

PSYCHODYNAMIC CONCEPTS THAT ARE ESPECIALLY RELEVANT IN THERAPEUTIC CARE FOR CHILDREN WHO HAVE SUFFERED TRAUMA AND OTHER ADVERSITIES

This is a brief introduction to some useful psychodynamic concepts that can be very helpful in therapeutic care contexts and other types of therapeutic work with children and young people. This section is adapted from,



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PSYCHODYNAMIC CONCEPTS

Several psychodynamic concepts are specifically important in therapeutic work with traumatized children, particularly in therapeutic residential care settings. We will be referring to and elaborating on them throughout the book and shall briefly describe them here.

Transference and countertransference

Transference was first described by Freud (1912, 1914), who observed in his psychoanalytic work that patients transferred feelings that belonged to past relationships

onto the analyst in the present. Most commonly, but not exclusively, it is feelings associated with the formative relationship with mother and father that tend to be transferred. Freud (1950, p.116) wrote that

... a whole series of psychological experiences are revived, not as belonging to the past but as applying to the physician at the present moment.

If these feelings are thought about, it is possible to gain an understanding of earlier conflicts and enable psychological changes to take place in the patient.

Whilst this concept initially developed in the context of a psychoanalytic relationship between analyst and patient, the same dynamic is now understood to take place within a wide variety of different relational contexts. For instance, a child may transfer his experiences, both positive and negative, with parental figures onto other adults in the present who have a parental type of role, such as a therapist, teacher or caregiver. To some degree, we all transfer some of our feelings associated with past experiences onto people in our present relational context. Therefore, it is important in our work with traumatized children that we attempt to recognize these tendencies in ourselves, so that we can reduce the unhelpful aspects of this being acted out towards children and our colleagues.

One of the key ideas in psychodynamic thinking is that the patient and therapist have two separate subjectivities that interact in a meaningful way during the course of therapy. The psychotherapist is not a scientist looking through a microscope at a specimen. Rather, she is a fellow human being with conflicts and emotional struggles of her own. She unconsciously experiences the patient as someone from her past at the same time that the patient experiences her as someone from her past. (Gabbard 2010, p.15)

When we are on the receiving end of transference, it is likely that we experience a feeling in reaction to this. So, if a child is treating us as if we are uncaring or even abusive, we may find ourselves feeling angry or punitive towards the child. This happens at an unconscious level and has been termed countertransference. If we are able to recognize and think about our countertransference feelings, they become another avenue for understanding, which could further illuminate the nature of the child's and our own earlier experiences.

Gabbard (ibid) referred to countertransference as a 'major therapeutic and diagnostic tool that tells the therapist a great deal about the patient's world'. Recognizing and thinking about our feelings in this way, they become a vehicle for therapeutic change rather than an unhelpful reaction. So, if we feel punitive towards a child, we don't punish the child but try to understand why punitive feelings are being evoked in ourselves. It could be that the child is behaving in a similar way to how we were punished as a child, in which case our countertransference is more to do with our own past experiences. On the other hand, the child may be unconsciously provoking us to react in a punitive way, similar to how he may have been treated by his parents. The understanding we reach will then influence our response to the child. Donald Winnicott (1992, p.195) emphasized how important it is that we can acknowledge the existence of our countertransference feelings, however uncomfortable we may be about them:

However much (the psychiatrist) loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients... Above all he must not deny hate that really exists in himself.

If we are not in touch with these powerful feelings, it is more likely that we act them out either directly or indirectly. Therefore, it is necessary that we have the opportunity to openly and safely discuss these feelings in professional forums.

Projection, projective identification, and envious attacks

Projection is a similar but in some ways more primitive process to transference, and is what psychodynamic theory refers to as a defence mechanism. Whereas transference takes place in the context of a relationship that may evoke aspects of previous relationships, projection is a way in which someone gets rid of overwhelming, distressing, or persecutory feelings by projecting them into someone else.

This begins in early infancy, where the infant who is becoming overwhelmed projects this feeling through his behaviour into a caregiver. The caregiver finds herself suddenly feeling

anxious, for example, and tries to understand what this is to do with – that is, the infant may be hungry or feeling discomfort. It can be seen that the infant has not only got rid of some of his troubling feelings but has also communicated something to the caregiver. Stien and Kendall (2004, p.148) argue,

Getting someone else to feel the same emotion we are experiencing is one of the most basic techniques that human beings use to feel understood. Rather than becoming enmeshed in the negative emotions of the traumatized child, adults must try to empathize, and simultaneously maintain a 'meta-mood' of relative calmness.

Where things go well, the caregiver thinks about the infant's feelings and responds, often intuitively, by meeting his needs. This provides the infant with the experience that his overwhelming feelings can be thought about, understood, and responded to positively. Gradually, through the emotional containment provided by the mother, the infant internalizes this experience and becomes increasingly able to think about his own feelings and communicate them more specifically.

The way in which the infant's projections are handled and responded to is crucial to the infant's development and lays the foundation for mental stability. However, as Trevithick (1995, p.4) described, this process is not straightforward,

For instance, it is recognized that as the infant develops, he may become envious of the mother's capacity for creativity, which includes thinking. This can result in envious attacks towards the mother by the infant, which can cause difficulties in her thinking. The realization that the mother has her own thoughts, which the infant is not in control of, is also the cause of anxiety for the infant, related to separation and fear of not being in control. If the mother can contain these anxieties, they can be a spur to the development of the infant's healthy curiosity and individuation.

Where the caregiver is not able to think about or respond to the infant's feelings, the infant will feel that these feelings continue to exist but are located outside herself, in a way that feels threatening to her. For example, feelings of intense hunger that belonged with the infant are now felt by the infant to be located in the caregiver. In a primitive sense, the caregiver is then perceived by the infant as someone who may literally devour her. As adults, we may be able to recognize a similar process where, for instance, we deny our own anger and project it into another who we then feel afraid of. Our unconsciously 'split-off' anger now resides in the other person.

To take this a step further and confirm our fears, we then provoke the other person into becoming angry with us. The other person can find himself becoming angry and expressing these feelings in a manner whereby she feels she is acting out of character, as the feelings did not originate in herself. Talking about the therapeutic context, Gabbard (2010, p.13) explains,

Thus the patient may behave in an irritating way until the therapist becomes irritated and unconsciously conforms to an angry object from the patient's past.'

To describe this process and building on Freud's concepts of transference and countertransference, Melanie Klein (1946) first used the term projective identification from her observations of relationships between babies and their mothers and infants. Gabbard (2010, p.13) explains how the process manifests itself in therapeutic work: 'In projective identification, the patient unconsciously projects a self or object representation into the therapist and then, by exerting interpersonal pressure, "nudges" the therapist into taking on characteristics similar to the representation that has been projected.' The major difference between projection and projective identification is that in projective identification the person who is targeted with the projection begins to behave, think, and feel in a way that is consistent with what is being projected into them.

Splitting

The process of splitting is also connected to projection, as specific feelings are split off and disowned. Splitting is normally used to describe the way in which polarized feelings such as 'good' and 'bad' feelings are separated and split off. Initially, both good and bad feelings are projected into the mother, whom the infant does not yet perceive as a whole person. So there is the 'good' mother and the 'bad' mother. As the infant develops and begins to realize that the good and bad mother is the same person, this creates a conflict for the infant. The good mother whom the infant projects positive feelings into is also the bad mother whom she projects negative and hostile feelings into.

Therefore, the infant becomes concerned about hurting the good mother. The infant may respond to this in a number of ways. With the mother's support, he may begin to recognize that the mother is neither all good nor all bad. He may develop reparative behaviour towards the mother to compensate for his attacks on her. This is what one would hope for in healthy development. Alternatively, in conjunction with the mother's lack of capacity to contain these splits, he may find this too difficult to resolve and continue to keep the mother as a split rather than a whole person. This will hinder his development and result in a relationship that swings from being all good to all bad. If he perceives the mother to be vulnerable or reactive to his negative projections, he may either find another person to project these feelings into or repress these feelings, possibly by turning them inwards.

This response can be seen in children who project all bad feelings into one adult whilst preserving all good feelings for another adult, or who turn their difficult feelings, such as anger, on themselves. It is clear from this brief description to see how the handling of projection and splitting processes is central to a child's development. Where there are difficulties in this, the child's development will be hindered and potentially distorted. When this happens, as it invariably does with children who are severely traumatized, we can expect projection and splitting to become major areas of work until the child's developmental difficulties are resolved. Emphasizing the importance of these concepts to the work we are writing about in this book, Stokoe (2003, p.86) states that,

I believe that projective identification is the main language of the therapeutic community. The young people are continually filling staff and other young people with those parts of themselves that they are unable to handle. A classic example is bullying: the bully is unable to handle fear, so they use projective identification to make someone else experience fear. In this way, the bully has the pleasurable experience of seeing fear outside of himself and, therefore, controllable.

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