me have come from articulate children who are able to sustain verbal interaction for the whole session — the youngest of these was only four years old. It is tempting from an adult perspective to think that the work can

be done on this level. However my experience is that these children use verbal interaction as a defence and a way to avoid dealing with feelings and emotions.

It is important to remember when working with abused children that abuse is an intrusive experience and the therapy must be non-intrusive if it is to avoid reinforcing the child's experience of adults taking control (Gil: 1991). There is often an expectation that therapy will "fix" children who have experienced trauma. If adults assume that we have this power there is a high risk that we will subject children to processes that are intrusive and counterproductive. Sometimes children engage in repetitive re-enactments of trauma. Such play is not helpful to the child and may keep them locked into the trauma and associated feelings (Terr: 1990; Gil: 1991). Considerable skill is needed to intervene in such play and facilitate healing.

In choosing to work this way I have four primary aims: to provide a safe environment for children to do the play-work they need to do; to provide the child with the opportunity to express themselves in the way that is most comfortable for them; to allow a relationship of trust to develop in order that children are able to do this play-work; and to provide an opportunity for the child to learn about feelings and behaviour and find new ways of being.

Each child uses the therapist and the playroom in different ways. Some children focus primarily on play, often appearing to ignore me. Some children maintain high levels of interaction sometimes to the exclusion of play. Some children require my active involvement in their play, sometimes scripting me into roles that allow me to see how they experience their world. Because I have the opportunity to work with children long term I see children move through different phases in their use of the playroom. No two children are the same. There have been many moments of confusion and "not knowing" for me. Sometimes it takes several sessions for a particular issue to become clear and with some children I have sat through weeks and months of intense play, knowing that something of importance is taking place but not fully understanding until much later. What I have learnt is that I have to manage my "need to know" so that I do not interfere with the child's process. I also have to be willing to learn from them and not get caught up in my own expectations about how the therapeutic process should unfold. At the same time I have a responsibility to ensure that the process facilitates the child's growth and assists them in the resolution of the issues that led to their referral.

Before the work is complete it is important to assist the child in transferring their learning to home and to school. It is also important to ensure that adults

in these environments are receptive to, and supportive of, the changes the child is trying to make. No amount of therapy can make up for the lack of a "good-enough" family (Winnicott: 1965) and "good-enough" school environment.

Implications for parents, teachers, and other adults

In the final part of this paper I want to consider the implications of this way of working for parents, teachers and other adults who interact with children. I also want to explore the implications for work with adults dealing with childhood trauma. Much of the work involves being with the child while they play — sometimes in the role of observer, sometimes as participant, and sometimes in the role of helping the child make sense of their experience. When the primary issue for a child is an attachment difficulty I prefer to work with the child and the parent(s) or caregiver(s). In this situation the child is told that they are in charge and free to choose what they want to do; I encourage the parent to observe the child and only become actively involved when invited to do so by the child. This way of working is very effective and can facilitate change in the relationship within a relatively short time. When working in this way I encourage parents to look for opportunities to be with their children while they are playing at home. Sometimes when I am working with a child I suggest that parent(s) set aside five minutes each day to spend with the child. What is important is consistency — the adult does not have to do anything in this time, the child is free to use the time however they choose. Considerable patience is required but if parents persist, this technique often opens up possibilities for communication about matters of importance and leads to an improvement in the relationship. (Refer Donovan & McIntyre: 1990 for a description of this technique).

When I was growing up my mother did not work. From the time we got home from school she was often in the kitchen preparing the evening meal. This was a time when each of us took the opportunity to talk about our day — often waiting until no one else was in the kitchen. Many children today have parent(s) who are in full or part-time work outside the home. Many families do not sit down to a shared evening meal. Television and computer games provide passive forms of entertainment with limited possibilities for interaction even if there is more than one person in the room. Children are expected to complete homework from a young age and if they are also involved in structured activities such as clubs and sport the possibilities for unstructured, creative play are limited. Furthermore, parental concern about safety frequently means that children no longer have the freedom to roam beyond the immediate home environment (Valentine: 1997). If Winnicott is right, and play provides the

creative space in which we can discover ourselves, then today's children are severely constrained.

If there is no space within which to process the interaction between the child's inner and outer worlds then the child is likely to become reactive - constantly responding to external stimuli, whether that be the demands of adults, or television and computer games. It seems likely that the escalation of disorders such as ADHD, learning difficulties, and conduct disorders may be no more that the reflection of the world we have created for our children. Alternatively children may choose to withdraw into their own inner world, emerging only reluctantly to engage with the external world.

I believe adults are responsible for ensuring that children have the opportunity to play. As parents we need to make time to be with our children, not in highly structured "quality time" but simply at home and available, choosing to spend time being in the same physical space as our children. Outings in the outdoor environment are vastly preferable to shopping expeditions. We also need to respect the significance of play, not assuming that the child can just stop what they are doing when we want them to. Winnicott (1971) reminds us that playing is a preoccupation akin to adult concentration and that it cannot be easily left nor can it easily admit intrusions. I am sure that this suggestion will be met with derision from parents who envisage not being able to manage busy family lives. I am not suggesting that children be permitted to rule the household but rather that we are respectful and do not assume that what we want is automatically more important. When I work with children I let them know when there are five minutes left so that they can begin the process of disengaging. Children do not always find it easy to leave but this transition from the playroom to the external world becomes easier when they realise that they will be coming each week. I am sure that when children have confidence that there is space for their play and that this is respected they become more amenable to fitting in with household routines.

School is often characterised as being about work, not play and there may be a very clear demarcation between the classroom and the playground. However, play is work and the playground world may be as significant for the child's learning as the classroom. Furthermore, learning in the classroom may be greatly enhanced by incorporating elements of play (Strom & Ray: 1971). It is possible that bullying has become such a problem because adults have tended to be dismissive — just children playing — instead of looking closely at what is going on and the negative impact on both the victim and the bully. When children are having difficulty in the school environment they are unable to partici-

pate in formal learning. The whole environment needs to facilitate both learning and play.

Play is valuable in the therapeutic environment because it is such an important aspect of children's lives. Play is the primary medium through which all children make sense of their experiences and the world around them. Children deprived of the opportunity to play are unlikely to discover the sense of self that enables them to be active participants in social interactions. Instead they become withdrawn or reactive and their lives lack coherence and a sense of continuity. Play is a unique activity and the only parallel with adult work is that it is of equal significance. As adults I believe we have much to learn from children and we have much to gain from allowing them to lead us back into the world of play from which our own development emerged.

Implications for Adult Psychotherapy

I noted earlier Winnicott's statement "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self (1971: 54)." In the adult world I think we are not always comfortable with this notion of play and there is a heavy reliance on verbal communication and cognitive processing. Even the psychodynamic therapies, which acknowledge the role of the unconscious, rely on accessing this primarily through verbalisation. Until recently psychology has relied heavily on cognitive-behavioural techniques which emphasise cognitive processing. However, there appears to have been something of a rapprochement between psychodynamic approaches and cognitive-behavioural strategies. Briere (in press: 3) in a recent paper outlining a model for treating adult victims of childhood abuse acknowledges the significance of material that is not directly accessible to the conscious. He identifies six areas in which childhood abuse and neglect impact on later adolescent and adult psychological functioning: negative preverbal assumptions and relational schema, conditioned emotional responses to abuse-related stimuli, implicit/sensory memories of abuse, narrative/ autobiographical memories of maltreatment, suppressed or "deep" cognitive structures involving abuse-related material, and inadequately developed affect regulation skills. Only the narrative/autobiographical memories are directly accessible in the conscious mind. Briere stresses the importance of recognising the survival value of many of the defensive strategies employed by adult survivors of abuse. His model emphasises the need to avoid activating these defences in therapy and he argues that therapy may require sessions over a considerably longer time. I believe that change in adulthood is so difficult to achieve because, as I noted earlier, all of the child's development

and growing is affected by the trauma. Verbalising within a therapeutic relationship may not be enough to facilitate change. Indeed, like the children I mentioned earlier, verbalisation may be a defensive strategy. In working with adults it is important to be mindful of the role of play in childhood development and exploring this aspect of client's lives may alert us to possibilities for other ways of working. Art and music are recognised modes of therapeutic intervention, narrative therapy highlights the importance of taking a 'playful approach' to problems, and gestalt therapy includes an action component. Because each client is unique I believe it is important to explore the range of interventions available, especially if it becomes clear that a client is stuck. Sometimes we need to bypass the conscious mind in order to open up to new possibilities. I have seen play facilitate change for adults participating in parent-child work and I see no reason why it may not be beneficial in some adult work.

References:

Atwool, N. R. (2000). Children who have been exposed to risk and trauma. In A. B. Smith, N. J. Taylor & M.M. Gollop (Eds.), *Children's Voices* (pp. 56-71). Auckland: Pearson Education.

Armsworth, M. & Holaday, M. (1993). The Effects of Psychological Trauma on Children and Adolescents. *Journal of Counselling and Development*, Vol. 72, no. 1, pp 49-56

Briere, J. (1992). *Child Abuse Trauma*, Newbury Park,CA: Sage Publications.

Briere, J. (in press). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment, 2nd edition*. Newbury Park, CA: Sage publications.

Cairns, E. (1996). *Children and Political Violence*, Oxford: Blackwell Publishers Ltd.

Cattanach, A. (1992). *Play Therapy with Abused Children.* London: Jessica Kingsley Publishers.

Donovan, D. M. & McIntyre, D. (1990). *Healing the Hurt Child.* New York: W. W. Norton.

Fraser, S. (1987). *My Father's House: A Memoir of Incest and Healing*, New York: Harper & Row.

Gil, E. (1991). *The Healing Power of Play.* New York: The Guilford Press.

Glaser, D. (1996). The Voice of the Child in Mental Health Practice. In R. Davie, G. Upton & V. Varma (Eds.), *The Voice of the Child: A Handbook for Professionals* (pp. 78-90). London: Falmer Press.

Goodwin, J. M. (1993). *Rediscovering Childhood Trauma.* Washington DC: American Psychiatric Press.

Hall, N. (1996). Eliciting Children's Views: The Contribution of Psychologists. In R. Davie, G. Upton & V. Varma (Eds.), *The Voice of the Child: A Handbook for Professionals* (pp. 61-77). London: Falmer Press.

Henderson, D. A. (2000). Play Therapy. In C. L. Thompson & L. B. Rudolph (Eds.), *Counselling Children* (5th ed.), (pp. 373 – 399). Belmont Ca: Wadsworth.

Herman, J. L. (1992). *Trauma and Recovery.* London: Harper Collins Publishers.

Johnson, A. G. (1995). *A Rock and a Hard Place.* London: Warner Books.

Lyotard, J-F. (1984). *The Postmodern Condition: A Report on Knowledge.* Minneapolis: The University of Minnesota Press.

Mayall, B. (1996). *Children, Health and the Social Order,* Buckingham: Open University Press.

Miller, A. (1985). *Thou Shalt Not Be Aware,* London: Pluto Press.

Miller, A. (1987a). *The Drama of Being a Child,* Virago, London.

Miller, A. 1987 (b), *For Your Own Good,* x London: Pluto Press.

Monahon, C. (1993). *Children and Trauma,* San Francisco: Jossey-Bass Publishers.

Neumann, E. A. (1971). *The Elements of Play.* New York: MSS Information Corporation.

Piers, M. W. & Landau, G. M. (1980). *The Gift of Play.* New York: Walker and Co.

Prout, A. & James, A. (1990). Anew paradigm for the sociology of childhood? Provenance, promise and problems. In A. James & A. Prout (Eds.), *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood* (pp.7-34). London: The Falmer Press.

Rutter, M. & Rutter, M. (1993). *Developing Minds. Challenge and Continuity Across the Life Span,* New York: Basic Books.

Sanford, L. (1991). *Strong at the Broken Places. Overcoming the Trauma of Childhood Abuse,* London: Virago.

Schaefer, C. E. & O'Connor, K. J. (Eds.). (1983). *Handbook of Play Therapy.* New York: John Wiley & Sons.

Schwarz, E. & Perry, B. (1994). The Post-Traumatic Response in Children and Adolescents. *Psychiatric Clinics of North America,* Vol. 17, No. 2, pp 311-326

Sereny, G. (1998). *Cries Unheard. The Story of Mary Bell,* London: Macmillan.

Smith, P. (1996). Social Work Perspective. In. Davie, G. Upton & V. Varma (Eds.), *The Voice of the Child: A Handbook for Professionals* (pp. 49-60). London: Falmer Press.

Stainton Rogers, R. & Stainton Rogers, W. (1992). *Stories of Childhood,* Toronto: University of Toronto

Strom, R. & Ray, W. (1971). Communication in the affective domain. Theory into Practice, 10 (4), 268 – 275.Press, Toronto.

Terr, L. (1990). *Too Scared to Cry,* New York: Basic Books.

Terr, L. (1991). Childhood Traumas: An Outline and Overview. *American Journal of Psychiatry* 148:1, pp. 10-20

Valentine, G. (1997). 'My son's a bit dizzy.' 'My wife's a bit soft': gender, children and cultures of parenting. *Gender, Place and Culture,* 4 (1), 37 – 62.

Winnicott, D. W. (1965). *The Family and Individual Development.* London: Routledge

Winnicott, D. W. (1971). *Playing and Reality.* London: Tavistock.

Sweet Chilli in the Soup

Joy Haywood

Abstract

Psychotherapists know a great deal about child development, attachment theory, systems theory and ways of relating. They have a lot to contribute to the education system, which is currently in need of a great deal of help. Teachers in the grip of the current crisis for the education system are compromised in their ability to think about children's experiences and to create an environment where children feel safe, understood and cared about. This paper posits ideas as to why the system is failing children and teachers. It explores ways in which psychotherapeutic understanding could help to fire up the "gey soup" of the education system, and at the same time soothe the palate of teachers and the children in their care.

Introduction

One of my passions is to think about the way therapeutic knowledge can be useful in everyday life, particularly in the service of children. I can think of nowhere more in need of the understanding that we as psychotherapists have to offer than the education system, which I see as a very needy patient. It attempts to contain its psychotic anxiety by trying to control, streamline and standardise everything. Most teachers are over-stressed and depleted, many are cynical and emotionally withdrawn, and some are at crisis point. And all children are affected by the teacher and the school system.

Weaving Psychotherapy with Teaching

In 1999 I was visited by a very disturbing dream, which initially I understood to be about war torn Kosovo.

In the dream, I am with my family in a place that we realise is going to be unsafe. We need to pack up and move and we travel to a grassy glade, which seems a safe refuge. We plan to settle down for the night. It becomes apparent, however, that this place is not safe and the adults start preparing to do battle by arming themselves with sharp sticks, rocks and anything they may be able to defend themselves with. Being deemed more geriatric than the other people present, I am sent to some distance away to look after the children. I am look-

ing at my granddaughter's face. She is playing happily. In my mind's eye, I anticipate the change in her face as the fighting starts. I am aware that there will be bloodshed, possibly death. I imagine her face changing from contentment, to puzzlement, to terror and I feel distraught as to how I can ameliorate the forthcoming traumatising experience for her.

With the assistance of my Dream Group I began to make further sense of this. I had just been running Post-Graduate Professional Development courses for teachers. I had entitled these "Where the Wild Things Are, How to Still Them (without the use of Ritalin) and Be Home in Time for Tea", and the second course was called "The Child You Don't Want to See on Monday Morning". Most teachers felt very sustained and stimulated by these courses but they also elicited enormous distress. I recognised that they were being asked to look after a classroom full of children and to hold the feelings of distress which accompany this. As an ex-teacher, I am no longer in the front line, but am a safer distance away. This allows me the luxury of being able to fully experience feelings. Many teachers are so busy trying to stay alive that they can't afford to experience the feelings of being in the front line, a phenomenon we understand as disassociation. Paradoxically the teachers most beneficial to children are those who can experience strong feelings in response to a child and not act out their own.

After 17 years of working as both a Primary and Secondary teacher, I left teaching in 1982 to train full time in Child Psychotherapy. During my training I became aware of a whole world of knowledge about children. As a teacher, I had struggled to understand their behaviours. Suddenly things I had not been able to make sense of opened up before me. In my naivety and with limited knowledge, I felt proud of ways I had intuitively managed to be with children, and ashamed of things I had not understood and the ways I had, at best, failed some children, and at worst, been destructive to others.

In 1990 when the opportunity came to return to the education sector by working as a counsellor at the Dunedin College of Education, I was keen to apply. I felt excited at now being able to be part of an institution whose key focus was preparing students to work with children. I felt a sense of delight that today's students could have opportunities to tap into the vast wealth of knowledge that has emerged about children's emotional development since I was a student.

Although I love the counselling work with students, what has emerged over the last ten years is a sense of disillusionment about the way teacher training happens, and the way the education systems currently functions. I believe teaching is in a state of crisis. Teachers, like other occupational groups who work with

children, are distressed, exhausted, and in desperate need of soothing. The pressures they are under often render them unable to think about children's experiences. This can easily lead them to experience themselves as victims and children as perpetrators or attackers.

The centrality of attachment

The fact that little is taught about attachment during teacher training exacerbates the difficulties in thinking about children in a psychological way.

The post-graduate teacher courses I have been facilitating for teachers are fundamentally about children's emotional development, and I have included the notion of how important teachers are to children. By the age of five onwards most children will spend more waking hours with their teacher than with any other adult.

I have looked at the process of attachment and explained something of the work of Winnicott, Bowlby, the Robertsons, Mahler, Ainsworth, Main et al. We have looked at attachment categories and the way attachment patterns are transferred from parent relationships to other relationships. We have worked with the significance of this in the school situation, enabling teachers to better understand the significance of a child's attachment pattern. It has been helpful for teachers to understand that the behaviour patterns they are dealing with have been at least five years in the making before children started school. Whilst they cannot fix things for children from distressing backgrounds, teachers can impact positively on their well-being and they can ameliorate their difficulties. It is also possible for the child and the teacher to establish a different attachment pattern from the one which operates at home.

In my work with adults who have suffered profound early abuse at home, often the only person who has believed in them, tried to understand them, or showed kindness to them, has been the teacher. This has enabled the child to hold on to the first realisations about themselves as not all bad, maybe even likeable. "*Unlike Mum or Dad's face that frowns and contorts, the teacher's face lights up when she looks at me.*" "*She is gentle when I have fallen over and she washes my knee and bandages it, and is not rough and cross like my Mum when I hurt myself.*" I want teachers to understand how significant this is to the child.

The costs of a curriculum focus

Unfortunately I believe it is becoming more and more difficult for teachers to respond thoughtfully, positively and empathically to children. Teaching has become focussed on the curriculum, not on children. As our social values have changed, schools have become a business, in competition with other schools. What children

have to learn and what teachers have to teach is prescribed entirely by the curriculum. In the past if I had a Sri Lankan child in my classroom, this would be a wonderful opportunity to discover more about Sri Lanka. It would also allow a different child to feel special. It was an opportunity to call on the expertise of the parents and to involve them in the school. Currently, unless the curriculum specifies that Sri Lanka could be covered this year, this would not be possible.

There is the notion that each year children will attain certain educational goals. For some children, learning not to disrupt, learning that you can matter to someone, or learning that you don't have to try to please the teacher all the time, represent the acquisition of significant learning. This learning may be deemed important in so far as it affects classroom management or teacher's stress levels, but it does not meet the prescribed learning objectives.

At one time there was an understanding that children learn by doing and the doing needs to be fun. When teachers are stressed and exhausted it is difficult for them to create an environment where fun is possible. Play is regarded as a luxury for both teachers and children, not an essential way of being in the world. Teachers increasingly work too hard to have much time for it, and the belief that children need to attain objectives is put above creatively experiencing and acting out their inner world, and thus allowing space to work out attachment conflict issues.

When we go back to the beginning of teaching and the selection procedures for prospective students, it is not seen to be appropriate to ask interviewees about their personal lives. It would seem that the current climate wants to put aside all possible reference to our personal selves, be they students, teachers, or pupils, and to focus instead solely on academic goals. At the same time some teachers are saying that teaching takes up 20% of their work – the rest is managing the difficult classroom relationship issues and social problems.

Education's operating syndromes

I am struggling to make sense of what is happening in education and would like to suggest that a number of syndromes are operating.

Firstly, there is the 'Tell me what to do' syndrome.

Education, perhaps more than any other profession, is firmly entrenched in a dependency model (Bion). Children are dependent on their teachers for approval, provision of access to learning, safety and enjoyment. Having exited the secondary system, many students then immediately enter the tertiary system. Whilst some things are different, this is none the less a continuation of dependency. Students have to attend 90+% of their classes in order to pass the course, a roll is taken, and errant students are followed up on. Those students

who wish to develop independence - e.g. mature students - commonly complain that they are treated like children.

Teachers are therefore caught in a system that fosters dependency. Not only must the curriculum be followed in the prescribed way, it also must be recorded in ways which fit the Education Review Office's notion of how this should be, rather than the way that is easiest and most efficient for the teacher. Failure to comply leads to a negative report for the school. Many teachers have described thoughtful and innovative ways of managing bullying, teasing, peer relationships and a positive classroom climate. Some of these fall outside of ERO's prescription so, like children who need to be compliant in order to be rewarded, teachers too recognise that their career continuance or promotion also hinges on compliancy.

A greater proportion of teachers than ever before, are employed in tenuous limited term jobs. They are dependent on the Principal or Deputy Principal's good opinion of them for continuation of the job or a reference, which may earn another appointment; e.g. a forty-eight year old woman, after teaching for 15 years, eventually managed to attain a permanent position.

Secondly, there is '*The Little House on the Prairie*' syndrome.

In Laura Ingalls Wilder's classic stories of the 1870's, she describes a family who journey 600 miles by covered wagon to Kansas, where they build a little house on the prairie. It is inhospitable, lonely territory where the family live hand to mouth and confront the dangers of wolves, prairie fires and Indians 'turned unfriendly'. With courage, luck and resourcefulness the family battle adversity.

The family therapy literature describes families who function in closed, homeostatic or enmeshed systems where there is a lack of information exchange, a lack of environmental input, a lack of differentiation, and a lack of effective communication and conflict resolution skills. Pamela Alexander describes the experiences of living in these families as "a diet of grey soup". I think teaching suffers in a similar way to an enmeshed family. Teachers form a numerically significant number of our national workforce. They are intelligent, well educated, often resourceful and innovative. They do not, however, generally experience input from outside of the teaching profession. They must be one of the few work forces who are so isolated in this way. Most other professions interface with allied professionals. Nurses, for example, have professional involvement with doctors, social workers, OTs, and Radiographers as well as their patients. Teachers on the other hand have professional involvement with other teachers. This is therefore a closed system with no permeable points from the exterior and no 'circuit breaker'.

Teachers see teaching as *their* area of expertise and believe that 'outsiders' have little to contribute to it.

As in *The Little House on the Prairie*, all the family gather together to pool resources and to keep threats at bay. There is, however, little looking outside the system for help. Connecting with the outside world would be almost akin to traversing Kansas, or asking your grandmother to enjoy sushi.

A recent example of this is that of Resource Teachers in Learning and Behaviour (called RTLBs). Within teaching, concerns about problematic children have led to the introduction of RTLBs. In the school system RTLBs are seen by many people as counsellors, and the people to whom the teacher refers a child who is exhibiting difficulties. Whilst there are undoubtedly people who do this job with devotion and care and skill, for the most part the people doing this work have had on the job training using the internal resources of the education system. They, like teachers, are often wedded to the same way of seeing children's difficulties and the same kind of behavioural approaches. There is not much scope for carrots, courgettes and sweet chillis in the soup.

As well as the isolation from the external world, most teachers spend their time isolated from each other. They are encapsulated in their individual classrooms with very little opportunity to overlap. Whilst they may observe other teachers' ways of being with children at assembly, sports day or the end of year show, there may be little opportunity to see how their next-door neighbour sets limits, offers comfort, shares fun, or develops creative thoughts. There is inadequate opportunity for teachers to give or receive support or to vent feelings safely. Not only is Kansas a long way off, so too is the next-door classroom when you have 30+ children to manage.

Robert Karen, in his excellent book *Becoming Attached*, quotes Karin Grossman who suggests that it is quite possible to imagine a whole culture functioning on the avoidant principle: "you mind your own business, you don't show your emotions, you don't go to anyone for help" (1998: 261). The education system certainly demonstrates a significant number of avoidant characteristics – a dislike of neediness, a turning away from physical contact, anger, aggression, isolation, the dismissing of the importance of love and connection and shallow, if any, self reflection.

Thirdly, there is the 'Let's Not Talk About the War' syndrome.

As for many returned servicemen, sharing feelings opens the possibility of being overwhelmed and losing the capacity to manage. Expressing feelings, particularly of distress or anger, is an indication that a teacher is 'not managing'

and this may be detrimental to the teacher's status or career prospects. I recall my own attempts to communicate that a child was 'driving me up the wall'. The inevitable shaming response was "he is all right with me". I also recall a classroom I overlooked where there was a continual riot, with the teacher often being under siege - e.g. pinned forcibly up against the door by a group of aggressive, angry teenagers. To my knowledge, he never uttered a word of this assault or humiliation to the other staff members, nor we to him.

Other significant changes

As well as this, in the last two decades some very significant things have happened in education.

1 There have been structural changes with Tomorrow's Schools, which brought in the system of Boards of Trustees, changes to the allocation of funding, and competition rather than cooperation between schools.

2 There have been changes in teacher accountability. At one time teachers were deemed to know best and unlikely to be questioned. Whilst this meant at times that highly unacceptable behaviours were not challenged, nowadays teachers feel they can't breathe without a parent asking "why?" For a long time it seemed that teachers remained the authority figure that no one ever became grownup enough to question. In a climate of challenging authority figures, teachers are stripped of that which is necessary and appropriate for them to retain their own authority, and to make their own decisions. It seems teachers are dependent on the opinion of the community more than ever. Dependency repeats dependency.

Gordon Lawrence describes this phenomenon in his paper entitled "The Presence of Totalitarian States of Mind in Institutions" (1995). He describes fears present in earliest infancy being reactivated by adults in groups and institutions:

> The fear of annihilation.
>
> The fear of being made a nothing.
>
> The fear of not being able to make sense of what realities may be.
>
> The fear of disorder and chaos.
>
> The fear of disintegrating.
>
> The fear of loss ending in death.

He sees much of our group behaviour as being specifically designed to avoid group members having to consciously experience psychotic anxiety. He hy-

pothesises that "as environments become more uncertain – and there is reality to this – the management of institutions has become more anxious" thus evoking psychotic anxiety. The pressure on those in charge is to bring into being a feeling of certainty which, in fantasy, will withstand the environmental uncertainty. Unconsciously "the majority of role holders mutually collude" in this way to banish psychotic anxiety.

> The corollary is: Such an organisational culture diminishes the capacity for thought and thinking and so role holders at all levels become less able to relate to the external environment....They become entrapped in the inner political world and life of the institution, in a life of action and reaction, doing not being. (1995: 2)

I am speculating that the overwhelming distress involved in daily contact with neglected, abused, out of control children, as well as the market forces thinking which has entered education, stirs paranoid fears in teachers and the whole education system. ERO and school principals, and boards of trustees, unconsciously take up the roles which will banish the psychotic anxieties. The classroom teacher may protest but may also collude. Limiting the capacity for thought, having a curriculum that offers little flexibility and is narrowly prescribed, give the system some illusion of control and order and defend against anxiety. It also reinforces itself by rewarding only "thinking which is sure-fire and certain" since the over-arching fear is of making mistakes. The fear of mistakes is such that it becomes dangerous to have thoughts which are different from the majority. Even creative, dedicated and experienced teachers have a hard job not to fall prey to the power of paranoid anxiety.

As well as the increased rigidity in the system there are other illustrations of this:

e.g. The fear perhaps instilled by fundamentalist Christian parents, around talking about or reading books about witches and wizards. Banning such stories deprives children of a way of learning about good and evil, their own 'shadow' feelings, and of attaining mastery over their fears. It also protects adults from their shadow feelings or primitive psychotic anxieties.

There is also a climate of fear around touching children. Teachers have described how they have to walk the playground with their hands in their pockets for fear a child will try to hold their hands, and how they have had to evacuate all children from the classroom when a five year-old child has become out of control, because they are not allowed to physically restrain him. How terrifying for a child desperate for adults to take charge, to be

left with this omnipotent power which can't be contained. I was grateful not all teachers have given up this practice when, on my granddaughter's first day at school, the fire alarm went off. She had waited five years to get there, and was bursting with excitement and was distraught believing that the fire alarm meant the school was burning down. The long wait to become a schoolgirl had been in vain. I felt so grateful that there was still a teacher who was willing to risk giving exactly what was needed – a reassuring hug.

What has all this to do with psychotherapy?

I believe we can weave our knowledge into the field of education.

The education system is a very needy patient. It attempts to contains its psychotic anxiety by trying to control, streamline, and standardise everything, rather like an anorexic who weighs, measures and quantifies everything and is terrified of deviating from the prescribed amount. This serves to suppress the deeper feelings of depression, rage, terror, distress and envy. Individuals who do not subscribe to this group starvation are often treated with suspicion, envy, contempt and denigration. It is rather like living in a flat with eating-disordered women. A non-eating-disordered person eventually starts to worry about his or her own food intake and whether they are being greedy, abnormal and unrestrained.

The capacity to think and feel is being lost. The pain of engaging with children at an affective level is almost impossible to bear without a 'holding environment'. The pain of engaging with one's own feelings is also extremely difficult. This is not a safe climate to express uncertainty, vulnerability, fear, helplessness, distress or anger. Given the opportunity and sufficient time, however, my experience has been that teachers do express their distress and discover intense relief at discovering that others feel the same.

Psychotherapists may be able to help in the following ways:

- **Find ways to make therapy more possible or more accessible for teachers.**

  I wonder if other therapists have noticed how few teachers, proportionately to other occupations, present for therapy. Teaching must be one of the largest occupational groups to have no access to Employment Assistance Programme funding for therapy. It is one of the few occupations where leaving the job for an hour is an impossibility.

I believe therapy with teachers can be very useful. As the teacher understands more about him/herself, there is often 'spin off' of the significance of this in classroom. I recently worked with a teacher who had been very cruelly treated as a child. She had unconsciously entered into teaching to attend to her own small inner child who was neglected and abused. As she described her interactions in the classroom, however, I became aware of her own unconscious cruelty, particularly with needy, deprived, less able children, like the child she had been. When she began to treat me contemptuously, to distort my words, and to accuse me of being uncaring and unfeeling, and unresponsive, I had evidence of her cruelty in the transference. When we were able to work with this, it became possible for her to recognise her cruelty in the classroom.

- **Get elected on to Boards of Trustees** (preferably with another two to three like minded people).

- **Encourage and suggest supervision to teachers.** This is a foreign concept for teachers. In my experience there is significant resistance to supervision since teachers fear it would be another way that they could be checked up on and controlled. There is a hierarchical belief about supervision – e.g. like line management. I believe, however, that were teachers able to access this in an ongoing way it would greatly sustain their work.

- **Challenge ERO reporting.** Whilst I have no quibble with setting goals and reviewing whether they have been attained, I believe ERO creates "false self" teachers. Showing weakness, vulnerability and uncertainty leaves them open to attack. Teachers, like psychotherapists, have to be able to not know, at times; to watch, wait and wonder. Teachers feel on trial with ERO, without legal representation, without the right of reply, and sometimes without even knowing what is being written and recorded about them.

- **Suggest psychological books for teachers and children.** Books on self-esteem, grieving, adoption, separation, fears or anger, enable teachers to be able to think more psychologically and enables them to talk with children on a different level. Emotional literacy means that feelings can be put into words rather than acted out, both by teachers and children.

- **Run courses for teachers.** Of the 143 available in-service courses for teachers in Otago, *all* are based on the curriculum with the exception of the two I have offered. I believe psychotherapists can offer valuable information to teachers, such as attachment theory and its implications in classrooms.

A teacher described how she collided forcefully with a child when she turned

around from the blackboard. She felt immensely irritated at the invasion of her personal space. She wanted him 'out of her hair'. In working with her to develop an understanding of anxious attachment she came to realise what her turning away meant to this child and his need to maintain the connection at any cost. Teachers do need to be able to set limits, but sending an anxiously attached child out of the room increases his anxiety and thus increases his need to be 'in her hair'.

We can also offer courses on the importance of touch (supported by the research on failure to thrive), the importance of interplay between parents and infants, the importance of looking, the importance and meaning of play. There is a lovely story in *A Rock and a Hard Place* (1998) about a boy from an abusive family who feared dire consequences of his failure to remember. He rushed out from the class in a state of anxiety to return home to put the rubbish out. On his return to the classroom, his teacher gently put his hand on his shoulder and looked him in the eye and said "One day all of this will be different for you". That's what he took from his school years.

We have things to say regarding childhood depression, acting out and grief, to mention but a few.

e.g. Teachers need to know that the child who becomes unable to concentrate, unable to sit still and whose work habits have deteriorated may be experiencing an intense grief rather than a deliberate intent to sabotage the class.

Support for healthy changes

- **Support teachers.** They need appreciation for the tough job that they do and they need their importance to be promoted. One way to do this would be to get invited as a speaker to your local school. Even teachers who *can* think psychologically are having to unlearn it and need help to hold on to it.

- **Help teachers redefine the roles they enact in the school system.** In the current climate of working with many abused and neglected children, teachers are struggling with their roles. They feel they are being asked to be social workers or surrogate parents. It is helpful for them to understand that whilst they can't fulfil these roles, the work they do can be a respite from the trauma and neglect at home and can be of great significance to a child.

- **Support teachers in appropriate touch.** When my children began school, in the days prior to the abolition of corporal punishment, I stipulated to the school that I didn't want them to be hit. For those of you who are

parents and have trust in your child's teacher, maybe it would be helpful to give permission to the teacher to respond to his or her own instinctive desires re touch. Being comforted, congratulated, or acknowledged in positive ways maybe the only loving touch some children experience. Depriving them of this may be almost as detrimental as hitting them.

- **Support male teachers.** In the current climate male teachers are particularly under suspicion. I believe attuned male teachers have a vital role, particularly with boys whose fathers are absent, unavailable or unsafe.
- **Volunteer to sit on selection panels for colleges of education and schools.** Psychotherapists have a great deal to offer in this process.

I have to tell you none of this is easy. Do not expect that because you have crossed Kansas you'll be welcomed in. Your food is suspect and if it isn't the right flavour it will be spat out. At the same time teachers want to be told what to do. They want a 'strategy'. The notion that you firstly have to have a relationship with the child and hear what she is saying *before* you produce the strategy is not instantly gratifying enough for most teachers.

Changing the homeostasis of the paranoid dependent system requires a considerable psychological paradigm shift on the part of the teacher.

e.g. I have a collection of stories written by 12 year-olds. These are about being at a fun park in an unfamiliar city and getting separated from their parents. The stories are moving, heartening, disturbing and concerning. I used these with teachers in the in-service training course to help enable them to think about attachment patterns and what they might be able to learn about children through these separation and (usually) reunion stories. Some teachers were unable to do this and instead focused only on the spelling, grammar, story structure, and whether or not they considered the story to be imaginative.

I am aware that most of us are already overloaded with work. How much one actively seeks to have influence and how much one capitalises on opportunities which present, will, of course, be an individual decision. It may also be easier for those of you who have school age children to find ways to assist and influence the system.

I am anxious to tread the fine line between being critical of the education system and supportive of the teachers in it. The last thing teachers are needing is attack. What needs to be attacked, however, is the mindset that has infiltrated teaching. I believe the policy makers are doing a disservice to teachers and most of all to children.

I am conscious that for all of us, whether we are in the front line, or further back, holding children is a distressing and lonely place to be. I am aware of my need to share my therapeutic skills and passion in the field of education in the hope of in some small way bringing about some changes in the system. I also hope that some of you will find ways of directing your skills to this task. Gordon Lawrence states that "we are left with little choice but to expose the presence of psychosis in our social institutions, no matter where it may lead us. Let us not commit treason, once again, against the human role by remaining silent. Our silence will have catastrophic consequences" (1995: 8).

Psychotherapists, I believe, have a lot to say. We could both fire up the soup and at the same time soothe the palate.

Bibliography

Alexander, Pamela (1985). A Systems Theory Conceptualisation of Incest. *Family Process, Vol. 24.*

Johnson, Anthony Godby (1993). *A Rock and a Hard Place.* Boston: Little, Brown & Company.

Karen, Robert. (1998). *Becoming Attached.* Oxford: Oxford University Press.

Lawrence, Gordon. (1995). *The Presence of Totalitarian States of Mind in Institutions.* Unpublished paper read at the inaugural conference on "Group Relations" of the Institute of Human Relations. Sofia: Bulgaria.

The Sussicranistic Mind: a new diagnostic category?

Richard O'Neill-Dean

Abstract

This paper presents a thought for a new diagnostic category equivalent to narcissism. Taking as its starting point Neville Symington's definition of narcissism, the paper puts forward the existence of a correlative state of mind, 'Sussicranism'. This state is described and illustrated with clinical and day-to-day examples. The paper concludes with some comments on the relevance of sussicranism to the profession of psychotherapy.

Introduction

Neville Symington, a keynote speaker at NZAP's 2000 Tauranga conference, gave his most distilled definition of the psychic action of the narcissistic mentality at work in the mind as 'the obliteration of the other'. This central idea has been much elaborated, expanded and developed in his book, *Narcissism, A New Theory* (1993), one of the great books of psychotherapy. To give a speedy review of the central idea, what I understand by 'the obliteration of the other' is that, when the narcissistic state of mind is active within a person, the separate autonomous other does not exist. This may not be visible or evident at first glance but it is profound and total and very real. Where the narcissistic mind is in action what appears to be the other that is being related to, is not actually the other that has been sought out, inquired into, discovered and become known as something separate and autonomous in relation to the self. For the narcissist, it is, rather, an assumption that matches in with the requirements and motives of the self. In the relatively subclinical narcissism of everyday speech this is very common and unremarkable: "You know what I mean" when, in fact, you may not!

The narcissist obliterates the other to offset the fear or terror of annihilation of the self in the face of the existence of the other. The narcissist constantly feels that no-one is listening when in fact no-one can get a word in edgeways. Approaching the narcissist is a little like approaching someone in a swimming pool who feels they are drowning. This in fact may be a very dangerous thing to do as that person may push you under in a desperate attempt to save themselves.

When I heard Neville Symington give his compact definition, 'the narcissist obliterates the other', his aphorism re-arranged itself in my mind: the narcissist obliterates relationship by effacement of the other.

Sussicranism

I have previously put forward the idea that when you notice a state of mind or mentality at work in a person there will always be its direct, if unrecognised, and sometimes deeply hidden psychic equivalent or correlative in the other. This might be so for example in a couple, where the 'other' is the person being related to. What then is the correlative to the mentality of the narcissist? I am going to introduce a neologism. The psychic equivalent or correlative to narcissism is sussicranism.

There are two distinct, different yet intimately associated or paired mentalities both of which obliterate relationship: narcissism and sussicranism. Just as the narcissistic mind obliterates relationship by effacement of the other, so too does the sussicranistic mind obliterate relationship but by a different path. The sussicranist obliterates relationship not by effacement of the other but by effacement of the self.

The narcissist effaces the other. The sussicranist effaces the self. Both destroy the opportunity for relationship and both do so for the same reason - the terror of annihilation of the self. In a moment I will introduce a clinical situation but before I go on I need to acknowledge that there is nothing new under the sun. Do not be surprised if what I have to say is already familiar, even perfectly well-known, using different names, different conceptualisations, with different associations.

A case

So, to the clinic. I am going to refer briefly to an aspect of my work. The patient, Polly, a woman in her twenties, intelligent and capable in the outward show of her life, has been unable to bring to an end, by outright refusal, her father's wilful and malevolent incestuous misuse of her that has carried on since her childhood. One day, after a sustained engagement in psychotherapy over a period of more than a year, she reports a dream in which her father uncharacteristically is smiling and laughing benevolently at her. She comments on the dream that: "Wow! Dad must be changing!". A short while after this dream she meets again with her father who has habitually used their meetings to coerce his daughter into sexual liaison with him. This time when they meet she manages with great trepidation

to say: "No!" - she does not want to have this sexual relationship. To her complete astonishment he immediately acquiesces and accepts this. She thinks back to her dream and concludes: "Wow! Dad really has changed".

I am going to use this simple outline of case material to make the following suggestions. Right away the father can be considered to operate from a narcissistic state of mind. He has no register for the actual experience of the other, his daughter. However our focus is on her mind and not his. Up until the moment of her dream she has been operating in relation to her father's narcissism from an equivalent but sussicranistic state of mind. In the dream, as a result of the therapy, she shows herself to have broken free of the tyranny of an inner 'other' that must be appeased. This allows her, when she actually meets the person of her father, to no longer have to efface herself and she says, in fact for the first time: "I do not want this, it must stop". It is not her father who has changed. Why should he have - he has not been doing the therapeutic work. She has changed. Throwing off the shackles of her sussicranism she is prepared to be herself for herself. Her father is affected by this inner change, as he must be. It is impossible for it to be otherwise, and he acquiesces. He no longer finds the psychic correlative to his narcissism in his daughter. Echo has spoken her own words with her own voice. She has made herself heard and Narcissus is brought to the recognition of the other as separate and autonomous. A subtitle to this paper could have been 'Echo also had a problem'.

Derivation

By now you have waited long enough for the root or derivation of this strange word I have chosen.

The root word 'Sussicran' is the reversed form of the word 'Narcissus'. I am trying to suggest a mirror state, an echo, an inverted or reversed form of narcissism not easily recognised as such at first, in its intimate connection with nar-

cissistic tendencies. If Echo had a problem, rather than simply a misfortune, what was its nature and structure? Was Echo an unrecognised Narcissist?

Back to the case

To go back to the case material, the idea I am trying to convey is that while taking the father's psychopathology for granted, Polly too has had a problem - a sort of inverted narcissism, a destructiveness directed not towards the other as in the case of her narcissistic father but towards her own self-hood, her point of view, her wishes. When she recovers from this everything changes. An important detail here is that it is an inner change that takes place and it can be seen in the dream. It gives rise subsequently to outer manifestations, for example in what she says to her father. But if she had simply said these words: "No, I do not want this" as if someone had told her to say these words, without the inner change having taken place, then the words would have been to no avail.

A misgiving

In what I have been saying there is one detail that may catch the attention and cause a misgiving about this way of thinking. All very well that the narcissist negates the existence of the other to secure the imagined wellbeing of the self. But how can it be that the sussicranist negates the self, rather than the other, in order to secure that same self? It just does not appear to make sense. I think the answer to this very worthwhile question lies in thinking that the situation might be like that of the suicide imagined in unconscious phantasy to secure psychic wellbeing. To our conscious mind this is a paradox.

Further examples

It is a risk, when I give a case example to illustrate a style of thinking, that the style of thinking will get welded in the mind of the reader to the particular example I have used. This can greatly restrict its availability as a useful concept in a wide range of situations. I do not want you to think at some point in the future: "Oh sussicranism, that's the thing that has to do with saying 'No' to incest". So I want to give some other simple examples.

I have found when I finally cotton onto something in the fundamental structuring of the inner world that I start to see evidence of it everywhere. It is no surprise to us to see the hidden face of human sexuality as the cap is pulled in a coke ad. or to read the anxiety in the play of a child. Likewise when one's interest is taken by envy or narcissism no day will pass without the chance to

observe their signs in action in a myriad different day-to-day moments visible both without and within. I have found this is so with sussicranism too. Narcissism can be considered to lie at the core of much everyday psychopathology. Where it is, there also will be found, somewhere round about, the clear evidence of the sussicranistic mind. Take the visitor, a narcissist, who blithely outstays his welcome. He may be coupled with a host, who, as a sussicranist, cannot ask him to leave. Watch the narcissist who cannot enjoy a film chosen by an other; see the sussicranist who is plagued by anxiety if forced to make the choice. The sussicranist cannot bear to finish the last of the strawberries; the narcissist cannot bear it when someone else does. For the narcissist it is a torture to take in a painful home truth. For the sussicranist it is a torture to speak one. The narcissist and the sussicranist are like paired polar opposites.

Character traits

We might be familiar with thinking there are typical (even if well hidden) character traits in those under the dominance of a narcissistic mentality. These traits are often thought of as unpleasant, hence the pejorative connotations of the term 'narcissist'. It connotes puffed-up, conceited, disagreeable, mean-spirited, arrogant, impatient or intolerant, unreliable, inconstant, easily offended; in a word - selfish. The narcissist is quintessentially selfish. It is possible to get one's tongue around the word and hurl it out: "You're selfish!" How disagreeable.

How often is it recognised that someone could be equally disagreeably 'otherish'. "You're otherish!" It just doesn't seem to work as well. And yet I am asking you to consider in all seriousness that this is an equal if correlative or inverted problem. The sussicranist may show all the dastardly hallmarks of humility, agreeableness, niceness, selflessness, helpfulness, tolerance, forbearance, commitment and dependability. What a rascal, eh? It is true, for these traits to be sussicranistic they must be used in the service of the destruction of relationship. For the sussicranist these traits efface the self and therefore work against real relating just as surely as the narcissist's effacement of the other works against relating.

Genesis and recovery

How might we imagine the genesis of sussicranism? Neville Symington pointed out in his book which I referred to earlier, that the origin or genesis of narcissism lies in a deep inner choice that is made in response to overwhelming trauma. He argues, convincingly for me, that because a choice is made in response to trauma, a choice to turn away from relational life with the other, then such a

choice can be remade in favour of a different outcome at a later date. It is possible to recover, to make a new choice away from narcissism and in favour of the recovery of relationship and life.

It seems to me that a comparable choice in response to trauma has been made in the sussicranistic mentality. As a colleague suggested to me recently, it is possible to imagine that, where the narcissistic path is chosen, the infant is, in phantasy, subsuming the power of the m(other). This is an 'I-am-everything' state of mind. Where, for whatever reason, a sussicranistic path is chosen in preference, then the infant is, in phantasy, being subsumed by the m(other). This is, in contrast, more of an 'I-am-nothing' state of mind. Both represent absolutely desperate attempts to secure psychic survival. They are the choices of No Choice, diametrically opposed yet each as surely destructive of relationship. In either case such a choice can be reviewed. A new choice in favour of life can be made when what is happening is seen, recognised, understood and renounced. This is usually a terrifying, daunting and painful task. It involves re-entering the relationship between 'You' and 'I' and, as such, is experienced as an invitation to re-enter an annihilatingly traumatic situation. It involves both 'self' and 'other', each experienced as separate and autonomous yet relating to each other. This is the challenge of recovery.

Envy and risk

The narcissist, as Neville Symington has pointed out, finds intense pleasure and excitement in the destruction of the other. The equivalent in the sussicranistic mind is the hidden enviously driven pleasure or excitement of self-destruction.

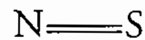
The creative act as far as I can see requires an overcoming of envy directed against one's own creative self and a capacity to bear the risk of failure and consequent shame. Essentially in sussicranism and in narcissism it is the destruction of the relationship that is so exciting. This is what is common to both of them though they take different paths. In the destruction of relationship there is a huge perverse pleasure which, in narcissisism, offsets envy of the other. In sussicranism it offsets an inner envy of the creativity of the self.

A wilful destruction of relationship also offsets the risk and vulnerability that lies in suffering a breakdown of relationship that is not of one's own making. Intuitively for me this is like the child who, building a tower with bricks, will come to a point where the increasing risk of failure outweighs the creative pleasure. At that point the more certain pleasure of destruction wins out and the

tower is smashed down with great delight. No-one fails at smashing things down. The narcissist delights in the smashing of the other, the sussicranist delights in the smashing of the self. For both, the horrendous risks of relationship are managed by this manoeuvre.

The Sussicranist and pairing

I said earlier that narcissism and sussicranism are polar opposites. Anyone who recollects their schoolday physics will recall those little diagrams of magnets.



'Like poles repel. Unlike poles attract', and all that.

In 'pairing relationships' it is often so; N═══S. The narcissist, N, pairs up with the sussicranist, S. I have imagined that when you meet with an individual in your work, one of your first questions within your own mind can be: N or S? In a couple you can ask yourself: Is it: N and N, or N and S, or S and S?

Each of these pairings has its own characteristics. A relationship that is N and N is an unstable, overt hell. I think of the joke-like caption where a presumably quite narcissistic person bitterly complains of another: "He's so narcissistic even I notice!"

A relationship that is N and S is a stable, covert hell. Many stable, abusive, subjugating relationships fall into this category and, to describe them, clinicians often use such words as co-dependence, masochism, passivity, confluence.

And a relationship that is S and S? Well, at first I couldn't imagine such a pair existing, until a friend described a relationship that was surely S and S: "After you!" "No, no, after you!" "No, really!!" "What would you like to do?" "Well, what would you like to do?" (Could this have been a hell for everyone else?) Actually my friend told me the unconscious rageful tension in this relationship was dreadful for those round about.

While narcissists are trying to make themselves happy, sussicranists are trying to make everyone else happy. This is why pairing structures between N and S so often come into being. Opposite poles attract.

The tragedy for the sussicranist in this style of relationship, N and S, is that, no matter what the suffering, the sussicranist actively maintains the very situation that he or she cannot abide; there is a dread of 'making things worse' which I will return to in the final section. It is also, incidentally, a tragedy in like man-

ner for the narcissist of the pair whose actual if more unrecognised suffering is none the less for all its invisibility.

Sometimes the way a sussicranist effaces themselves is very blatant but often it is very subtle and its operation may leave the sussicranist totally bemused as to how they have arranged for their wishes to be utterly ignored by the other. I had a very good opportunity once to study a very ordinary sussicranistic moment, just the sort of thing I would do myself, though of course it is far easier to see such a moment in an outside situation. There was a large audience and a chairperson was taking questions from the floor. Several people had their hands raised to attract the attention of the chair. The person in front of me had her hand up for longer than the rest. As it came to the last question to be taken from the floor, matters became urgent and she insisted herself onto the attention of the chairperson. As his focus turned to her I saw clearly that she minutely, subliminally, withdrew her hand. The movement was minute and totally unconscious but it was enough. The chairperson had in like manner unconsciously read the sign and the chance was past. His attention moved on to someone else. Her frustration was palpable. "He ignored me!" she said afterwards, enraged. "Did you see?" A person in this situation does not readily want to know their part in what has happened.

Resentment, guilt and shame

In this way, while a narcissist may store up unconscious guilt at the destructiveness of their actions, for the sussicranist their fate tends to be the accumulation of massive amounts of resentment. This can become terrifying in its proportions and make recovery a very frightening prospect. The narcissist, in the process of recovery from a compulsive tendency to destroy the other within the mind, may have to feel the guilt of what he has been doing. In this process of therapy the narcissist in recovery becomes for others a much more likable person. By contrast, the sussicranist in recovery may unleash a dam-burst of resentment. Where the narcissist is becoming freed from guilt, by contrast, the sussicranist in recovery has to bear guilt, maybe for the first time (perhaps there is no guilt in self-effacement?). In the process of recovery the sussicranist becomes in a shallow sense a less likable person, though a more real one. In the process of recovery the sussicranist also has to be able to bear the risk of shame. There is always the risk of failure and of shame in any creative action.

Oscillators

Often, of course, what actually happens in the process of recovery is that the sussicranist 'flips over' into the worst excesses of narcissism. All the pent-up rage and resentment of the years of self-imposed servility pour out without

regard for the other. It is hard to get it right. As a result a person may oscillate backwards and forwards between narcissism and sussicranism.

I had the chance once to work with people in recovery from addiction, in a group situation that included their partners. I often saw this pattern in the recovery path of the co-dependent partners, who would spill out great torrents of resentment for the wasted years only to quickly fall back through the guilt of 'being themselves' into active supportive co-dependence, (supportive, that is, of the addiction).

It seems to me the great challenge of relationship - to truly have regard for both self and other, perhaps Buber's 'I - Thou'.

Sussicranism and groups

Another fruitful area to think about from the point of view I have been outlining is the psychology of groups. Broadly, again, the two basic positions of narcissism and sussicranism will be well represented in any group situation. Often the leader who emerges is in some sense narcissistic and the group in relation to him or her sussicranistic. The oft-referred-to 'silent majority' is essentially sussicranistic. In Neville Symington's Tauranga address he said that in a group, as in a session of clinical work, it may be that 'silence is a sin'. This is the sin of sussicranism. In group situations the narcissist commits the 'sin of speaking without listening' and the sussicranist 'the sin of listening without speaking'. If you are an oscillator between a narcissistic and a sussicranistic condition of mind, then you will be able to observe both of these tendencies within yourself.

Sussicranism and psychotherapy

I hope at this stage that I have managed to put across some thoughts on the existence, style, structure and origins of the sussicranistic mind. What then is the relevance of sussicranism to the profession of psychotherapy? It is easy to think that psychotherapists are nice people who want to help other people feel good. You might go further and say that therapists ought to show in high measure a capacity for humility, selflessness, tolerance, forbearance, commitment and dependability. Indeed it is reasonable to imagine that the profession of psychotherapy attracts a certain proportion of people who are particularly motivated to make other people feel better and that they have developed to a very high degree some of the personality tendencies that I have just outlined. What if some of these are actually motivated sussicranisticly? It is useful, as a

therapist, to be able to see and think about and even reduce sussicranistic tendencies operating within one's mind, just as it is with narcissistic tendencies, or at least to be able to notice when this aspect of oneself is particularly brought into action.

People have often commented that the counter-transference to narcissism is a tendency to have one's own narcissism triggered: "Bloody hell! What about me!"

N═N produces an unstable hell. This at least, being unstable, has a therapeutic potential for change if it can be contained and directed usefully towards a truly therapeutic end. The greater problem seems to lie more in the area of N═S.

The Sussicranistic Therapist.

Where the therapist is a sussicranist dealing with either narcissistic or sussicranistic problems operating in the mind of the person in therapy this situation would be expected to produce a stable, covert hell, that is a hell that may is not even come to attention, let alone alleviate actual suffering. This is not a promising seed bed for psychotherapeutic progress. Especially so if there is a fundamental underlying idea at work in the mind of the therapist, that psychotherapy is supportive and has to do with generating good feelings. Here we can think back to the sussicranistic 'dread of making things worse' that I mentioned under 'Pairing'. The ability of the therapist to 'make matters worse' in a useful way, is a vital ingredient of growthful change in psychotherapy. The trouble with supportive psychotherapy is that it usually supports the psycho-pathology.

The sussicranistic state of mind is specifically orientated to generating good feelings in the other, out of fear, and with a totally hidden motivation of complete self-interest. This has nothing to do with relationship despite any appearance to the contrary.

Actual therapy takes place in relationship and has to do not with generating good feelings, but with developing the abilities to bear pain and to think. Where sussicranistic tendencies are predominant in the mentality of the therapist the scene is set at best for some degree of therapeutic stasis. At worst, it will always be either the narcissism or the sussicranism of the therapist's mind that wreaks havoc.

References

Symington, N. (1993) *Narcissism: a New Theory* London: Karnac Books

Emotional ties that bind: weaving a healing tapestry for an attachment disordered child

Judith Morris

Abstract

The paper presents therapeutic work with a child, directed towards repairing his capacity to form secure attachments, and demonstrating the use of symbolism woven into play therapy sessions. Attachment theory is used as the framework for analysing the process of therapy, the interface between the therapy and the day-to-day care of the child, and the overall decision-making context when the child is in the care of the state (Department of Child, Youth and Family). The weaving together of these strands aims to create a healing tapestry for the child to attain secure attachments to the emotionally significant adults in his life and to reach his potential in other aspects of his development.

Introduction

Daniel, aged eight and a half years old, was referred to me for therapy one year after he had been removed from the care of his family of origin and placed in a residential school. During this time, Daniel's progress had been intermittent, unpredictable and unstable, especially regarding his capacity to form and sustain relationships with the caregiving staff at the school and the children he lived with. As a child in long term care, with little likelihood of returning to his family of origin or kinship care, the Department of Child, Youth and Family had a responsibility to provide substitute care where Daniel "should be given an opportunity to develop a significant psychological attachment to the person in whose care the child .... was placed" (Clause 13h, Children, Young Persons and their Families Act, 1989). Attachment theory was therefore seen as particularly relevant, and was used as the framework for undertaking Daniel's therapy.

The theme of the narcissus represents one of many strands in Daniel's therapeutic process. Communication through the imagery of the narcissus was a natural extension of the use of metaphor in my therapeutic work (Babits:2001), and the recurrence of the symbol marks important stages in his pathway to healing. The image is used in different ways to explore a mutual understanding

of Daniel's sense of self and his relationships with significant adults, and of the therapeutic process itself. The case material examines the many layers of therapy: Daniel's representation of his inner world; his work during the therapy sessions and his developing relationship with myself as social worker-therapist; and the interface of his sessional work with his experiences and relationships in the outside world. This paper illustrates the complexity of weaving a healing tapestry so that the many layers come together to create a coherent fabric for the therapeutic treatment of an attachment disordered child.

Initial presentation

When Daniel came into care aged seven and a half years old, he was admitted to a residential school. He presented as a very disturbed child, with extremes of behaviour from total withdrawal - curling up in foetal position and continual nonsensical fantasising, so out of touch with reality that it verged on the bizarre - to other times when he flung himself into ferocious temper outbursts, kicking, fighting, screaming, a danger to himself and others. Occasionally, he ended up running away from the unit, later claiming that he was searching for his mother.

On the residential unit, Daniel's behaviour was not particularly unusual compared with the other emotionally disturbed children he lived with, although he was one of the more difficult to manage. He tended to resist being cared for, believing that he was capable of being independent, telling staff when he was in a bad mood "I can look after myself", "leave me alone", "stop bossing me around". His social skills with other children were minimal, and he had difficulties joining in their activities and games. He could not bear to lose, and he was very poor at sharing, be it toys or taking turns with equipment or during games. He wanted to control everything, even when he was not capable of doing the activity or did not know the rules, yelling and screaming if he was not allowed to get his own way. Nor was he able to play alone or occupy himself constructively. He was unable to look after his belongings, continually breaking his toys and even losing his favourite bear. Daniel had difficulty getting himself to sleep, making strange animal noises, and he was often troubled by nightmares.

It was at school, where he was expected to conform in a carefully structured classroom, that the extreme oddness and unpredictability of his behaviour showed up. From the moment that he entered the classroom, it was evident whether it was going to be a good day or not. His hair standing up on end was always a bad sign. Other aspects of his physical appearance also changed when he was in a bad space, his eyes looking more sunken and partly closed, his face long, thin

and pointed, and his body crumpled and hunched up. Even his clothes looked dishevelled and untidy. On a bad day, Daniel would not start to work and was unable to co-operate with any instructions from the teacher. He was generally fidgety and could not sit still, continually annoying the other children. He often complained of aches and pains. One day when he was wailing and moaning about a sore leg and was told there was nothing to be seen, he got out a blue crayon and drew marks on his legs for bruises and sores.

At one stage, Daniel became obsessed with being a cat. He crawled around the classroom on all fours. When no-one was watching, he jumped up onto the kitchen bench and ate a piece of cake, lapping the food from the plate, just like a cat, looking up periodically to hiss and miaow. He would only accept his medication by taking it with his mouth from the teacher's open hand. In the teacher's opinion, it was more than a child pretending. This behaviour persisted for long periods of time, increasing in duration each day, and the quality of Daniel's involvement was total absorption.

Generally in the classroom, even on good days, Daniel found it hard to remain on task, and despite working with him on a one-to-one basis, his behaviour remained very difficult. His threshold for frustration was low and he threw major tantrums at perceived injustices or requests to comply with instructions. He seemed to have problems retaining what he had learned from one day to the next. There were gross discrepancies in his academic performance. He could barely read and yet, in science, in art and creative construction work, he had remarkable knowledge and skills, capabilities way beyond his years.

When Daniel was referred to me, a year after his admission to the residential school, he was still a complete enigma to the staff. Apart from his rage, he shared little of his thoughts or feelings. On the other hand, there had been periods of improvement and stable behaviour, and also signs that Daniel was making relationships with a particular child or staff member. Then suddenly, and for no apparent reason, Daniel would revert to his original bizarre behaviour patterns, and withdraw from these relationships. Some time later, and equally unpredictably, his behaviour would become more settled again and he would start making relationships but often with a different child or staff member.

At this stage Daniel was given a dual diagnosis of Asperger's syndrome and ADHD, for which medication was prescribed. There was also a possible differential diagnosis of reactive attachment disorder, and given Daniel's history of abuse and dysfunctional parenting, there was, in my opinion, a reasonable likelihood of some success in undertaking therapy with Daniel based on attach-

ment theory. At the same time psychological and psychiatric overview was maintained to review diagnosis and progress.

Attachment theory and the therapeutic process

Historically, Bowlby developed attachment theory out of the roots of object relations theory (Karen:1994), which he also integrated with concepts from ethology (animal behaviour), cognitive psychology, and control theory. Like object relations theorists such as Winnicott and Fairburn, Bowlby believed that real events in the child's life, such as separation or trauma, as well as the actual quality of the infant-parent relationship, were the most important influences shaping the child's personality development. Bowlby rejected some aspects of traditional psychoanalytic theory, including the concept of libidinal drives (Bowlby:1969). Instead, he considered that the propensity to make affectional bonds is a prime motivating need in its own right. Attachment behaviour is seen as one of several behaviour systems with its own specific function. Other systems include sexual behaviour, eating and exploration. The function of attachment behaviour is to ensure that children remain in close proximity to an attachment figure for protection and a sense of felt security. A natural consequence of disruption to the child's attachment to its caregivers, through unwilling separation or loss, is emotional distress, including anxiety, anger, depression and emotional detachment, and possible personality disturbance (Bowlby:1984). Furthermore, there is a reciprocal relationship between the attachment and exploration systems, such that it is only when attachment needs are assuaged that the child is free to engage in creative or playful exploration (Holmes:1997).

During the first years of life, children build up internal working models or representations of themselves and their primary caregivers in interaction with them. These models, based on real experiences, incorporate generalised beliefs and expectations founded on the child's attempts to gain comfort and security, and the success or otherwise of doing so. They are "working" models because they can be updated. However, over time, they tend to persist, are taken for granted and end up operating unconsciously, guiding interactions not only with the primary caregivers but also with other new attachment figures, such as with a teacher, foster mother or therapist (Bowlby:1988).

The internal working models are outwardly manifested in patterns of attachment behaviour. Three principal patterns were identified by Ainsworth and her colleagues (1978), based on observations of young children and their caregivers both in natural environments and in a highly structured laboratory situation often referred to as the "strange situation procedure". These patterns

were found to be related to the quality of early mothering experienced by the infant.

In the first pattern of *secure* attachment (about 65 per cent of a normative population (Holmes:1993; Karen:1994)), the child is confident that the mother (or other attachment figure) will be available, responsive and helpful when adverse or frightening situations are encountered. With this assurance, the child feels bold in exploring the world, and internalises a representation of self as loveable and worthy of care. This pattern is promoted by the parent being readily available physically and emotionally, sensitive to the child's signals and empathically responsive when protection and/or comfort is sought. In the strange situation procedure, the infant is often, but not necessarily, distressed by the mother's absence. On reunion, the infant seeks and obtains comfort, and readily returns to play.

A second pattern (about 12 per cent of a normative population) is that of *insecure ambivalent* attachment, in which the child is uncertain whether the parent will be available or responsive or helpful when called upon. Because of uncertainty caused by the parent's inconsistency, the child is always prone to anxiety, tends to be clinging, and is anxious about exploring the world. The core anxiety of the insecure ambivalent child is the fear of abandonment. In the strange situation procedure, the infant is often distressed by the mother's absence. However, on her return the infant is difficult to comfort, angry and resistant while at the same time seeking contact. Such infants often become clinging towards the mother and are reluctant to return to play.

In the third pattern of *insecure avoidant* attachment (about 22 per cent of a normative population), the child has no confidence that there will be help when care is sought. On the contrary, the child expects to be rebuffed. In the extreme situation of repeated rejections, the child tries to become emotionally self-sufficient and avoids emotional contact with others. The core anxiety of the insecure avoidant child becomes a fear of impingement. In the strange situation procedure, the infant rarely shows distress at the mother's departure. However, they are often watchful and their play is inhibited.

A fourth pattern, that of *insecure disorganised* attachment, has been identified since Ainsworth's original research. These infants showed no coherent pattern of responses, suggesting the infant views the parent as frightening, and thus making it uncertain which behaviour will be appropriate in the presence of the parent (Main and Hesse:1990). This category represents only a small percentage of a normative population (less than 5 per cent), but the proportion goes

up dramatically in vulnerable groups, such as socio-economically disadvantaged families and those with mothers who have themselves been abused as children (Crittenden:1988).

These patterns of attachment behaviour tend to be maintained not only because caregivers tend to parent consistently across time, but because the process is inherently self-perpetuating (Bowlby:1988). The internal working models of insecurely attached individuals may become habitual and not respondent to the world. They may persist even when other adults treat them in ways that are totally unlike how they were treated by their primary caregivers. The circularity then continues because individuals with unchanged internal working models of self and others will elicit behaviour which confirms their working models.

Bowlby's model of clinical intervention is therefore based on clients' reappraising and re-structuring their internal working models. This is accomplished by the therapist providing conditions in which clients can gain new understandings, both by exploring and gaining insight into the various aspects of their internal working models through therapy, as well as from the actual experience of a therapeutic attachment relationship. Bowlby (1988:138-9) outlines five tasks for the therapist using attachment theory, as follows:

1. To provide clients with a secure base from which to explore the various aspects of their lives - past and present - many of which the client may find difficult to think about without a trusted companion providing support, encouragement and empathy.

2. To encourage clients to consider how they engage in relationships with significant figures in their current lives, what their expectations (often unconscious) are for their own feelings and behaviour and for those of other people.

3. To encourage clients to examine the client-therapist relationship, recognising that clients will import perceptions and expectations about attachment figures into this relationship.

4. To encourage clients to consider how current perceptions and expectations may be the product of childhood events and interactions with attachment figures.

5. To enable clients to recognise that their models of self and other may or may not be appropriate to their present situation, and to reflect on the adequacy of earlier models, and whether these are accurate in the light of current experiences with others, especially the therapist.

The application of Bowlby's concepts to clinical work has been slow, and indeed this was a source of disappointment to him (Bowlby:1988). There has recently been a gradually growing literature relating his ideas to counselling and psychotherapy with adults (for example, Pistole:1989, 1999; Sable:1994; Krause and Haverkamp:1996; Holmes:1997). There has also been a systematic application of attachment theory to family therapy (for example, Byng-Hall:1991) and to therapeutic interventions in early infant-mother relationships (for example, Fraiberg:1980). In contrast, there has been little literature about applying attachment theory to therapy and counselling for children, although Bowlby and subsequent researchers such as the Robertsons (Robertson and Robertson:1989) have had a profound influence on the quality of substitute care for children. These include: acknowledgement of the importance of parents' visits to children in hospital; the preference for foster care and the resultant closure of large residential nurseries and children's homes; and the recognition of children's need for permanent family placement or adoption when they cannot return to their family of origin.

In considering Bowlby's five tasks for the therapist, I would suggest that the application of attachment theory to the field of therapeutic work with children has been hindered by developmental issues that necessarily change the ways that these tasks can be undertaken. This is partly related to children's cognitive development, where the stages of egocentric and concrete thinking (Piaget and Inhelde:1957) preclude a child's capacity to participate in abstract reflection about relationships, past and present, as outlined by Bowlby. Furthermore, children's natural medium of communication is through play and symbols in addition to talking, although for some emotionally disturbed children, like Daniel, part of the task of therapy is to bring the child to a state of being able to play (Sanville:1999). Because of this, the provision of the actual experience of a therapeutic attachment relationship becomes the primary vehicle for helping the child revise his internal working models of self and attachment figures. However, unless the quality of day-to-day care of the child is good enough and work is undertaken to facilitate attachment to the primary caregivers, the overall effectiveness of therapy can be compromised (Morris:1997, 2000).

Thus, whether working with adults or with children, the primary initial task of the therapist is to encourage the client to form a therapeutic attachment. Unless there is a measure of felt security therapy cannot even begin (Holmes:1993). The therapist emulates, in many ways, the conditions under which the infant develops secure attachment to its primary caregiver. The function of attachment is to provide comfort, security and safety, to serve as a secure base from

which the individual can explore the world. To actively promote attachment, the therapist needs to be consistent and reliable in his or her presence, emotional available and focused on the client's needs (Pistole:1989). This is provided partly through empathic acceptance and understanding. The therapist modulates the client's affect and becomes a source of comfort or a soothing agent for the client (Pistole:1989). Safety and security is also provided by the structure and regularity of the therapy sessions, and boundaries related to professional role and ethics. The therapist's office may literally become a secure base to which the client can return (Pistole:1999). For children it is essential that the playroom is experienced as unchanging with a consistently laid out set of toys in order to provide a sense of safe haven and security (Axline:1949).

Work with Daniel: a shared understanding of the therapeutic process

As outlined above, the initial work with Daniel focussed on developing a therapeutic attachment relationship. Communication with Daniel was at first limited solely to reflecting what he volunteered to discuss. I quickly learnt that any questions I asked went unanswered, and furthermore they stopped the flow of conversation from Daniel. Besides, in this initial stage, even simple reflection can lead to a sense of empathic acceptance and understanding. The next stage would be to find an activity and a venue that would provide the opportunity for Daniel to express needs that could be interpreted as cues for attachment, and to which I could respond appropriately. The search itself would become part of the strategy for forming a therapeutic attachment.

We started our sessions in a play therapy room at a local clinic. Daniel occupied himself building a scene in the sandtray, then constructing a working model with gears, and taking a photograph of me which he stuck to a large piece of cardboard headed with his name printed in glitter. A good start, it seemed. But after two sessions, Daniel declined to return to the playroom.

On the first occasion that Daniel refused to come to the playroom, he clearly mistrusted whether or not he would be forced to go. He half-heartedly ran away, and took refuge in a small patch of woodland adjoining the residential unit. I followed, but not too closely. I commented to Daniel that he could choose what we did and where we went, and whether or not he involved me. What he did not get a choice about was whether I would visit him. I would come each week, at the same time, and I would stay with him for an hour.

Daniel was watchful and wary. I assured him that I would not chase him or make him come with me. Suddenly, Daniel issued a warning not to follow him: "It is not safe here for you." I crouched at the edge of the wood, wonder-

ing how this session would evolve. I waited and I watched. I then realised that Daniel was right. It was not safe. I was being attacked by mosquitos, to which I am very allergic. I explained to Daniel that I needed to get myself protection, that I would be back soon and I went to find some insect repellent.

When I returned, Daniel had retreated deeper into the wood. He was hiding. He remained anxious that I would come too close. I moved slowly and cautiously towards him. He ventured behind a large tree. I stopped. I commented again that I would not chase him and I assured him that I would come no nearer.

Daniel started to dig. "I'm searching for bulbs," he said. I expressed serious doubt that he would find anything - but it seemed that Daniel knew better. He suddenly found a narcissus bulb, dormant. He tore it out of the soil and brutally ripped off its roots. He started to collect the bulbs in a pouch formed by pulling up his jersey. Eventually, I was invited to join in. "You will need to get your hands dirty, too." I started to dig in the soil searching for bulbs.

Daniel came across a sprouting bulb. Immediately his actions changed tenor. Great care was taken to remove the bulb from the soil without damaging its roots. It was handed to me for safekeeping. Daniel continued. The dormant bulbs were added to his pouch, their roots ruthlessly removed. The sprouting bulbs were all given to me, until there were half a dozen. Daniel then indicated that he had finished. He wanted to plant the growing bulbs in a pot. I was then given the pot to take away. "You will look after them every day, otherwise they will not grow."

I was stunned by the power of Daniel's allegory, and his evident astuteness about the process of therapy: the visit to the wood, territory of the unconscious; the instructions to me, as therapist, to nurture the tender growing shoots of the narcissus, while he took charge of the dead-looking, dormant bulbs; the fact that I, too, needed to get my hands dirty if we were going to work together.

I wondered whether to share with Daniel a demonstration of "loving and caring water"[1] (Batty and Bayley:1984), which would explain symbolically to Daniel about his need for therapy. It was with some hesitance that I decided to do so, because anything that I had previously initiated in the sessions had led to com-

1 The demonstration of "loving and caring water" is a way of providing a child and caregivers with a narrative for their experience of attachment difficulties (Batty and Bayley, 1984; Morris, 1997). The adults are represented by jugs, the children by cups, and nearby there is a "well" where the adults can replenish their supply of loving and caring water. The children are born, full cups emerging from the mother jug after she has been filled by the father jug. In everyday life, all

plete closure by Daniel. It felt a big risk after the depth of his revelation, and we had already had one false start in the playroom.

Daniel attentively watched the demonstration of "loving and caring water". As I finished, Daniel took over the dialogue. He showed me that he allowed his cup to be filled through the hole in the "suffering skin", but only partially. He then spent considerable time closing over the hole in the "suffering skin". He talked about opening the hole from time to time, to fill up a bit more, and then carefully closed the hole again. In this way he showed how much he needed to control his relationships with the adults around him, only risking brief interludes of closeness. His explanation reflected the pattern of intermittent attachment that had been observed. He also described the way he withdrew from close relationships, for no apparent reason, except that it would seem that Daniel made conscious decisions about when and with whom to allow relationships to develop. Again, I was struck by Daniel's profound astuteness.

Work with Daniel: the first steps towards attachment

The next sessions were problematic. While he trusted me enough to risk going in the car, he continually checked that I would not make him return to the playroom. However, it also became apparent that he was unsure how to use the time, what to do, where to go - a coffee shop, a playground, a shopping expedition. As a social worker trained in the use of direct work techniques, handing over the decision to Daniel about these things (activity and venue) was acceptable, whereas as a therapist these aspects of treatment may not have been negotiable.

There were several outings that felt aimless and unsatisfying. However, he seemed keen to go out with me, and for several sessions we visited playgrounds, a coffee shop and he browsed seemingly aimlessly in toy shops. The search was for an object or a potential space that would create the opportunity to engage in the

---

children spill their loving and caring water. They are hungry, they get hurt. In an ordinary family, "good enough" parenting (Winnicott, 1965) can refill the children's cups. But, when parents are unable to meet their children's needs, for whatever reason, their cups become increasing depleted. Eventually, children need to protect themselves and put on a "suffering skin" (cling film over a nearly empty cup). This stops any more "loving and caring" getting spilt. However, when such children are placed in a nurturing environment, the "suffering skin" now prevents the children's cups being replenished. Whatever loving and caring is poured forth by the new caregivers, it spills over the impervious "suffering skin". The result is a mess, "loving and caring" spilt everywhere. The caregivers feel drained and they experience the children as unresponsive. At the same time, the children, with their underlying needs unmet, often present escalating behaviour problems. The aim of therapy is to help children make "holes" in the "suffering skin", to risk opening themselves to relationship without dismantling all their defences, and to learn gradually the experience of having their cups refilled with "loving and caring".

attachment process. In the meantime, this was particularly difficult to negotiate because any questions I asked immediately resulted in Daniel's withdrawal into silence. Nevertheless, Daniel eventually arrived at a session with a sense of purpose and direction. He talked of a motorway nearby, and seemed surprised that I did not know its whereabouts. In contrast, he seemed to know exactly where he was and where he wanted me to go. He wanted us to find "the man with a boat".

This was the first occasion that Daniel had so clearly expressed a need. It was important that I did whatever I could to meet this need, and indeed, if possible, find the "man with a boat". At the very least, Daniel needed to understand that I took his request seriously, and that I would undertake a genuine search for the man with a boat, even if in the end we were not successful. I asked him questions about the identity of the man with a boat, and for the first time Daniel responded, albeit with tentative, monosyllabic answers. The faltering conversation was a breakthrough in terms of a beginning step towards attachment. However, attempting to meet Daniel's expressed need with any immediacy posed practical difficulties. Daniel was unable to give me any sense of where the destination might be, what distance or time might be involved, and the session was only one hour long. Apart from honouring the usual structure of the sessions, my time that day was also constrained by other commitments.

Naively, I talked with Daniel about the limitations of this session. I explained that we would go as far as we could in half the time, and then we would have to return to the unit. I showed Daniel on the car clock when we would have to turn around. I promised that if we did not reach the man with a boat, I would try to find out more and we would try to find him another day. Daniel seemed to understand and accept. However, at the half-way point, no sooner had I turned the car around, than Daniel started to kick and scream. He tried to grab my glasses to break them. He tried to destroy his own glasses. His little boots hammered the dash board with the fury of his rage. I eventually ended up holding Daniel by his arms and pinning him back into the car seat. I had to hold him so strongly that I worried that my firm grip would leave finger marks on his arms.

The violence of his anger subsided as suddenly as the initial explosion had erupted. Daniel flopped down off the seat into foetal position, curled up on the floor of the car. He jammed his legs under the car seat, and wailed and moaned for the rest of the journey about the pain he was suffering. However, he resisted any attempt I made to help him to free himself, crying out in pain if I simply touched him.

It was an unfortunate, and an unforgettable, experience. I confessed my fears of bruising Daniel to the staff, and learned that I had unwittingly re-enacted a scene that was commonplace on the unit. Sadly, it took another parallel experience before I understood the sheer terror that could be unleashed and expressed by him - the high arousal state, firstly manifest in his "fight" and then his sudden retreat or "flight" into withdrawal (Perry, Pollard, Blakley, Baker and Vigilante:1995).

The following session, I talked with Daniel about what had happened. He immediately commented that he had been "a little bit angry" last week. I said that I thought he had been "a big bit angry" because he thought I had broken a promise by not finding the man with a boat. I talked with him about promises, saying that I would only use the word "promise" for something that I was absolutely certain I could do. Thus, I could promise to search for the man, but I could not promise that I would find him. I gave Daniel a card that I had made especially for him. It was the shape of an egg and the front of the card was made with wrapping paper decorated with narcissus blossoms. Both symbols had been carefully chosen, though nothing was said by way of interpretation. The message in the card reiterated what I had already told Daniel about promises.

Daniel was very quiet. Eventually he commented that he would "have to decide whether I was one of the liars". I responded that indeed he would have to decide whether I was one of the liars; it was something that only he could decide. For a child who had so far mainly communicated through metaphor, this statement was truly profound. The hope now was that he would find in me, as a therapist, someone who was consistently trustworthy so that he would risk giving me his trust, and thus consolidate this initial stage in the formation of a therapeutic attachment.

We didn't ever manage to find the man with a boat. The staff and teachers were sceptical about the reality of his existence and it was not until a year later that I established his identity. In the meantime, the reality or otherwise of his existence was not relevant to me. My immediate response to Daniel's request was intended to validate the genuineness of his expressed need. Furthermore, Daniel's interest in the boat led to my suggestion that we might make a boat together.

We bought a balsa wood model boat that became the focus of our work for many weeks to come. Working together was a painstaking process. Daniel's need for immediate gratification meant that he was often impatient with the long-winded task of building the model boat. In addition, he was continually

irritated with me as a helper, while I grappled with finding an appropriate emotional distance in our relationship. His tolerance for frustration in relation to the task of boat-building was low, but his tolerance for allowing help was even lower. As the therapist, I struggled to find an appropriate balance between imposing help at the critical moment to avoid failure, or standing by and allowing Daniel to grapple with the task and perhaps have some sense of success, while at the same resisting his need for total independence by retaining a continuously supportive role.

For the practical task of boat-building to be therapeutic, it was essential to consider our complementary activities as a re-enactment of the process of attachment formation. This experience could then create the basis for Daniel to revise his internal working models of self and attachment figures. Because the concept of internal working models is described in terms of cognitive representations, it is easy, as Bowlby (1988:156) points out, for the "unwary reader to suppose that these terms belong within a psychology concerned only with cognition and one bereft of feeling and action". Rather, attachment theory is essentially a spatial theory (Holmes:1993) in which the care-seeker (child or client) is constantly monitoring his or her emotional and physical distance from the caregiver (attachment figure or therapist) depending on the level of perceived anxiety and the strength of the drive to explore. Balint's (1986) description of the importance of the therapist getting the right emotional distance from the client encapsulates the dilemma that these boat-building sessions posed for Daniel and myself. The therapist must be

> felt to be present but must be all the time at the right distance - neither so far that the patient feels lost or abandoned, nor so close that the patient might feel encumbered and unfree - in fact at a distance that corresponds to the patient's actual need. (quoted in Holmes: 1993: 155)

The sessions felt perilous and uncertain. It was difficult to know whether I was ever finding the appropriate distance. There was no evidence that I satisfied Daniel's needs, not even fleeting moments with any sense of synchrony. Daniel only ever indicated through his irritation when the balance was wrong. My experience in the counter-transference was a sense of dissatisfaction, and an atmosphere that felt somehow prickly, yet Daniel was often reluctant to leave, with the ending of sessions occasionally becoming a prolonged battle. Although I was left wondering, week by week, whether he would want to continue his sessions, he did keep coming. Gradually he incorporated other activities into his sessions: the two armies of fighting men; the doll's house peopled with monsters and aliens; floor games with farm animals, monsters and the train set;

scenes created in the sandtray; and eventually, a series of creations made with cardboard boxes and tape.

Work with Daniel: signs of progress

Building a secure attachment to the therapist is an important beginning of the therapeutic process, but it brings a further dilemma for the client. Pain and anguish about separation need to be re-experienced if a client is to feel safe enough to form new attachments, secure in the knowledge that, should things go wrong, the loss can be mourned and the client will not be left feeling permanently bereft (Holmes:1993). The real experience of the client-therapist attachment necessarily involves separations, the endings of each session and also enforced breaks in therapy during holidays or illness (Bowlby:1988). These may resonate with previous experiences of separation and loss of attachment figures, which the client will need to work through (Ruderman:1999). Otherwise, if the pain becomes overwhelming, the tendency will be for the client to revert to older defences that reflect previous internal working models corresponding to insecure attachment.

In his sessions, Daniel was gradually changing from being almost silent, shutting down completely if I commented or asked a simple question, to talking freely about his play in the session and allowing me to ask some questions, but only rarely mentioning anything about events outside the sessions (past, present or future). Eventually he talked about day-to-day incidents, allowing some questions, but also able to state quite clearly what he felt unsafe talking about. If I occasionally persisted in asking questions, he "reminded" me that he did not wish to discuss the topic.

The change in Daniel's capacity to express himself and to interact in ways that enabled the formation of a secure attachment is epitomised in the sequence of incidents, outlined below in sections (a) to (d). Each incident occurs during the last session of the term for four consecutive terms, when Daniel is anticipating the changes in caregivers and routine with the closure of the residential school and a break in therapy for the duration of the school holiday. A sense of loss and abandonment is triggered. This sequence demonstrates Daniel moving in stages from symbolic communication during the therapy sessions to sharing his needs and feelings explicitly and eventually experiencing his social worker's responsiveness. This sequence also illustrates the critical link between the therapy sessions and the interface with day-to-day caregivers so that the attachment process is facilitated and eventually repaired.

(a) Daniel was difficult and unco-operative in school all morning. During the therapy session, he was somewhat withdrawn, but for no explicitly stated

reason. Just before the end of the session, he wanted to show me "something magic", asking to use a wax candle, a piece of paper and food colouring from the loving and caring demonstration (see footnote 1). He drew with the wax on a white sheet of paper, and used the food colouring to reveal the picture of an aeroplane. I was going overseas during the school holidays, which he had known about for some time. However, until this picture, there had been no indication from Daniel that he had feelings about this. I surmised aloud about the meaning of Daniel's picture, but there was no response from him to confirm or deny my interpretation. Despite this, staff were made aware of his probably heightened anxiety and asked to be sensitive to his possible feelings of loss and abandonment, not just related to my absence but also to the holiday arrangements of camp and a week in a family group home. For the rest of the week Daniel's behaviour greatly improved.

(b) Daniel had complained continually at school about his injured foot. He did the same during the beginning of the therapy session. I offered comfort and special cream for the injury. He persisted in his complaints. In response to the continuation of this behaviour, I suggested to Daniel that maybe more than his foot was hurting, that maybe he was upset about the start of the holidays and the ending of his sessions. This seemed to meet his needs, in that the complaints about his sore foot stopped. He allowed me to talk about the holidays and what would happen before our sessions resumed.

(c) There were no presenting behaviour difficulties prior to the session. However, when we talked about the session being the last one for the term, Daniel suddenly developed a terrible headache, looking white and pinched. He said that he did not feel well enough to go back to school. He talked about how he hated the school holidays, and said that he did not like what had been arranged for him. I promised to share his concerns with staff. However, I also intimated that it was unlikely that things could change for this holiday, although I suggested that something different might be possible for the next holidays. I returned Daniel to the residential unit, and not to school. On our arrival, the staff member started to coax Daniel back to school. I relayed Daniel's upset about the holiday arrangements, and confirmed that they could not be changed at this late stage. I encouraged the staff member to comfort Daniel, including putting him to bed to nurse his headache, and gained agreement that he should stay at home for the remainder of the day. I suggested to Daniel that he needed to talk to his social worker before the next holidays so that he might get arrangements

more to his liking. In addition, I primed the social worker to facilitate a constructive response to Daniel's request.

(d) There was no disturbed behaviour prior to the therapy session. During the session, Daniel talked positively of his holiday arrangements. He was pleased that some of what he had wanted was now happening, and he seemed more tolerant towards the things he did not like. He talked confidently of the continuation of sessions the following term.

The changes shown in the above sequence reflected Daniel's growing capacity to express his needs and feelings. In addition, he gradually learnt that some adults were responsive to his needs, which resulted in his developing attachments to several significant adults involved in his day-to-day care, such as his favourite staff member on the residential unit and one of his teachers in his new class at school. Moreover, Daniel increasingly showed a capacity to understand himself and to make sense of his situation. An example of this was shown when he recounted an incident during which he was excluded from class for swearing, eventually being sent to the head teacher. "I told her that I decided not to store up my feelings, that I decided to let them out with bad words. She said I was just making excuses for bad behaviour." We talked about swearing not being allowed at school. I asked what happened on the residential unit when he had strong feelings. "You are allowed to say bad words, but you have to go to your bedroom and say them there." I commented that he was growing up, that using bad words was better than storing up the feelings, but that he needed to choose where he could say them. I reminded him that when he was younger his stored up feelings came out as bad behaviour, kicking and screaming, and that the grown-ups had no way of knowing what was troubling him, commenting that things worked better now that he could use words. Daniel observed, "You are the only one who listens and understands." I replied, my reflection not entirely accurate, "You think that I listen and understand", to which he responded, "You haven't listened. You are the *only one* who listens *and* understands". We talked about the importance of sharing feelings and I suggested that part of growing older was finding people who understand. He then commented, "The only trouble is that as you get older, you know more bad words!" Daniel's final remark, with its wry humour, reflected another crucial development which was his increasing capacity to bring enjoyment and fun into his relationships.

Work with Daniel: weaving the threads together

In the next stage of therapy, Daniel started to integrate themes from previous sessions with accounts of incidents in his day-to-day life. He then synthesised

his experiences in both the inner and outer worlds in order to come to new understandings. This is exemplified in a session where the symbol of the narcissus re-emerged.

Earlier in the week, Daniel had been one of three children who had a special party to celebrate their progress at school. Daniel had now successfully completed a term in a mainstream primary school. He was proud of his achievement, and he showed great pleasure in each of the gifts he received to mark the occasion. Amongst the gifts was a "poster" made by his social worker. It was made from a sheet of cardboard covered in wrapping paper, decorated on one side with a poem and stickers, so that it could hang on his bedroom wall.

In the therapy session, Daniel created seven "posters", modelled on the gift from his social worker. He indicated that these were to be gifts for all the people on his unit. The most beautiful and carefully produced of the posters was allocated to his favourite residential staff member. The other six were for each of the children on the unit.

One of the posters he made was decorated with pictures of narcissus. "My favourite flowers," he said. He recollected the card that I had made him, some eighteen months previously. He commented that the card was about my broken promise. He then remembered another time I had disappointed him, another broken promise as it were, because I had forgotten to bring his birthday present on time. He remembered that he had been angry with me. He commented that he had "now forgotten". I suggested that he still remembered about it, so I wondered if he meant "forgiven" rather than forgotten. Daniel then recollected an incident in the previous week's session where I had accidentally knocked him on the head with my elbow and hurt him, saying that he had now forgiven me. He went on. "Sometimes you make mistakes, but I forgive you. You don't mean to make mistakes, but sometimes you do, and then I forgive you." He went back to discuss the original card I gave him that had been decorated with the narcissus flower. We talked about the broken promise and how he had needed to decide whether or not I was one of the liars.

This session marked further steps in Daniel's capacity to form a secure attachment. It was the first time that Daniel had used his creative energy to make gifts for those he cared about. Moreover, the idea for these gifts was modelled on a gift he had been given. This incident is a clear demonstration of Daniel's capacity to give and receive gratification. In addition, my failure to provide his birthday present in a timely fashion reminded him of other occasions when he had been disappointed and angry with me. However, unlike the catastrophic

experience on the occasion leading to the narcissus card, Daniel was able to weather the disappointment without any serious impact in terms of the stability of his internal working models, which now represented his self as worthy of love and his expectation that attachment figures would generally meet his emotional needs. Winnicott (1965:37) argues that healing occurs when the trauma is re-experienced in the therapeutic relationship in such a way that it "comes within the area of omnipotence".

> The patient is not helped if the analyst says 'your mother was not good enough ....' Changes come in an analysis when the traumatic factors enter the psychoanalytic material in the patient's own way, and within the patient's omnipotence.

Ironically, it was not only the provision of good enough "mothering" from myself as therapist that has been the source of healing, so much as also understanding the times when I had failed to meets his needs. Somehow these failures had been held within a therapeutic context that was basically secure. Winnicott states this paradox, as follows:

> The patient used the analyst's failures, often quite small ones, perhaps manoeuvred by the patient ...The patient now hates the analyst for the failure that originally came as an environmental factor, outside the area of omnipotent control, but that is now staged in the transference. So in the end we succeed by failing - failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. (1965: 258)

The healing tapestry: interweaving the roles of therapist and social worker

Therapy is always a joint journey in which both participants, the client and the therapist, are challenged and each has opportunities for growth. It is humbling when a child shares something of his or her innermost self. Daniel was remarkable in his willingness to give me glimpses of his profound vulnerability, the sheer terror that he experienced if I misjudged the narrow band of emotional safety where his feelings were close enough to the surface to engage but not so heightened that he became unreachable. As his therapist, he gave me a profound insight into the way he could oscillate between two extremes, his fear of impingement versus his fear of abandonment. Even when I made mistakes, however, he was prepared to forgive me and to risk again whether I would be worthy of his trust. Once a secure therapeutic attachment had been established, the co-operative venture of working together became a satisfying experience for both of us. Daniel learned to express a full range of emotion, from

painful anguish to exuberant joy. It was a privilege to observe the subsequent release of energy, which was channelled into creative and imaginative production during his sessions: a cardboard model of a hockey field; a secret hideout and garden for dinosaurs; a puppet theatre; a cardboard lorry; and a cage for transporting cats.[2]

In the world outside his therapy sessions, Daniel also made significant progress. He was able to occupy himself constructively through play. He began to make and sustain relationships with the children at school and on the residential unit. His capacity to form secure and discriminatory attachments to a chosen few amongst the residential staff and teachers showed that he could transfer his experience of attachment from therapy to the relationships in his real life. Increasingly he shared his feelings and thoughts with these attachment figures rather than spiralling into difficult and unmanageable behaviour. There was a striking contrast between this and the now isolated incidents of "bad behaviour", when he was mishandled by unfamiliar adults who did not understand and therefore could not be sensitive to his emotional needs.

As a social worker-therapist, I had undertaken tasks that would not traditionally be associated with a therapist role to create a bridge between therapy and his experience of day-to-day care. For instance, in transporting Daniel between his sessions and school or the residential unit, there were informal opportunities to share insights into Daniel's emotional state with his caregivers. In addition, I could translate the caregiver's experiences of his difficult behaviour so that these could be interpreted differently and understood as distorted cues for attachment. This was particularly important at the beginning stages of Daniel's revising his internal working models so that his attachment experiences were not limited to his therapy sessions but were also generalised to his everyday life. In addition, I also gave advice about a bedtime comfort programme to create a special time of nurture and comfort that would help him move from high arousal to a more relaxed state for going to sleep, as well as enhancing his growing attachment to a specific residential staff member.

Over time, my role in facilitating attachment became decreasingly necessary as Daniel became more able to express his needs and feelings appropriately and to negotiate events and relationships satisfactorily for himself. This was demonstrated in his increasing capacity to cope with the changes at holiday time. He was now ready for placement in a permanent substitute family. Therapy would

2 Further case material relating to Daniel is recounted in "Heroes' journeys: children's expression of spirituality through play therapy" (Morris: 2002).

then change focus. Introduction to a new family usually causes issues of separation and loss to re-emerge, as well as triggering a need to understand the reason for being in care and the experience of abuse and rejection from the family of origin (Jewett:1980; Fahlberg:1991). In addition, work would need to be undertaken with Daniel and the new family to facilitate the transfer of attachment to the new caregivers (Fahlberg:1991; Morris:1997, 2000). Unfortunately, in Aotearoa New Zealand it seems that there are not the resources, training and knowledge nor the mandate to facilitate the placement of an older child like Daniel in permanent out-of-family foster care, in contrast to social work practice in the United States and Britain.

In the meantime, as a social worker-therapist, I also became aware of a vast discrepancy between Daniel's evident intelligence and capacity for total absorption in constructive activity and learning experiences in his therapy sessions compared with his intermittent progress at school. Daniel's immature emotional needs could not be contained in a school system where the imperative was to move him from his small special class into a mainstream classroom and where cognitive-behavioural strategies were the only treatment offered for his subsequent behaviour difficulties. Indeed, the proposed behaviour modification techniques were directly antithetical to treatment strategies based on attachment theory. Furthermore, although specialist psychological testing confirmed Daniel's superior intelligence, it was also evident that he had a serious specific learning disability, but there were no resources to involve a specialist psychologist because they were outside the remit of Special Education Services. It was decided that Daniel's needs would best be met by placement in a long term residential school. The change of school and the termination of therapy were undertaken without any reference to attachment theory and the need to "bridge" attachments (Fahlberg:1991) to a different therapist and to new caregivers.

Conclusion

The process of therapy using attachment theory as a framework has as its overall aim the restoration of a child's capacity to form secure attachments. One of the consequences of such therapy is that it enables children to get back in touch with their feelings with an expectation that particular adults will be available to respond empathically and reliably to their emotional needs. Through the presentation of one strand of Daniel's case material focussing on the symbol of the narcissus, it can be seen that attachment theory provides not only a means of analysing the process of therapy itself, but it also shows the need for addressing issues about the day-to-day caregiving for children in care and the decisions

about where and with whom they live. If the context of caregiving and the overall decision-making framework does not protect the attachment needs of the children, then there is a very real danger that children are re-traumatised by their experiences in the care system (Hayward:1992; Morris:2000). As a social worker-therapist I was aware of the many threads of treatment that needed to be drawn together to create healing that would encompass all aspects of Daniel's well-being. However, the definition of my role by the funding agency as therapist only, and not as social worker or social worker-therapist (Nathan:1993; Meyer:2000; Phillips:2000), meant that involvement in the overall management of Daniel's care was outside my remit. In the final analysis, there were gaps in the weaving of the fabric of Daniel's healing tapestry, and it is too early to know whether the safety net created will be adequate to hold him.

References

Ainsworth, M.D.S., Blehar, M.C., Waters, E. and Wall, S. (1978). *Patterns of Attachment: Assessed in the Strange Situation and at Home.* Hillsdale, NJ: Erlbaum.

Axline, V. (1949). *Play Therapy.* Boston: Houghton Mifflin.

Babits, M. (2001). Using therapeutic metaphor to provide a holding environment: The inner edge of possibility, *Clinical Social Work Journal,* 29 (1): 21-33.

Balint, M. (1986). The unobtrusive analyst, in G. Kohon (Ed) *The British School of Psychoanalysis.* London: Free Association. Cited in Holmes (1993).

Batty, D. and Bayley, A.J. (1984). Working with Children, *In Touch with Children: Training Pack.* London: British Agencies for Adoption and Fostering.

Byng-Hall, J. (1991). The application of attachment theory to understanding and treatment in family therapy, in C.M. Parkes, J. Stevenson-Hinde and P. Marris (Eds.), *Attachment across the Life Cycle.* London: Routledge.

Bowlby, J. (1969). Attachment. *Attachment and Loss.* Vol. 1. London: Hogarth Press.

Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds.* London: Routledge.

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory.* London: Routledge.

Crittenden, P. (1988). Maternal antecedents of attachment quality. Cited in Holmes (1993).

Curtis McMillen, J. (1992). Attachment theory and clinical social work. *Clinical Social Work Journal.* 20(2), 205-218.

Edward, J. and Rose, E. (1999). (Ed.). *The Social Work Psychoanalyst's Casebook: Clinical Voices in Honor of Jean Sanville.* Hillsdale NJ: The Analytic Press.

Fahlberg, V. (1991). *A Child's Journey through Placement.* London: British Agencies for Adoption and Fostering.

Fraiberg, S. (1980). *Clinical Studies in Infant Mental Health: The First Year of Life.* London: Tavistock.

Hayward, J. (1992). The trouble with children. Paper presented at the N.Z.A.P. conference, Dunedin, Aotearoa New Zealand.

Holmes, J. (1993). *John Bowlby and Attachment Theory.* London: Routledge.

Holmes, J. (1997). Attachment, autonomy, intimacy: Some clinical implications of attachment theory. *British Journal of Medical Psychology.* 70, 2312-248.

Jewett, C. L. (1980). *Adopting the Older Child.* Harvard, Mass.: The Harvard Common Press.

Johnson, D. and Fein, E. (1991). The concept of attachment: Applications to adoption. *Children and Youth Services Review.*13: 397-412.

Karen, R. (1994). *Becoming Attached: Unfolding the Mystery of the Infant-Mother Bond and its Impact on Later Life.* New York: Warner Books.

Krause, A.M. and Haverkamp, B.E. (1996). Attachment in adult child-older parent relationships: Research, theory and practice. *Journal of Counseling and Development* 75: 83-92.

Main, M. and Hesse, E. (1990). Parent's unresolved traumatic experiences are related to infant disorganised attachment status: Is frightened and/or frightening parental behaviour the linking mechanism? Cited in Holmes (1993).

Meyer, W.S. (2000). The psychoanalytic social worker/the social work psychoanalysts: What shall be our message? *Clinical Social Work Journal.* 28 (4): 355-367.

Morris, J. (1997). Julian: A boy in a glass cage - The adoptive placement of an older child with attachment problems. In *Adoption and Healing,* Proceedings of the international conference on Adoption and Healing, Wellington, Aotearoa New Zealand.

Morris, J. (2000). Beyond Freud: Unchartered territory for social workers in New Zealand - Iatrogenic trauma in the care system, Paper presented at the conference for RANZCP Faculty of Child and Adolescent Psychiatry and the Child and Adolescent Mental Health Services: Beyond Freud: partnerships and multi-modal interventions for the new millennium. Auckland, New Zealand.

Morris, J. (2002). Heroes' journeys: children's expression of spirituality through play therapy. In M. Nash and B. Stewart. (Eds.), *Spirituality and Social Care: Contributing to Personal and Community Well-being.* London: Jessica Kingsley.

Nathan, J. (1993). The battered social worker: a psychodynamic contribution to practice, supervision and policy. *Journal of Social Work Practice.* 7 (1): 73-80.

Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and 'use-dependent' development of the brain: How 'states' become 'traits'. *Infant Mental Health Journal.* 16 (4): 271-291.

Piaget, J. and Inhelder, B. (1969). *The psychology of the child.* New York: Basic Books.

Phillips, D.G. (2000). CSWJ Forum: Is clinical social work a profession? Preliminary considerations. *Clinical Social Work Journal* 28 (2): 213-225.

Pistole, M.C. (1989). Attachment: Implications for counsellors. *Journal of Counseling and Development.* 68: 190-193.

Pistole, M.C. (1999). Caregiving in Attachment Relationships: A perspective for counsellors. *Journal of Counseling and Development.* 77: 437-446.

Robertson, J. and Robertson, J. (1989). *Separation and the Very Young.* London: Free Association Books.

Rudeman, E.G. (1999). The patient, the analyst, the termination phase: Transference and countertransference considerations. In J. Edward and E. Rose (Eds.), *The Social Work Psychoanalyst's Casebook: Clinical Voices in Honor of Jean Sanville.* Hillsdale NJ: The Analytic Press.

Sable, P. (1994). Attachment, working models and real experiences. *Journal of Social Work,* 8 (1): 25-34.

Sanville, J. (1999). Playing in Time and Space: An interview with Jean Sanville. In J. Edward and E. Rose (Eds.), *The Social Work Psychoanalyst's Casebook: Clinical Voices in Honor of Jean Sanville.* Hillsdale NJ: The Analytic Press.

Winnicott, D.W. (1965). *The Maturational Process and the Facilitating Environment.* London: Hogarth.

Roadblocks in the way of Passion

Stephen Appel

Abstract

Free association is the fundamental rule of psychoanalytic psychotherapy. It is through the patient's associations that a glimpse can be had of what has been repressed. But, at least with some patients, this is easier said than done. There appears to be a conundrum in force: the inhibitions which caused the patient's desire to become repressed are precisely those which inhibit "the irruption of copious ideas".

Freud said: "In my opinion the physician has taken upon himself duties not only towards the individual patient but towards science as well" (1905[1901]: 8). In its own way this article is both a clinical and a theoretical matter. It considers free association as a therapeutic problem, giving a case to illustrate grappling with the patient's inability to free associate. The article also speculates on free association as an intellectual puzzle, and proposes a model which encompasses both empty and full speech.

I

In Ray Bradbury's short story 'The Man in the Rorschach Shirt', Simon Wincelaus, the narrator, is riding on a bus in California when, to his amazement, a man in his seventies boards—Dr. Immanuel Brokaw, the famous psychiatrist who ten years before had disappeared from New York. Instead of the familiar sober, dark suit, Brokaw wears a marvellous shirt.

> A wild thing, all lush creeper and live flytrap undergrowth, all Pop-Op dilation and contraction, full-flowered and crammed at every interstice and cross-hatch with mythological beasts and symbols!
>
> Open at the neck, this vast shirt hung wind-whipped like a thousand flags from a parade of united but neurotic nations. (1948: 242-3)

It transpires that Brokaw, disillusioned, has retired from formal psychotherapy only to have taken up informal, ambulatory therapy.[1] Wearing one of his dozen technicolour dream shirts (one was designed by Jackson Pollack) Brokaw does therapy on the go, asking passers-by what they see in the shirt. Now as he

1 The sources of his disillusionment—the two straws that broke his two humps—deserve an article on their own. Suffice to say that Bradbury beautifully and simply shows what it is to encounter the

moves slowly down the aisle, a boy sees dancing horses, a young man sees fleecy sheep clouds, a young woman sees surfers, big waves, and surfboards. Laughter spreads infectiously between the passengers. A woman sees skyscrapers, a man sees crossword puzzles, a child sees zebras. An old woman saw Adams and Eves being driven from Gardens, while a young woman saw them invited back in. Brokaw sewed "all our separateness up in one"; he "asked for, got, and cured us of our hairballs on the spot" (243-244).

The therapeutic point is that there is something healing about simply telling another what your inner eye sees. The sociological point is that there is something unifying about sharing the personal. The epistemological point is that each person sees something different in the shirt, something distinctly personal. We call this projecting, free associating, playing, fantasising, daydreaming.

Now imagine a passenger on that bus who looks at the shirt, opens her mouth to speak, and then catches herself: "Oh how ridiculous. Maybe there is something to this but I can't do it. I feel lost and down and hate myself right now..." and so on, making her way into a horrible, unproductive eddy of despair and self-reproach. This article is about working with such a woman—a woman who couldn't (wouldn't?) daydream.

II

The fundamental rule of psychoanalytic psychotherapy is that the patient should free associate. Freud used the term *freier einfall*—what falls into the mind, what comes to mind, the free irruption of ideas.

> Say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. Finally, never forget that you have promised to be absolutely honest, and never to leave anything out because, for some reason or other, it is unpleasant to tell it. (Freud: 1913: 135)

"The first goal of the rule of free association is the elimination of the voluntary selection of thoughts" (Laplache and Pontalis: 1980, 170). The purpose of free association is not to give free rein to primary process itself, but rather it is "a type of communication in which the unconscious determinism is more accessible"

Lacanian Real. Or, rather, what it is to no longer be able to take for granted the Symbolic (what one hears) and the Imaginary (what one sees).

through fresh connections or gaps in the patient's discourse (178). "The pure metal of valuable unconscious thoughts [is to] be extracted from the raw material of the patient's associations" (Freud: 1905[1901]: 112).

The clinical questions, then are: "How do you get people to associate freely?", and "If there is trouble doing this, what is the nature of the trouble, and what can be done about it?" (Will: 1970: vii).

Between primary process and secondary process is a barrier—first censorship, or repression, the unconscious, automatic inhibition of activity. But there is also second censorship, or suppression—conscious, voluntary inhibition. Free association is designed to do away with suppression so that the workings of repression can be encountered.

If the patient must talk in a particular way, on the therapist's side there is an equivalent way of listening. Freud calls it "evenly suspended attention". "The rule for the doctor may be expressed: He should withhold all conscious influences from his capacity to attend, and give himself over completely to his 'unconscious memory'" (1912: 112).

III

Let me introduce my patient. Her presenting problem was whether to sever the relationship with a partner from whom she'd been separated for some years, or to get together with him again. In other words, gridlock from the get-go. My immediate impression was of a chronically worried and puzzled woman. She had generally flat affect and considerable anxiety. To the question, "What do you feel?" she had no response.

It soon became apparent that my patient had an over-developed inner self-critic which strangulated her activities and her talk. For her it was not a case of, "There's something I *could* say but something tells me not to say it". I doubt whether back then she would have been able to say with any confidence that there *was* more to be said. Instead a steady stream of exasperation, self-doubt, and hopelessness simply drowned anything else which might have been brewing. As I understand it, this stream of negativity became a blockage; it simply filled up the part of her mind which she had conscious access to. And yet, as her exasperation showed, part of her was aware that there might be more going on inside her and that she was inhibited.[2]

2 I recall here Charles Rycroft's definition of the defences: "all techniques used by the ego to master, control, canalise, and use forces 'which may lead to neurosis'" (1968: 28).

We spoke of how her niceness meant that she only had easy access to the middle range of feelings: liking, but not loving and hating.[3]

It was quite useless to ask her to put the self-reproaching thoughts aside and to free associate; after all she *was* reporting exactly what was on her mind![4]

The strange thing was that when I was with my patient *I* had no trouble at all free associating. I regularly had very clear visual images and strong feelings. In the very first session I had the distinct image of my patient and me waiting to cross the busy road outside: a little girl of about three, she was holding my hand. The fact that I could so easily free associate led me to think that she was *disowning* her creativity and 'lending' it to me. Consider patients unable to complete dreams. They "may project into the analyst dilemmas that they are unable to dream about in order that the analyst's functioning may transform the dilemmas into ones that can be thought and dreamt about" (Sedlak: 1997: 295). This seemed to fit with the case at hand as the dream is, as Ralph Greenson said it is, the freest of free associations (cited in Barnett: 1998: 624).

Steadily my patient's symptoms improved over the course of the therapy. Her anxiety diminished, and her steady anhedonia developed into a movement between feeling alive and interested to feeling depressed. Along the way she decided to finally end things with her partner. Over time she became better able to identify how she was feeling, or even *that* she was feeling. Now and then she would report feeling a strong "spiritual feeling" in the room; and eventually she began hesitantly to use words like "intimacy" and "love". These moments of deep connection were few and brief; they would be shut off by her characteristic self-critical talk. She would subsequently feel disappointed, hopeless, and sometimes quite depressed.

We might say that thinking which is divorced from feeling is a kind of disorder of thought. Jung had a notion that "the feeling part of the personality is at the opposite pole to the thinking part" (cited in Symington 1993: 24). We see this in the defence of intellectualisation, when an idea is dissociated from feelings. The opposite defence, when feelings are dissociated from thinking Symington calls "sentimentalization". Like the difference between sympathy and empathy,

3 Lacan said that there are three passions: love, hate, and ignorance. Our symptoms keep us ignorant, but there is satisfaction there too. See, for example, the chapter 'Truth Emerges from the Mistake' in Seminar I (1975: 271).

4 Having said that, I know of a woman aged sixtyish who was referred to a psychiatrist by her minister because she felt depressed. This was a woman with no experience of psychotherapy. What she encountered was absolute silence for the full hour; no greeting, no explanation, nothing. The experience was a complete mystery to her—not to say frightening—and, needless to say, she never returned. *Some* explanation is necessary even if we expect that the patient is unlikely to do quite as asked.

sentimental feelings are not genuine: "genuine feeling is backed up by knowledge. The difference between these two is enormous and of crucial importance to psychotherapists" (24). And, conversely, in the case under question, genuine thought is that which is backed up by feeling.

My patient had come to me because she couldn't make up her mind. Theodor Reik tells how one day when out walking he met Freud and told him of a decision he was struggling with. Freud said:

> When making a decision of minor importance, I have always found it advantageous to consider all the pros and cons. In vital matters, however, such as the choice of a mate or a profession, the decision should come from the unconscious, from somewhere within ourselves. In the important decisions of our personal life, we should be governed, I think, by the deep inner needs of our nature. (1948: vii)

My patient's problem was that she didn't know much at all about her "inner nature", about her heart's desire; as a consequence, her thinking did not have an affective motor/compass.

She described her mother in this way. Though she had been good with the children as babies, she was a critical woman who was absolutely sure of what was black and what was white. A woman who did not countenance opposing views. As for her father, he had been an inoffensive drinker who was of little consequence in her life as far as she could see. I had an idea, thus, that my patient had completely internalised the critical aspect of her mother and this demeaning and defeating object would be roused whenever my patient started showing signs of asserting her own wishes and desires.

Though the therapy went well, the blockage I am discussing remained unmoved. No amount of empathy, analysis, or waiting could shift the roadblock's bar once it had been lowered across her path. Gradually it came to seem to be not just an inhibition, but the symptom itself. It is as though the therapy was raising her temperature, yet no sooner did bubbles begin forming than she poured on cold water.

Some time into the therapy I had a thought/image which I subsequently realised was a development of that very first fantasy of crossing the road. I told her that I was understanding things in the following way. She desired to go somewhere (to find the object of her desire), but along the way the road went into a foggy dip (a zone of unfamiliarity), and rather than drive carefully through toward her heart's desire, she assumed the fog to be an impenetrable barrier and so took a deviation,

and meandered about feeling lost (the directionless, critical talk) and increasingly distant from where she wanted to be (i.e. depressed).[5] She took the fog to be an uncrossable road, as in my original fantasy[6]. This story made sense to her but on its own it was not enough to change things. Something else was needed.

IV

The most obvious thing to say might be that my patient was not free associating. Or is it? Another way to think about my work with my patient is that what my patient was doing *was* free associating in the sense that "by revealing our errings [free association] allows us to grasp the truth that is concealed in our hiddeness, by revealing the unconscious secrets contained in our everyday speech" (Thompson: 1994: 68). In my patient's case one might think that this suggested that her hesitancies, exasperated grumblings, and self-critical denunciations were evidence of "unconscious secrets"—they constituted free associations. Resistance, one could say, is a good sign: it means that the unconscious is being touched. However, this would seem to be confusing the roadblock for the vehicle: to extend what counts as free association so as to make it almost meaningless. What is *not* to count as free association in this case? It is not what Thompson means. Free association, he makes clear, is a "technical use of the mind, whose sole aim is to 'reveal the concealed'" (1994: 82).

Just say what comes to mind...this is easier said than done. Indeed, some would say that when one is able to free associate one is cured! This view would have it that what my patient was doing was *not* free associating. To my mind free association is in the same ball park as play, daydreams, fantasies, reveries, creativity, full speech. Lacan contrasts full speech with empty speech. Empty speech "takes its orders from the ego....and demands that the analyst falls in with it." (Benvenuto and Kennedy: 1986: 84) Examples are the demand for reassurance, and the demand to be treated as the patient was treated by his or her parents. Lacan speaks of the danger of:

> the patient's capture in an objectification...of his static state or of his 'statue', in a renewed status of his alienation.
>
> Quite the contrary, the art of the analyst must be to suspend the subject's certainties until their last mirages have been consumed. (1953: 43)

5 The symptom, then, is the turning off the path, not the depressed state which is, rather, a consequence of the defence.

6 Or to use Lacan's metaphor, she mistook a mirage for a certainty (1953: 43).

Or let us think here in terms of play. For Winnicott "*play is an achievement* in individual emotional growth" (undated: 59). Play is primarily "a *creative activity* (as in dream)" (60). When it goes wrong he speaks of "the psychopathology of play"(61); "without play the child is unable to see the world creatively, and in consequence is thrown back on compliance and a sense of futility, or on the exploitation of direct instinctual satisfactions" (60).

For his part, Freud likened free association to the poet when creating. He quoted in this regard from a letter of Schiller. But, as Janet Malcolm points out: "Just as there are few people who can write poems like Schiller, there are few analytic patients who can free associate easily, if at all" (Malcolm: 17).

Then there is the contrary view on the nature of free association. 'Aaron Green'[7] describes the first patient allocated to him when he was a trainee analyst. She gave "vapid, inconsequential answers", talked in an "inane, girlish, monosyllabic way", and complained about his not helping her.

> I found her in every way disappointing. I had expected a patient who would free-associate, and here they had sent me this banal girl who just blathered. I didn't understand—I was so naïve then—that her blathering *was* free association, that blathering is just what free association is....Only after years of terrible and futile struggle did it dawn on me that if I just listened—if I just let her talk, let her blather—things would come out, and this is what would help her, not my pedantic, didactic interpretations. If I could only have learned to shut up! (in Malcolm: 1981: p. 71)

Conversely, as 'Green' found with his second patient—"a refined, cultivated woman, eager to do the analytic work, appreciative of Aaron, extremely pleasant and interesting to be with, and very good-looking" (Malcolm: 1981: 79)—fluent conversation can be something else entirely.

How do we know when a patient's talk is to count as free associating? Sullivan: "When a person keeps on talking about the bees and the flowers, and so on, I may say quite sardonically, 'This seems to be *really* free associating, but I wonder what on earth it pertains to'" (1970: 80). While Sullivan is on to something here, not for the first time his technique doesn't sit well with his theory of the functioning of the mind: "The mind usually does not spend much time on irrelevant and unimportant details" (80). If this is the case, why interrupt and attempt to influence someone who *is* spending much time talking about the bees and the flowers, and so on?

7 The pseudonym which Janet Malcom (1981) gives for the analyst she interviews.

Anything can be defensive. Is there a corollary, anything can be productive and communicative? In the words of Otto Will: "It is this remarkable intermingling of the communicative and defensive aspects of speech which characterises every interview" (1970: xxi). How is one to recognise empty speech? And what then of the patient's speech which is both flowing (in terms of verbiage), but blocked (in terms of content)? In the case of my patient, she had little difficulty using up the time with self-critical, exasperated, hopeless comments. Why do I assert that this was not productive free associating? First, her face would change from lively and radiant to uptight and worried, and she would make her disappointment clear. Second, my countertransference reaction was an exasperation which matched her own; a sense of, "oh no, it's gone again—the stuckness is back".

In any event, there is a theoretical problem here. How are we to schematise speech which holds back, speech which is blocked, and speech which is full? Let us separate out three types of speech here (see Table 1).

Table 1

TYPE A	TYPE B	TYPE C
Consciously selects and omits what comes to mind, i.e. deliberately puts a blockage in place.	Does not consciously select or omit; instead is only aware of the blockage itself and reports this.	*Freier einfalle*, free irruption of copious ideas.

V

The introduction of active intervention into therapeutic passivity is very cautiously accepted in principle in mainstream psychoanalysis. In a paper published in 1953 Kurt Eissler introduced the term 'parameter' meaning the chary use of instructions, directives, and advice to end stalemate. Perhaps the best known adaptation to orthodox technique is that of Jacques Lacan's abbreviated sessions. This practice (along with his novel training methods) resulted in his expulsion from the International Psychoanalytic Association. Lacan would routinely reduce the length of a session to as short as five minutes, sometimes even a single interaction in the waiting room. He is also reported to have eaten meals and counted money during sessions (Roudinesco: 1990). All these were attempts to simply stop the flow of empty speech. "Variable time is valuable," Lacanians believe, "in combating many forms of resistance" (Leader and Groves: 1995: 56).

The question which confronts all technical attempts to unstick therapy stands out starkly here: what about the defence which is thereby being avoided? Is being combated what the resistance needs? Should it not be analysed, understood, worked through? But, all technique—including free association itself—has originated as experimentation. Then, if it works, it has been theorised.

Winnicott, too, was wont to adapt his technique. Winnicott said that either therapy happens in the overlap of two areas of play (that of the therapist and that of the patient), "or else the treatment must be directed towards enabling the [patient] to become able to play" (1964-1968: 300). (So too in the case at hand, free associative playfulness is the goal, not the rule of the therapy.) Margaret Little (1990) reports that when she was his patient Winnicott decided that an hour wasn't enough for her and so extended session to an hour and a half. He also spent these sessions holding her hand in both his hands; during long silences he sometimes fell asleep.

Freud himself, it is well known, was not averse to adapting his practice. Take the case of the Wolf Man (1918). Writing of speeding up the treatment, Freud describes an intervention.

> In the course of a few years it was possible to give him back a large amount of his independence, to awaken his interest in life and to adjust his relations to the people most important to him. But there progress came to a stop. We advanced no further...and it was obvious that the patient found his present position highly comfortable and had no wish to take any step forward which would bring him nearer to the end of his treatment. It was a case of the treatment inhibiting itself: it was in danger of failing as a result of its—partial—success. In this predicament I resorted to the heroic measure of fixing a time-limit for the analysis. At the beginning of a year's work I informed the patient that the coming year was to be the last one of his treatment, no matter what he achieved in the time still left to him. At first he did not believe me, but once he was convinced that I was in deadly earnest, the desired change set in. His resistances shrank up....When he left me...I believed that his cure was radical and permanent. (1937: 217)

Is any practice, then, to be permitted if it seems to work? This is highly doubtful. Never one to accept easy victories, Freud came to realise that he had been mistaken; several times afterwards the Wolf Man needed further therapeutic treatment (with Ruth Mack Brunswick). Though he employed this fixing of a time-limit in other instances, it did not become a standard technique for the following reasons.

> There can only be one verdict about the value of this blackmailing device: it is effective provided that one hits the right time for it. But it cannot guarantee to accomplish the task completely. On the contrary, we may be sure that, while part of the material may become accessible under the pressure of the threat, another part will be kept back and thus become buried, as it were, and lost to our therapeutic efforts....Nor can any general rule be laid down as to the right time for resorting to this forcible technical device; the decision must be left to the analyst's tact. A miscalculation cannot be rectified. The saying that a lion only springs once must apply here. (1937: 218-219)

In the case at hand, too, it would be well to keep these factors in mind: *when* might a "forcible technical device" be implemented? My view is the standard one that one shouldn't be in a hurry to knock down defences. We had been doing productive work for some years. I had some confidence that pushing her would not be destructive. And I was mindful of Freud's warning about what might be lost.

VI

Though the cramped lack of free associating continued in my patient's speech, that is not to say that things were constantly deadly. Indeed, they were often very alive only for that aliveness to be squelched by her criticisms and doubts: sometimes only after 40 minutes, sometimes before the session even started. In what follows I describe how my technique changed for a time with this patient. What I intuitively came to might be taken as standard practice in some therapeutic modalities. Nevertheless, it is always necessary to think deeply about what we do especially when what we do takes a turn. Without auto-critique, supervision, and some agonising, what's to stop a therapist doing any thing?

I have said how I would easily get images and feelings and that I thought that these were to some degree being disowned by my patient. I began handing these back to her. When a session seemed to peter out I'd say something like: "For me the emotional shape of the session has been like this: first there was a strong erotic feeling in the room, then there was a cosy warmth, and then, when we began talking about..., I felt a bit empty. Right now I feel a tenseness in my solar plexus—I don't know what feeling it is". Usually she would respond with some kind of recognition—yes that's right, or no it's a bit wrong in some respect—and then she would be able to talk further. It occurs to me that this is a bit like Winnicott's squiggle game (1964-1966). We'd take turns to add material. (This kind of thing is powerful but obviously demands absolute truthfulness from the therapist. It would be worse that useless to make up something here.)

The erotic nature of our relationship became a charged topic of conversation; my patient wondered aloud whether she had been identifying a spiritual nature in her feelings in order to deny the erotic. And then her father came to the fore in the therapy. It began with my patient saying that she realised that she knew nothing about her father. I got a desolate image of a bright, cold, empty room, followed by a heartbroken feeling—and said so. It occurred to me that here was something which may lie on the other side of the fog—she turned away from the object of desire (father) and then felt lost. She spoke of feeling devastated about what she hadn't got from him, also about her disappointment and anger with me for not realizing how important father material was to her, despite the fact that she had thrown me off the scent several times. (This dynamic has since shown itself to be part of the complex.)

At about this time we decided to meet twice weekly, for two reasons. First, she was spending much of each session filling me in on the week's events and then getting into richer material only towards the end. Also, she seemed not to be able to keep the feelings and ideas generated in one session alive until the next session. (Again, losing touch with her heart's desire, and then meandering.) I agreed to offer a link to the previous week: "You may not want to go there today, but last time we were talking about ...".

As can be seen, I had decided to do all I could to encourage her creative inner work; to find "détours by which repression can be evaded" (Freud: 1905[1901]: 15). I spoke of us needing to pry apart two blocks which jammed together too quickly. What I meant was that when a wish came into view ("I'd like to live in...") this would straight away be confronted with a reason why not ("but I can't do that because..."). I said that it would be good to be able to delay making any judgments and just daydream to see how much emotional and fantasy oomph the idea had. Then and only then should any decisions be made.

And then I found a way to put all of these modifications together into a technique which has worked remarkably well on several occasions.

She reported, for example, that she wondered when driving to the session whether I was really there for her, this was not a real relationship after all, she shouldn't have come because in this mood nothing would happen. I interrupted this flow: "Let's put those thoughts aside for now. Can you say what you can feel in your body?" After a minute she said the word "together". All through this, not wanting to apply even more pressure, I looked out the window into the distance, listening with the third ear. She went on at my prompting to say that it wasn't a localised feeling, but was all over her body. As she concentrated on

noticing her sensations her demeanour relaxed. As before, I said what was going on for me: warmth, and a focused intensity around my heart.

After a few minutes of this I asked: "Staying with this feeling, what comes to mind?" She said: "There's something but I can't say it because it has a double meaning". But remarkably this didn't pull her into the characteristic unproductive cycle. I pressed on and asked, "Can you see anything?" She said: "A mountain". Aha! Here was the internal view I'd been looking for. I asked for details. What kind of mountain was it, a range or a peak? Was it rocky, grassy, or snow-covered? Then, was it a particular mountain? "Yes it's my favourite mountain near X." She described it vividly. Then, "Now it's become another mountain, the one near my father's house where he lived after my parents divorced." By now she was hiking easily through this fantasy/memory.[8] At the end of the session she expressed astonishment that there was so much there. I said: "This is your internal world, it's very precious—we need to take it seriously and not treat it with disdain."

I have described how my patient's speech would repeatedly be of Type B. But in the session just outlined her speech became Type C—a free-floating daydream not unlike Lacan's full speech. Notice the path that her speech took. It didn't go from Type B to Type C, as one might have expected. Instead, her speech moved from Type B which is strictly speaking free association ("I shouldn't have come because in this mood nothing will happen"), to Type A which might be thought of as the least promising form where the patient consciously selects and omits what comes to mind ("There's something but I can't say it because it has a double meaning"[9]), and only then to Type C, the most desirable form (the mountain reverie).

The advantage of Type A, then, is that even though something is being suppressed, the patient knows something about what this is and that it is being held back. This can be overcome. We can speculate that as the enormous barrier was evaded for her she became aware of something embarrassing, a new barrier which she was able to simply drive over to the land which has been her/our goal for so long.

8 "Things that were not in the center of our attention, things that were at the fringe, a passing impression, a fleeting presentiment, now take on importance" (Theodor Reik: 1948: 172).

9 Incidentally, while he does not advocate harassing the patient to disclose a suppressed thought, Freud is adamant that the therapist not collude in keeping certain no-go areas. "It is very remarkable how the whole task becomes impossible if a reservation is allowed in any single place. But we only have to reflect what would happen if the right of asylum existed at any one point in a town; how long would it be before all the riff-raff of the town had collected there?" (1913: 135n-136n).

VII

Why had I waited so long to act? I considered that in this case earlier use of such a technique would not have borne fruit as the patient was not ready for it; for a long time her pooh-poohing would extend to not being able to take seriously my words either. But it is a worthwhile question to keep in mind, not to needlessly extend therapy for its own sake.

Perhaps I should have waited longer. It occurs to me that there is a danger of forcing patients—via free association, the very epitome of freedom—to think in a particular way—namely free association. Perhaps the patient should be allowed to bore her own symptom to death; the stuckness should be seen as an accurate reflection of her inner experience and should simply be followed. Or in Lacan's terms, there are two types of ignorance: the ignorance of the therapist who knows that s/he doesn't know but wishes to know, and the patient who loves his/her ignorance and does not want to know.[10]

In the case of my patient, what about that characteristic defence? Why does she, like all of us, seem not to want what she desires? Most people, says Harry Stack Sullivan, "wish that they could talk things over frankly with somebody, but they also carry with them, practically from childhood, ingrained determinations which block free discussion" (1970: 9). I think of the defence as having been placed there long ago in order to help her to avoid the pain and frustration of disappointed playfulness as a youngster, a playfulness that might have been addressed by father. So, the therapy becomes in part an 'after-parenting'; developing psychic playfulness in part through side-stepping the defence.

But, as Freud warned, one always loses something when introducing a technique, a parameter. What about the transference issues with regard to the emergence of the defence in the therapy, and also with regard to my shunting it aside? "In order to complete the concepts of empty and full speech, one needs to take account of the nature of the person to whom the speech is addressed" (Benvenuto and Kennedy: 1986: 86). This has become clearer. There is oedipal transference, there is erotic transference—the unspoken *double entendre* turned out to be the word "passion", meaning both aliveness, generally, and eroticisation, specifically.[11] Linked to this, no doubt, it has also become evident how great is her fear of dependence and loss.

---

10 Slavoj Žižek (2001) develops this them is his book titled *Enjoy Your Symptom!*.

11 Interestingly, this spontaneous emergence of a surprising, hard-to-say word (always to do with our relationship) has occurred more frequently in the period subsequent to that described in this article. The obstruction has become that described by Freud in his paper on writers and day-

And, as importantly, what about *counter*transference? Could it be that, as in the cases above of Lacan, Winnicott, and Freud, deviations from standard technique come about when the *therapist* reaches the end of his or her tether, and all the rest is intellectual justification? While I do believe that the argument about the nature of free association is one worth having, it is also true that I find a lot of pleasure in a particular mutual playfulness in therapy. And conversely, I feel some frustration and loss when this is missing for too long. That is what I bring to the situation and must beware of fitting Thomas Szasz's sarcastic definitions:

> Free association: the term the psychoanalyst uses to register his approval of the patient who talks about what the analyst wants him to talk about. The opposite of resistance.
>
> Resistance: the term the psychoanalyst uses to register his disapproval of the patient who talks about what the he himself wants to talk about rather than what the analyst wants him to talk about. (1973: 82)

I have schematised three types of speech: consciously holding something back, not being able to speak freely but neither consciously holding back, and speaking freely. If to free associate is to "speak without thinking" (Rodriguez: 2002), then could my patient said to be free associating? Indeed, she said freely what she thought, which was *that she was thinking*. So there's a type of speech (Type B) which *is* free association in that there is no suppression, but at the same time *is not* free association in that it is restricted and unplayful. In Table 2, the first of these (Type A) is not free associating, indeed, it is precisely what free associat-

Table 2

Not Free Association *Sup*pression (second censorship between Cs and PCs)	**Free Association** *Re*pression (first censorship between PCs and Ucs)	
Consciously selects and omits what comes to mind, i.e. deliberately puts a blockage in place.	Does not consciously select or omit; instead is only aware of the blockage itself and reports this.	*Freier einfalle*, free irruption copious ideas.
(Empty Speech)		(Full Speech)

dreaming: "The opposite of play is not what is serious but what is real" (1908[1907]: 144). Now, though, it has become a simpler matter for both of us to notice the barrier being erected and to hurdle it.

ing is designed to prevent, viz. suppression. The second and third types of speech (B and C) can both be considered free association as they comply with the fundamental rule of saying whatever comes to mind. However, there is something unsatisfactory about the second, blocked type of speech—the characteristic speech of my patient—which is alienated from desire. It is not, in Lacan's terms, full speech.

The contribution here, then, is of a model whereby free association can encompass both empty and full speech.

As for the defences, the reality is that "say whatever goes through your mind" is an instruction which cannot be followed. "Under the dominance of the resistances, obedience [to the rule of free association] weakens, and there comes a time in every analysis when the patient disregards it. We must remember from our own self-analysis how irresistible the temptation is to yield to these pretexts put forward by critical judgement for rejecting certain ideas" (Freud: 1913: 135n). What Freud was able to see was it is *all* of interest, the content of the associations and the defences encountered in the attempt to associate. Not only that, even "the manner in which our patients bring forward their associations during the work of analysis gives us an opportunity for making some interesting observations" (1923: 235). There is something there even with the most stuck of records. Lacan says: "Even if it communicates nothing, the discourse represents the existence of communication; even if it denies the evidence, it affirms that speech constitutes truth; even if it is intended to deceive, the discourse speculates on faith in testimony" (1953: 43).

References

Appel, Stephen (2000) Visual disturbance as occult communication, *Forum*, 6, 32-50.

Barnett, Bernard (1998) Review of *The Dream Discourse Today*, *International Journal of Psycho-Analysis*, 79, 623-626.

Benvenuto, Bice and Kennedy, Roger (1986) *The Works of Jacques Lacan* (London: Free Association Books).

Bradbury, Ray (1948) The man in the Rorschach shirt, in *I Sing the Body Electric!* (London: Rupert Hart-Davis).

Eissler, Kurt (1953) Remarks on some variations in psychoanalytic technique, *International Journal of Psycho-Analysis*, 39, 222-229.

Freud, Sigmund (1905[1901]) Fragment of and analysis of a case of hysteria, *Standard Edition*, 7, 3-122.

Freud, Sigmund (1908[1907]) Creative writers and day-dreaming, *Standard Edition*, 9, 141-153.

Freud, Sigmund (1912) Recommendations to physicians practicing psycho-analysis, *Standard Edition*, 12,109-120.

Freud, Sigmund (1913) On beginning the treatment, *Standard Edition*, 12, 121-144.

Freud, Sigmund (1923) Negation, *Standard Edition*, 19, 235-239.

Freud, Sigmund (1937) Analysis terminable and interminable, *Standard Edition*, 23, 211-253.

Lacan, Jacques (1953) The function and field of speech and language in psychoanalysis, in *Écrits: A Selection* (New York and London: Norton, 1977).

Lacan, Jacques (1975) *The Seminar of Jacques Lacan. Book I: Freud's Papers on Technique. 1953-1954* (Cambridge: Cambridge University Press, 1988).

Laplanche , J. and Pontalis, J.-B. (1980) *The Language of Psycho-Analysis* (London: Hogarth).

Leader, Darian and Groves, Judy (1995) *Introducing Lacan* (Cambridge: Icon).

Little, Margaret (1990) *Psychotic Anxieties and Containment: A Personal Record of Analysis with Winnicott* (Northvale, NJ: Jason Aronson).

Reik, Theodor (1948) *Listening With the Third Ear: The Inner Experience of a Psychoanalyst* (New York: Farrar, Straus & Giroux).

Rodriguez, Leonardo (2002) Contemporary passions, key note address NZAP conference 'Arenas of Passion', Nelson.

Roudinesco, Elizabeth (1990) *Jacques Lacan and Co.: A History of Psychoanalysis in France, 1925-1985* (Chicago: University of Chicago Press).

Thompson, M. Guy (1994) *The Truth About Freud's Technique* (New York and London: New York University Press).

Sedlak, Victor (1997) The dream space and countertransference, *International Journal of Psycho-Analysis*, 78, 295-305.

Sullivan, Harry Stack (1970) *The Psychiatric Interview* (New York and London: Norton).

Symington, Neville (1993) *Narcissism: A New Theory* (London: Karnac).

Szasz, Thomas S. (1973) *The Second Skin* (London: Routledge & Kegan Paul).

Will, Otto Allen (1970) 'Introduction', Harry Stack Sullivan, *The Psychiatric Interview* (New York and London: Norton).

Winnicott, D.W. (1964-1968) The squiggle game, in *Psycho-Analytic Explorations* (Cambridge, Mass.: Harvard University Press, 1989).

Winnicott, D.W. (undated) Notes on play, in *Psycho-Analytic Explorations* (Cambridge, Mass.: Harvard University Press, 1989).

Žižek, Slavoj (2001) *Enjoy Your Symptom! Jacques Lacan In Hollywood and Out* (2nd Ed.) (London: Routledge).

Problems, Pitfalls and Potentials of the Unexpected in Psychotherapy

Jan Currie

Abstract

When the life-threatening illness of the therapist necessitates an unexpected and prolonged break in therapy, intense transference and countertransference responses are evoked. This discussion paper considers the complex repercussions for the therapeutic exchange following re-engagement with clients, when awareness of conflicts over separation, loss and the inevitability of death are likely to be heightened.

Introduction

Gaily I lived at ease and nature taught
And dispensed my little life withour a thought
And am amazed that Death, that tyrant grim
Should think of me who never thought of him.

This epigram by Rene Regnier (1935:376) suggests the avoidant defence we are prone to bring to the uncomfortable subject of our mortality.

Irvin Yalom, from within his existential commitment to the quality of life, challenges us to confront that which most of us would rather deny or ignore. He speaks to both our personal and professional selves as he addresses the "truths of existence":

> . . . the inevitability of death for each of us and for those we love; the freedom to make our lives as we will; our ultimate aloneness . . . . However grim these givens may seem, they contain the seeds of wisdom and redemption. . . . it is possible to confront the truths of existence and harness their power in the service of change and growth. (1991:4-5)

As psychotherapists we are well aware of the impact of changes or situations occurring in our lives that may affect our clients' perception of us, and may thus affect the course of therapy. These situations can range from a change of hairstyle or therapy room, to a move to new premises, to a therapist's pregnancy. The sudden unplanned disappearance of the therapist as a result of

illness inevitably creates a more complicated dilemma. This was the situation that my clients experienced when I underwent a totally unexpected cardiac bypass operation. I had a busy psychotherapy practice and no opportunity to prepare my clients for what turned out to be a four-month break from therapy.

The invitation to write this paper has provided an opportunity for me to stand back and reflect again on this experience, four months after having returned to my practice. The issues I have encountered remind me of an experience I had at the Grand Canyon, Arizona. It is as if, until now, I have been involved in the steep climb up from the depths of that canyon, seeing only parts of the view as I wound my way up, preoccupied with how to reach the next corner as the path twisted and turned upwards. But now I am on the rim, looking out over the whole of that vast scene. This seems an apt metaphor to reflect the myriad transference and countertransference issues I encountered on returning to my practice, and which needed the objectivity afforded by time to come into clearer focus.

The challenge of the unexpected

It is true that all situations or changes that occur in psychotherapy provide the opportunity for challenge to both therapist and client, which can encourage progress. It is also true that, depending on the nature and degree of the unexpected circumstance and the inherent difficulties of the client, problems can emerge, particularly if the event is in uncharted territory. Such was my experience when I returned to my clients.

The problems that arise usually signal transference or countertransference issues which may well become "pitfalls". What do I mean by pitfalls? In the arena of transference, this implies for me the sudden downward plunge which describes the sense I had with some (but not all) of my clients. It was as if something had suddenly shifted. The solid ground was no longer there: the easy rapport, the trust, the warmth of the relationship. Words like "betrayed", "lost", "can no longer rely on you", "abandoned", even "despair" became the language of the pitfall.

My countertransference pitfalls involved guilty feelings (how I had let my client down), hurt in that I was still vulnerable myself, anxiety (was I going to be able to be fully present?), even resentment at what seemed the incredible neediness surrounding me. I sensed within me an urgency to restore the status quo, to have my clients regain their security and trust, to return to the safe place we were in before, yet that was *my* need. What my clients needed was rather to have me match their pace and simply allow the process to unfold.

The phrase "grist to the mill" came to my mind as I realised that every pitfall can provide a potential in the task of psychotherapy. In the struggle to regain what seems lost, much is freed up to emerge. Unconscious motivations and defences become conscious, losing their grasp on the client's life, allowing a new kind of self-experience and relationship to begin to emerge. Guntrip's comment on the working alliance in psychotherapy and the therapist's contribution is appropriate here: "Only when the therapist finds the person behind the patient's defences, and perhaps the patient finds the person behind the therapist's defences, does true psychotherapy happen" (1969:352).

Three clinical vignettes

Three clinical vignettes may illustrate the conscious and unconscious responses in both client and therapist that were evoked by the unexpected break in therapy: the fear of loss, separation, the inevitability of death and a new awareness of the value of life.

Client A

Prior to our scheduled first appointment after the break A telephoned me stating that she wanted to cancel her session. I asked her what that seemed to be mostly about.

A: "Well, how do I know you're not going to do that to me again?"

I reflected how she might be feeling and said I thought it was important that we talk about it together, rather than on the telephone. The session began with A repeating her question, adding that she only came to please me. I again responded by reflecting her feelings and wondered whether she felt she could rely on me now to be there for her.

A: "Well, I can't, can I?"

Response: "There's a lot of intense feeling in that, A. What's there mainly?"

A: "I feel cheated. That's why I want to end. Not right today, but soon. I want to be sure I can say 'goodbye' to you, rather than not have a chance to do that."

Response: "Saying goodbyes are important - perhaps also you want to leave me before I leave you?"

A: "Yes. My security is believing you'll always be there, even years after I've left."

These themes occupied the following sessions, increasingly revealing the empty self clinging to the external object. More recently the theme has shifted somewhat and the following transcript demonstrates the continuing theme:

A: "I want to feel about you deeply and I don't know whether I do. I have needed you for security somehow, but when you die I'd like to think I'd be really upset. I'd like to feel the loss of you very very deeply."

There was quite a silence then, and I noted that I was probably adjusting to the therapeutic usefulness of my dying (with a mix of feelings!). I suggested she might be able to say some more.

A: "Well, it's as if, if I felt more intensely, then I'd know I really did care a lot for you. To sort of know it, to feel the pain of it."

Response: "Perhaps, if you did have loving, warm feelings for me and I died, and that caused you to feel real pain and grief, then you would also find something kind of alive in you? . . . a reaction, a response, a kind of realness?"

A: "Yes, but is it awful to say that?"

Response: "You mean, is it awful to speak about my dying, and to feel there could be something helpful for you in that? It's OK for me. I felt relieved you were able to say that. It's helpful for you, I think, to begin to wonder what that kind of deadness inside is about and to picture some kind of experience to prove to yourself you are alive and can feel and grieve and hurt and love."

A: "Yes" (said softly and tearfully). "I would feel relieved if I could do that".

I sensed the internalised, depressed (dead) mother and A's self-experience as being insignificant, empty, numb, dead, having no impact. I thought of Guntrip's words:

> Whereas all other parts of the psyche tend to the rigidities characteristic of defensive structures, the regressed libidinal ego retains the primary capacity for spontaneous and vigorous growth once it has been freed from its fears.(1961:433).

I believe A is at last moving slowly towards finding the real core of an aliveness, but for now it seems to her that it would take a "real" external experience to discover that was there. "It is the relationship with the therapist that creates a situation in which problems can be solved" (Stadter:1996:29).

Moments like these make our wise voices from the past, such as Guntrip's, come again to life!

Client B

Before the unexpected break, therapy with B was slow and ponderous, with nothing new coming through and I was wondering if we had travelled as far as we could at this stage. When I had telephoned after my discharge from hospital and explained the situation, B seemed appropriately concerned, but accepting. As with all clients, I offered the opportunity for a session or sessions with an alternative therapist should that be helpful. She did not take up that offer.

When we recommenced therapy I found B's mood was very depressed. She was abusing alcohol, had put on weight which she hated, and felt bad about herself. She wept with a kind of desperation and said, "I realise you could have died and I still need you so much".

I struggled silently with a sense of guilt at deserting her. I again felt overwhelmed at the neediness of those I was working with and a dull resentment that it was not me that would be missed, just the needs I could not fill. I felt just a function. The warmth, understanding and insight of colleagues in supervision was helpful. I recognised not only my countertransference issues, but also the elements of projective identification I was absorbing. I suspect B was also struggling with guilt, neediness and resentment, and her "clutch" of negativity joined forces with mine!

In subsequent sessions, B has begun to look in a new way at the quality of her life and the notion that one day she too will die. This has occupied many sessions in a fruitful way. She has made remarkable progress in valuing herself more and is no longer abusing alcohol. She is exercising and beginning to lose excessive weight, she is requesting more from her husband, and having more fun with her children. B has made remarkable progress in contrast to the relative lack of progress prior to our break in therapy.

Client C

C began psychotherapy with an advanced somatisation disorder, with loss of balance and inability to walk more than a few steps. She presented in a wheelchair, wearing dark glasses because of photophobia and appeared to be very unwell. In psychotherapy C has worked through well-repressed early trauma and from a physical aspect is now healthy, walking normally, without dark glasses, with her health well recovered.

In our first session she began immediately updating me with all the events that

had happened over the period we had been apart, without referring to the significance of the break and its meaning for her. Finally, I commented to C: "It's been four months since we were together here and I'm wondering what that has really felt like for you?"

C: (Said breezily): "Well, when I first heard what had happened to you, I was brassed off, because there's still a lot of work I want to do with you. But then I thought, 'Oh well, c'est la vie!'

Later, I dismally reflected to myself that the resolving of the somatisation disorder does not necessarily shift the rigid pathology of the personality structure. I suspect C's affective awareness and response could not penetrate her defence structure.

The view from the canyon's rim

These vignettes serve to describe some of the effects on both participants in psychotherapy when transference and countertransference responses occur in reaction to unexpected illness. This is especially so when the therapist's fallibility and mortality occupy the foreground and the safe, symbolic womb has indeed failed.

I am sure there is still much to be observed from my vantage up here on the rim of the canyon! I have gained valuable insights as I have reflected on the impact of the break in therapy and the response of clients to that situation. I have become more aware than ever of how closely our lives are interwoven in transference and countertransference. Through my personal experience I am grateful for the timely reminder that, although we may live as if we have forever, the reality for all of us - therapists and clients - is that "our life, our existence, will always be riveted to death, love to loss, freedom to fear, and growth to separation. We are, all of us, in this together" (Yalom:1991:14).

The final words must come from Morrie Schwartz, a man who used his dying experience to teach fundamental lessons about living:

> Learn how to live and you will know how to die
> Learn how to die and you will know how to live. (Albom:1997:82)

[Originally presented as a discussion paper for the New Zealand Association of Psychotherapists, Canterbury Branch, Christchurch, April 2002.]

References

Albom, M. (1997) *Tuesdays with Morrie.* Sydney: Hodder

Guntrip, H. (1961) *Personality Structure and Human Interaction: the developing synthesis of psychodynamic theory.* New York: International Universities Press

__________ (1969) *Schizoid Phenomena, Object Relations and the Self.* New York: International Universities Press

Regnier, R. (1943) *Stevenson Book of Quotations.* London: Cassell and Co. Ltd

Stadter, M. (1996) *Object Relations Brief Therapy.* London: Jason Aronson Inc.

Yalom, I. (1991) *Love's Executioner.* London: Penguin

Contributors

Stephen Appel, Ph.D., is in private practice as a psychotherapist and supervisor in Ponsonby, Auckland, and is also Associate Professor in the Department of Psychotherapy and Applied Psychology at Auckland University of Technology.

Nicola Atwool is currently employed as a senior lecturer at the University of Otago in Community and Family Studies. She has professional qualifications in social work and child psychotherapy. She has previously worked as a social worker, senior social worker, social work trainer and child psychotherapist with the Department of Child, Youth and Family Services, with a particular interest in work with children and adolescents. Research interests are focused on attachment, the impact of trauma and the social construction of childhood. In addition to teaching and research Nicola has continued to practice working with a small number of children and their families, with most of her referrals coming from Child, Youth and Family and including long-term therapy and attachment assessments.

Jan Currie trained in psychoanalytic psychotherapy at the Foundation for Religious and Mental Health, New York, in conjunction with the University of Bridgeport, Connecticut, graduating with a Masters Degree in Psychology. She has been in psychotherapy practice for the past 22 years, nine years with Presbyterian Support, and subsequently in private practice at the Bealey Centre. Jan is a supervising member and a Past-President of the New Zealand Association of Psychotherapists.

Joy Hayward received her training as a child and adolescent psychotherapist with the Department of Psychological Medicine at the University of Otago. She works in private practice and at the Dunedin College of Education. Although most of her current work is with adults, she retains a keen interest in working with children and families.

Judith Morris is a New Zealander. She trained as a psychiatric social worker in Britain, where she worked for the majority of her 25 years in social work. She specialised in working therapeutically with children in the care system, including those placed with permanent out-of-family caregivers as well as children being rehabilitated with their family of origin. She has a particular interest in applying attachment theory to

this work. In 1994, Judith returned to New Zealand and initially worked as a lecturer at Massey University, training social workers. She now works privately, undertaking research about foster care, providing training for professionals and working as a therapist with a small caseload of children with attachment disorders.

Richard C. O'Neill-Dean is a psychoanalytic psychotherapist working in private practice at the Tara Clinic in Dunedin. He also works at Ashburn Clinic. He trained in Ireland with the Irish Psychoanalytic Association and at the Irish School of Psychotherapy, University College Dublin.

Guidelines for Contributors

The notes that follow are intended to guide contributors in preparing manuscripts for submission to *Forum*. These guidelines have been chosen to conform with those used by most international journals in the fields of psychology and psychotherapy.

Submission of manuscripts

The editors welcome the submission of papers, commentaries, research notes, letters and book reviews from the association's members and applicants and from others outside the association with an interest in the field of psychotherapy. Contributors are asked to include an abstract (100 words approximately) and a brief biographical note. The biographical note should be in the third person and should be no more than 100 words long.

The closing date for the submission of manuscripts is **30 April**. Changes following the editing process need to be completed by **1 July**, when both a revised hard copy, and the disk that contains it, should be returned to the coordinating editor.

Preparing manuscripts for publication

Layout: Manuscripts should be double line-spaced throughout on one side of A4 paper, with margins of at least 20mm all round. Preferred font size is 12 point.

Endnotes: These should be typed on a separate sheet following the text, and numbered consecutively throughout the text, with numbers positioned as superscripts.

Tables and drawings should be in black ink or laser-printed, and clearly labelled to indicate their place in the text.

Copyright: Authors alone are responsible for securing, when necessary, permission to use quotations or other illustrations from copyrighted materials.

Acknowledgements: Acknowledgements should be typed on a separate sheet of paper.

Quotations: These must always be acknowledged, and full references - i.e. author, date of publication and page number - provided to identify their source. For quotations of three lines or less, the quoted passage is enclosed in quotation marks without a change in line spacing e.g.

This client's state of mind might be summed up by Phillips' conclusion that "adulthood . . . is when it begins to occur to you that you may not be leading a charmed life" (1993:82).

Longer quotations should be set out, without quotation marks, as a separate paragraph, with single spacing and indented five spaces from the margin e.g.

> The seduction theory had to do with the effect of manifest environmental evils on people's mental balance; the theories of infantile sexuality and the Oedipus complex were elements in a radical and quite fantastical conception of human nature which says we are ruled (and sometimes unhinged) by events that we only imagined as small children . . . (Malcolm: 1984: 77).

Omissions: When part of the passage quoted has been omitted (as in the quotations from Phillips and Malcolm above) this is indicated by . . . if words in a sentence are omitted, and by .... if the end of a sentence is omitted.

Citations: The source of ideas from the work of other writers should be acknowledged in the text, and all sources referred to in the text should be included in the list of references e.g.

Malcolm (1984) set out to chart the complex and sometimes explosive responses of Masson and Swales to Freud's archival legacy.

References: A full list of texts referred to, arranged in alphabetical order by authors' names, should be supplied. (A bibliography listing texts not cited in the paper is not required). All references should include the name and initials of author, date of publication, title, place of publication and name of publisher. Their format should be as follows:

A chapter in a book

Flannery, R. B. (1987). From victim to survivor: a stress management approach to the treatment of learned helplessness. In B. van der Kolk (Ed.), *Psychological Trauma.* Washington, DC: American Psychiatric Press Inc.

A journal article

Hofer, M. A. (1975). Studies on how maternal deprivation produces behavioural changes in young rats. *Psychosom. Med.* 37:245-264.

Books

Malcolm, J. (1984). *In the Freud Archives.* London: Flamingo.

Phillips, A. (1993). *On Kissing, Tickling and Being Bored.* London and Boston: Faber and Faber.

van der Kolk, B. (1987). *Psychological Trauma.* Washington: American Psychiatric Press Inc.

For further guidelines, authors should consult the *Publication Manual of the American Psychological Association* (4th edition, 1994).

Manuscript review

Where appropriate, manuscripts will be sent for peer review to a reviewer with expertise in the relevant subject area.