The role of the body as the medium in child psychotherapy: snapshots of therapy with an 11-year-old, severely abused, multiply placed girl

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SUMMARY In Victoria, Australia, children with a history of abuse and severe attachment difficulties, and who have experienced multiple carers and placements, have been traditionally viewed by mental health services as unsuitable for psychoanalytic psychotherapy. A number of factors, including the lack of integrated, long-term case planning; unstable residential placement; and the belief that psychotherapeutic treatment will be of an extended duration, have influenced the decision not to provide individual psychotherapy for these children. Currently, the movement within mental health services is towards responsive and briefer treatment models. The child psychotherapist is challenged to re-think theory, technique and practice. This paper identifies contextual constraints that have led to these children being precluded from accessing psychotherapy. An alternative model of intervention is discussed and illustrated with clinical material. The contributions of Alvarez, Trevarthen, Schore and other writers are drawn on to underpin the clinical work. This model involves a change in technique and role and the use of a time-limited intervention. Intrinsic to the model is the understanding of the child’s psycho-biological experience of trauma and disrupted attachment. The child’s experiences are conveyed in the pre-verbal, gestural domain to enable history to be given voice.

KEYWORDS Child psychotherapy; trauma; attunement; foster care; multi-agency work.
INTRODUCTION

As a child psychotherapist working in an outpatient mental health service in Victoria, Australia, I often receive referrals to undertake either generalist mental health or specific psychotherapy assessments of children who are in placements that are at risk of breaking down. Usually these children have experienced physical and sexual abuse, and witnessed domestic violence between their parents. The children will have been in a range of short-term to permanent placements, which have been unstable because of their attacking and regressive behaviours. Arcellus et al. (1999) estimate that up to one-third of children in care have clinically significant mental health problems, yet there are delays in mental health assessment and limited provision of psychotherapeutic services. In this paper, I will describe a way of working that has evolved over time, in a context of changing government policy on services to such children. The main influences have been the work of Alvarez (1992), and recent developmental research that identifies certain qualities of mother–infant interaction as crucial to adult psychological stability (Ainsworth et al., 1978; Stern, 1985; Brazelton and Cramer, 1991). The work of Schore (1994, 1996, 1997) on developmental psycho-biology, which documents the neurological effects of early trauma and attachment difficulties upon subsequent relationships, has provided further understanding in working with children with histories of disrupted residential placement and traumatic attachment models.

This paper is not about providing psychoanalytic psychotherapy to children with concerned, committed parents who are supportive of detailed and extended work. Rather, it is about the children who have not experienced a nurturing parental couple but a hierarchy of changing ‘foster carers’ and ‘case managers’, who are responsible for different aspects of the child’s day-to-day and long-term management. These children are under threat of removal and further rejection because of their emotional and behavioural instability. The service structure is also unstable and fragmented. Often there is confusion as to whose responsibility it is to initiate the referral. There is no guarantee that a child will be able to attend therapy on a regular and continuing basis. There are also constraints due to funding and service delivery models within the mental health service that employs the child psychotherapist. Factors such as these impact on the provision of psychotherapy to these children with very special attachment needs, and who show no capacity for trust.

However, it is possible to provide short-term therapeutic work that can address current placement dilemmas and prepare the way for more
satisfactory long-term care and the development of the capacity to trust. In turn, the interference of the past in the present can be ameliorated through appropriate care and, where it is arranged, through intervals of therapy. Such therapy can be provided in segments, similar to the ‘pulsed intervention strategy’ described by Pynoos and Nader (1993), for children who have been traumatized.

BODILY ATTUNEMENT IN INFANCY AND IN THERAPY

The link between early trauma, early rejection, and dissociative and negative feelings towards the body is made in Orbach’s (1996) paper on self-destruction in adolescents and adults. He states that ‘lack of attunement to bodily needs in infancy, eventuating in lack of awareness of bodily needs and bodily cues, not only hampers the development of a sense of self but may also be at the heart of a distorted perception of the body and a split between the sense of self and the body’ (1996: 610). Orbach conceptualizes the links from ‘distorted caretaking’ (1996: 614), to introjection of parental attitude with distorted bodily experience, to negative attitude towards the body and self-destructive behaviour, and suggests the need to investigate the ‘role of the body’ in suicide.

This idea of distorted body experience can be extended to children in care who, while not actively suicidal, are clearly traumatized, dissociative and destructive to others and themselves as evidenced in their placement histories. For these children, the experience of negative attachment and abuse is ‘within the body’. The therapeutic work involves the recognition, containment and processing, through the countertransference, of the child’s ‘body’ presentations in action. The receptive therapist is listening to what is neither yet symbolically formed nor yet able to be put into words. The child presents what her body experienced at a psycho-biological level, in a developmental form that predates neurotic re-enactment or conscious recall.

Meurs and Cluckers (1999) present clinical material from neurotic and borderline children which highlights how the countertransference – when experienced on a ‘bodily’ level – indicates those aspects of affective life that have been either ejected or foreclosed. They point to the importance of restoring links to the affectively experienced body during therapy, through the finding of words for what is experienced on a ‘bodily’ level. Schore, in a series of works (1994, 1996, 1997) that
link infantile experience and brain development, demonstrates the impact of trauma on the pre-symbolic infant. Trauma cannot be recalled or re-enacted, but only presented in bodily form. Analytic work with such traces involves bringing bodily experience into the symbolic realm, and thereby making the traumatic effects available to understanding.

The case of a traumatized, multi-placement child encouraged renewed consideration of the ‘bodily’ presentation of pre-symbolic experiences. It is the understanding of these ‘bodily’ traces of the experienced trauma that opens up the possibility of short-term work, with a therapeutic alliance based at a pre-verbal level. However, I shall first discuss the context in which the work took place, including service delivery constraints, case planning processes and engagement with the child’s permanent carers and case managers.

HISTORICAL CONTEXT – MENTAL HEALTH SERVICES AND RESIDENTIAL CARE

Over the last five years in the Western Metropolitan Region of Victoria, there have been major shifts in the provision of outpatient child mental health services, because of an increasing emphasis on efficiency and accountability. The profile of the service has moved from multidisciplinary teamwork to generalist case management and practice, mainly provided by individual therapists without a co-worker to share parent, child, or family work or case management. Conjoint parent and child therapy is a rarity. Funding is directly related to the number of children and parents seen in a given time period, and to the meeting of standards of data recording, such as diagnosis and individual service plans; both of which are open to regular internal and external audit processes. This enables clients to be reviewed to ensure the maintenance of the best standard of practice. With the move towards a more responsive and cost-efficient service, child psychotherapy has been viewed as expensive in terms of resourcing, particularly in relation to the length of treatment in the wider context of short-term therapies, such as cognitive behavioural therapy and single session interventions (Talmon et al., 1990).

The 1980s saw radical changes in the state residential services for children needing care and protection. When I began work as a social worker and family therapist over twenty years ago, the range of residential options included foster care, family group homes, small residential units, permanent care, and adoption. Working in a specialist
unit for severely disturbed children with horrific histories, I was struck at that time by the repeated attempts to find a ‘family’ placement when the message from the adolescents clearly was that they did not want another family placement. There were three central institutions that cared for children, according to age, sex, behavioural needs, and provided a period of containment in which to assess behavioural management and the emotional needs of the child. Such assessments would often inform the referral to the next placement as to the specific needs of the child.

The de-commissioning of the central institutions has placed much pressure on the providers of residential care, as there are now no structures for the thorough assessment of the child’s placement needs and of his or her mental state. When children enter care, there is little time to consider the suitability, duration or long-term planning of the placement for that particular child. Short-term residential units are established for the older, more difficult children, while the younger children are placed in the foster-care placement that is available at the time. Usually child protection workers, from the Department of Human Services (DHS), have minimal information about the child’s physical and emotional needs or about the details of the other children already placed in that particular foster home. There is a gap in ‘holding the child’s needs in mind’ as the DHS workers have responsibilities in relation to the court, while the foster placement agencies focus on the needs of the foster parents (usually volunteers). The impact of the placement on these children, who have already experienced betrayal in the care of their biological parents, and often by other carers, cannot be thought about because of the pressure to find a placement. Protective and foster-care workers often avoid the child’s emotional difficulty or label the child as ‘bad’ to protect themselves from being overwhelmed by the child’s needs (Rosenfeld et al., 1994). Little is known about what the child has experienced or witnessed, her capacity to form relationships, and even less about the way the child expresses her emotional needs.

These children require detailed assessment and multi-systemic interventions involving the current carers, respite families, teachers, siblings and biological family, the placement case managers and the Department of Human Services managers. Lieberman and Van Horn (1998) describe the development of the child who has experienced unmodulated terror without protection from a parent and use a quote from Bowlby’s (1980) work on *Loss: Sadness and Depression* to describe the child developing ‘a model of himself as unlovable and unwanted, and a
model of attachment figures as likely to be unavailable, or rejecting, or punitive’ (1990: 428). Within the current service model, children are faced with repeatedly changing carers, case managers, and therapists, further compounding the already damaged model of attachment.

CURRENT BARRIERS TO CO-ORDINATED PLANNING AND CARE

The level of complexity and intensity of involvement of multiple services (e.g. DHS, placement case management agency, foster services, Education Department), which may cover different geographical regions, place heavy demands upon the resources of the mental health service. Often, at the point of intake or initial consultation, the mental health service’s response is that the case is unsuitable for acceptance. This response arises from misunderstandings across services regarding entry criteria. A key concern is the perceived barrier to mental health services that applies to children who are not in a stable placement. The referrer is advised to ensure continuity and/or stability of placement before the service will accept the referral. If the referral is accepted, and intensive long-term psychotherapy is recommended, this has to be justified to service management concerning the commitment of specialist resources to long-term intervention. Often psychotherapy is considered unsustainable for a number of reasons. One of the more important is the resource constraints in the other voluntary services that limit the capacity of the child to access mental health care (e.g. staffing to transport the child). In addition, each service may have a different understanding or agenda for the involvement of the mental health service and, in particular, for the provision of individual psychotherapy. As an example, time-limited goals of treatment are often required to be written into formal case planning contracts. Finally, access conflicts affecting both siblings and parents, often with further court proceedings pending, may restrict mental health involvement. While advocating psychotherapy for foster children, Barrows (1996) highlights the complexity and problems involved in providing such treatment because of failures in the setting. Such children become defined as challenges, whom psychotherapists feel unable to treat, as neither can the ‘ideal’ model of therapeutic intervention be provided, nor can the system be a reliable ‘container’ or even ‘carer’ for either the child or the psychotherapist.
A pathway forward

Providing what is practical may be more useful than refusing to offer the ideal. Placements may break down and, in the chaos, it may be difficult to maintain the commitment of the carers, placement managers, and agencies to the continuity of therapy. The child may be moved to another geographical area with a change of mental health worker due to regional boundaries, or be placed on an allocation list for a new DHS worker, or a trial of reunification may be attempted.

An alternative model needs to be thought about for the provision of therapy for these children. Therapy may have to be brief and within a set time frame because of the possibility of a transition in placement, at ‘pulsed intervals’ or ‘on demand and intermittent’ (Winnicott, 1989) with one therapist; or in some situations with changing therapists but the one containing institution, as ‘the brick mother’ (a phrase used by Henri Rey to refer to the Maudsley Hospital). For these children to be seen and listened to at the point of crisis, when their internal and external worlds may be fragmenting, allows the current experience to be partially understood and integrated without adding another layer of rejection and self-disgust. Even if only momentarily, the child can feel seen, in all his or her mess, and acknowledged by another who does not turn away. This can be the beginning of an experience of containment. Seeing a child in this way may enable the carers, placement managers, and agencies to rethink and to have hope themselves. Following this model, practices and aims may need redefining and de-idealizing, to create a range of therapeutic options other than rejection for treatment or the more traditional long-term therapy.

As a psychotherapist, I believe that we can go beyond the traditional treatment methods to listen to and connect with these children’s very different inner worlds. We need to go behind the trauma to engage at the earliest developmental level at which the child’s emotional connectedness was first compromised. In so doing, we need to match our thinking, processing and integration at a psychosomatic or psychobiological level through our attunement with the child’s bodily and sensory experience. These children know they are unwanted, undesirable and they attack those who attempt to relate to them. They perceive themselves as disgusting, damaged, rejected, abandoned and they are full of envy. Therapists may turn away from relating to the child, because of the horror of what is believed and known to have occurred to the child. They defend against personally unbearable responses to the only partially known experience of the child. There is a wish to comfort, and therapists may be puzzled and frustrated by the child’s antagonism
and lack of desire to relate, and the therapist may avoid physical contact with such children for fear of triggering a re-enactment or projection of the earlier trauma. I would like to suggest, rather, that therapists should enter into a dialogue with the child, using a ‘bodily thinking’ to offer both a bridge and a boundary for establishing a space for integration.

In _Live Company_, Alvarez (1992) discusses the many developments that have occurred in psychoanalysis and particularly describes the changed focus on the quality of the relationship between the psychotherapist and the child. ‘Much greater attention [is now] paid to the interpersonal relationship . . . that is, to the patient’s changing transference and to the analyst’s changing countertransference’ (1992: 2), and she argues, this ‘study of the living interactions’ is ‘far more effective than simply resorting to elaborate detective-like reconstructions’ (1992: 3). Referring to Bion’s work on containment, Alvarez points to the parallel between the therapist’s role in the transformation of ‘the patient’s feelings and thoughts’ and ‘the primitive but powerful pre-verbal communications that take place between mothers and tiny infants’ (1992: 4). While the pathogenic past is beyond our reach, Alvarez concludes that holding with reliability, regularity, receptive listening and a firm attitude to the potential horror of a child’s projections can be helpful.

This two-person psychology is explored in Alvarez’s imaginative and intensive work with ‘Robbie’. In the discussion of this case, Alvarez reviews the growing knowledge from infant development research. Alvarez points to how the mother is active with the child, ‘pulling the child, drawing the child, attracting the child’ (1992: 77, author emphasis) towards the maternal object. To paraphrase, Alvarez highlights the tactile, visual way the child ‘reache(s) and grasps objects . . . at just the right distance’ (1992: 78, author emphasis). Alvarez draws a parallel with the conditions under which an idea may become graspable. This is no less than a psychotherapeutic position: Alvarez defines ‘live company’ as ‘the need for an intelligent, animate object’ (1992: 82), with whom what is being perceived and introjected ‘is (the) interpersonal behaviour in sequence and through time’ (1992: 83, author emphasis).

This therapeutic stance allows for the revelation of truths about the past trauma. We shall see in the case material to be presented that, while this interpersonal behaviour occurs through touch and vision, past trauma could also be described as being encoded in bodily form in ‘negative snapshots’, that is, bodily outlines of what has occurred, without the acquisition of emotional colour.
In the following case excerpt, the work of the infant development- 
alists (Ainsworth et al., 1978; Brazelton and Cramer, 1991; Stern, 1985; Trevarthen, 1993), describing how rhythm, synchronicity, dialogue, surging, turn taking and conversation-like exchanges help enlarge on 
this interpersonal patterning, is critical, as are the ideas of Alvarez 
psychotherapists working with severely damaged children are also 
explored, in particular the recognition of the need to be open to the 
pattern of emotions emerging from a primitive pre-symbolic level.

CASE MATERIAL: GINA’S STORY

I had heard about Gina, and her severe physical and verbal attacks 
on her permanent care family during the review discussions of the 
mental health team. Gina had been repeatedly rejected by her biologi-
cal mother and carers before being taken on by a short-term foster 
family. These foster parents had expressed their anguish and fear that 
Gina, then only 6, would continue through a merry-go-round of place-
ments if they did not take her on as a permanent placement. It was 
only in this most recent placement that part of the early traumatic 
history of physical and sexual abuse, against a backdrop of domestic 
violece and drug addiction, had been more fully revealed.

After an initial introduction to Gina, I met with her permanent 
carers, the placement agency and the mental health service case manager. 
Over the preceding term Gina’s behaviour had deteriorated, with verbal 
abuse such as ‘when I’m ready’ and ‘you fucking little dickhead’. She 
made physical attacks on family members with fists or knives, and then 
screamed to neighbours that she had been assaulted. She would not 
sleep, was gorging food and complaining of odd sensations in her 
skin. Major mood swings were described, between ‘calm and rage’. The 
permanent carers, an older couple, rejected the suggestion that this 
deterioration might be part of her rage at the loss of her closest ‘sibling’ 
(the foster carers’ biological daughter) who had recently married. The 
carers demanded medication, behavioural management and a planned 
removal from the placement. The carers agreed to continue with indi-
vidual therapy but insisted that it be time-limited, as they did not believe 
in psychotherapy ‘if there was no change in behaviour’. A meeting was 
arranged for two weeks later, to clarify planning and treatment options, 
after I had assessed Gina.

In my first assessment meeting with Gina, I was struck by her 
detachment, the flatness of her voice and the sense of being persecuted.
A dark-haired, awkward-looking child, she presented as emotionally and intellectually vacant with little interest in self-care. She drew expressionless stick figures, and chanted with increasing ferocity, ‘you, you, you, you’. She furiously began to turn the phone dial, saying her home number, progressively getting more muddled, louder, angrier, until the pencil, with which she was dialling broke. I commented that for her it felt there was no one at home to listen to her describe her previous experiences of abandonment. Gina, while pretending to dial a phone number, told me, in a flat, detached voice, about how she addresses her carers, ‘I call my mother (i.e. permanent carer), Jane . . . my father, (i.e. permanent carer) Peter . . . and my real [biological] mother . . . mum’. She began to play chess, which she is skilled at, then stopped and began repetitively stating her family names, then screamed at me, ‘you, you, you, you’. Any comment of mine was responded to with intense rage. She began to scratch at her skin, and stab with a pencil, then scissors, into the lids of the toy boxes. At the end of the session she ran clumsily away from the waiting area, avoiding contact with anyone. She seemed unreachable and I wondered if Gina was at breaking point.

In supervision, I expressed my concern about Gina’s persecuted presentation. The potential for psychological breakdown was discussed, but it was felt that it would be better for breakdown to occur now rather than later. The case manager and I prepared for the possibility of inpatient treatment and increasing conflict with carers and agency. Was I averting my gaze, and using reasons as valid as those of the institution and system, so as not to see Gina?

To my utmost surprise there were no emergency calls, and Gina appeared the next week for the second interview. I was both relieved and annoyed. I did not relish the idea of months of similar behaviour and having to deal with the negativity of all the systems, including justifying to colleagues and myself the reason for continuing to offer individual psychotherapy while waiting lists were increasing. Gina took out the pick-up-sticks game and, with no acknowledgement of my presence, mesmerically held, then dropped, them. I had decided to avoid interpretation. Words were felt on her skin and experienced as a physical assault. I tried to focus on thinking of the rhythm of her movements and play.

The beginning of rhythm

As the sticks fell, I sensed Gina’s experience of continually being shredded and feeling unheld. I merely stated what I saw occur (e.g,
‘the blue stick fell first’). As I spoke haltingly, I sensed that Gina was listening, as if tuned in at a much earlier developmental level. It was as if, through her body movement, she was recalling a previous experience in time. I began to say the number of sticks that fell together, with her intoning them, and then matching my intonation (e.g. ‘one’: ‘one: one’). I added a lilt to the end of the word, and Gina initially copied, then began to change and develop the rhythm. I was aware that we were both gazing intently at the sticks as they fell, saying the words in time, rhythmically. As I raised my eyes to watch her, Gina looked directly at me, and gave a little laugh of pleasure at the game.

Here was the maternal object, as Alvarez (1992) described, beginning to pull, draw and attract the baby, entering the rhythm of turn-taking and dialogue. Where were Gina’s emotions? Were they accessible at a pre-symbolic level, as Schore (1994) suggests? As we played pick-up-sticks, I was aware that Gina was seeking my commentary about her appearance, touching her now-growing hair with new hair bands and looking into my face. Often Gina would move, then pause, as if inviting me to see her. Using gesture or slight body movements, she would hold her painted nails just under my hands to touch, point to eye make-up for me to brush her cheek, or hold the hair band up for me to touch and tie her hair back. As the sessions progressed, Gina began providing the words as we played, commenting on what she had done and then what I had done. We had created a common physical and verbal dialogue about the shared space and experience.

Was this the potential space that both joined and separated us, that was based, as described by Winnicott, on attunement to an ‘underlying physicality and sensuous matrix . . . without insulting the delicacy of what is preverbal, unverbalized, and unverbalizable’ (1967: 131)? For Winnicott (1967), it was crucial not to resolve the paradox of the potential space; rather, he accepted that the experience of a space between inner world and outer reality creates the possibility for playing and for the filling of the space with symbols, such as transitional objects. In Gina’s case, physicality as understood begins to map the space and physical objects start to take on symbolic value.

**STRUCTURING CASE MANAGEMENT**

At the next case management meeting, the carers restated their concerns and demanded confirmation that psychotherapy would lead to change and would not be lifelong. They expressed their concern over
their age and the need to care for their own biological children and grandchildren, but equally they did not want to see Gina rebound through residential services if removed. I described Gina’s behaviour with me during the assessment and how this behaviour made sense in view of what little was known about her. Clearly, Gina had major problems with attachment and relating, which could be lifelong. When people became too close emotionally, she felt the fear and fragmentation of her early traumatic experiences with her biological family, and she turned and attacked. For Gina, to be seen, to be perceived as a legitimate other, was to be placed in a position of danger, pain and fragmentation. I suggested that Gina would need a hierarchy of carers to support her placement until she was an adult, and to help her diminish the ferocity of her attacks. I believed that she might only be able to sustain episodes of therapy, and it would be only as an adult that she would be able to utilize individual therapeutic work. Plans were instituted to have regular care provided by two after-school carers and a commitment made to bring Gina to therapy, with a review in three months, without the expectation of ‘never ending’ treatment. The carers were seen fortnightly, to discuss their responses, management concerns, future plans or any other issues. The carers seemed relieved, and to have felt understood in their concerns.

THERAPY UNFOLDS

Over the next school term, attendance at therapy was mostly regular, if occasionally a little late. In the third session, as we played, I referred to Gina’s need to pick up the pieces of ‘pick-up-sticks’, and she responded saying, ‘Daddy is the angriest’. Gina was now able to locate an emotion in ‘the other’, but still not within herself. After this comment, Gina asked to go to the ‘wet room’ (a therapy space with vinyl flooring, a sink for water play, a sand tray, and a painting easel with paints and brushes). I thought she wished to return to the previous therapy room she had used in her earlier contact with the Mental Health Service.

Having considered discussing the meaning of the request, responding at the level of language did not seem appropriate. I decided to meet her request at the physical level, and went with her to the room. Gina pulled out the metal sand tray and first sat on it, gently exploring the floor with her fingertips and hands. She then lay on her tummy and asked to roll around ‘outside’. There was an immediate sense of a baby trying to locate herself physically in space, but I was concerned about
using the outdoors, with no boundary at all, or my own office, which felt too confining. I thought of the clinic’s children’s gymnasium, which I had never used before for clinical work. (The clinic is part of a mental health service that includes outpatient, day-patient, special education, and residential services with input from speech, occupational and physical therapists, with both gymnasium and swimming pool.)

Gina had conveyed in her movements and with her word ‘outside’ the need for a defined, explorative space in which to be able to play with closeness and distance, that would remain constant throughout this period of therapy. I collected the keys, trying desperately to push aside my fear that Gina would bolt, or trash the gym, and my concerns about colleagues thinking that I had stepped outside the frame.

In the gym, Gina selected a scooterboard (a flat board, eighteen inches by two feet with four castor wheels mounted centrally underneath, designed for sensory integration use) and a large red ball, half her height, then said ‘look... space and walls’. The gym was a space with both a physical boundary and room in which to play. Rolling the ball to me, she gestured toward the direction in which I should, in turn, roll it. She then lay on the scooterboard, tentatively alternating touching the ground with fingers and toes. I commented on her ‘being a baby’. She indicated I was to roll the ball to her. As I did so, she used her hands as a ‘bat’ to push it away. I said the word ‘bat’. The play varied according to where Gina gestured and I repeated the words ‘bat away’ each time, which she echoed. I added that when people started coming too close they were huge, and that she had to ‘bat’ them away to survive. I deliberately chose physical descriptions from a babyhood stage.

The following week Gina was waiting at reception for me, having already asked for the key to the gym. She collected the red ball, a tennis racquet and the scooterboard, and as she picked up the helmet I commented that she was protecting her head. Gina spoke in sporadic phrases: ‘my dog... from another house... unmanageable... lived with us... one month... lost... no collar... no wait... to find... lost’. I said, ‘you might understand how the dog feels because you came from another family’. To my surprise, Gina responded ‘I don’t know my family, it would take more than two years... now ball’. As I threw the ball, she smashed it around the space with the racquet, and I commented on it being difficult to trust that I would get the ball to her under her directions. She then took the helmet off.

Briefly, Gina stated the different punishments she had received (no specific carers were named, just the events), and then used the red ball, alternately lying on it, kicking it, bouncing it and attacking it with her
hands and feet. I described her actions ‘kick, bounce, attack, bite’, and added that this was what happened when she got too close to people. (I did not know at this stage that she had regularly had her hands and feet tied, while her mother’s partner had kicked and punched her, then thrown her into the boot of the car. On occasions Gina had also been sexually assaulted.) Gina then repeatedly said her own name; then, intoning ‘mother’, ‘father’, ‘stepfather’, she threw the ball hard at the wall, adding ‘yucky, yucky’. I said how hard it was to put these yucky feelings and anger into words.

Gina then insisted, by pointing, that we play a game of throwing two balls so that they crossed exactly in mid air. I had a sense that the passing, synchronizing, and matching of the arc of the two balls was as if balancing her images of two mothers. Naming the names of her carers, I said: ‘real mother/foster mother, foster mother/carer mother, step father/foster father, foster father/carer father’. Gina joined in naming the pairs of people, and added that she had two brothers, who had left home before she was born. She helped pack up. I washed her hands and at reception I turned to find Gina offering me one of two glasses of water. I thought that Gina had begun to learn to count to two (entering a two-person psychology, cf. Alvarez, 1992). I reflected on the coming together of Gina’s history in a manner in which differences could now be tolerated, and perhaps would be able to be described in words, no longer in actions.

**Coming together**

The following session had two themes. The first was Gina’s mastering of closeness and distance in her use of a bilaterally hand-propelled bike or ‘wheeliechair’ to which, using a skipping rope, she attached the scooterboard as a trailer. Gina pointed with her hand for me to sit on the trailer. I tried to interpret her wish to lead me so that I would understand how she had felt being dragged around in different households with different carers. I also did not want to get on such a clumsy vehicle. She insisted and I climbed on, gingerly. As the scooterboard moved away or bumped into the wheeliechair, the coupling was quite unstable, and I felt likely to be thrown. Gina was enjoying herself, and was delighted when we finally got the balance correct. It dawned on me that Gina needed me to physically feel the bumpy road of relationship breakdown that had been her life, and I said that she had been pulled along without people noticing her being knocked around or bumped into. Gina responded saying that she had had lots of moves.
She did not know when she had left her mother, or with whom she had lived. She then pointed to me to swap places. We bumped across the gym until I got the rope tension correct, then Gina swapped and also found the correct tension. There was a sense of us moving into a rhythm, having gained the correct distance for bumps and disruptions to occur. Again, in the wheeliechair, Gina instructed me to roll the red ball at her, but only when she had shown me how she would avoid, then later deflect the ball. I had a sense of her physically mastering her distancing in relationships.

The second theme of the session was the development of the capacity to enjoy being seen, and for me to feel pride. Gina suggested a game of hitting a tennis ball against the wall and after accidentally hitting me with the ball, motioned for me to sit down, and began accurately hitting the balls away from me, making sure of my safety. As I watched, I found myself again saying exactly what she was doing and commenting on her intensity and skill. I was enjoying watching Gina, and as she looked at me, she clearly enjoyed my pride in watching her. She spoke of how she now enjoyed school, had friends and even liked some teachers. I noted her facial expressiveness, her evident self-enjoyment, and her fluid motor co-ordination with no sign of her former awkwardness.

**Being seen**

In the next session Gina produced her photo album, and pulled down the gym mat to place the album on. Then, pulling down the trampoline, she moved as if to jump from the trampoline to the thickly padded gym mat. I expressed my concern for her safety and requested that she wait to jump until I moved the gym mat closer to the trampoline. Gina looked at me with surprise, then jumped to sit beside me on the edge of the mat. I pulled my legs up, and was immediately aware of being watched carefully and, in turn, my watching Gina as she carefully arranged her body to mirror mine. She opened the photo book with photos of a previous foster family, a birthday with her biological mother, and her current carers. What was striking was that Gina became less animated and more expressionless with each photo, and mimicked others’ stances. There was no elaboration, and she spoke only to name the people in the photos. She mentioned how no one in the family would talk about the lost dog, probably because it was too old and not wanted. I felt any interpretation would have been meaningless for Gina, while talking, had turned her body, leaning,
moulding, as if requesting protection from me physically. I was reminded of how Hopkins (1987) discusses the times when a physical holding relationship may be necessary in therapy. I put my arms briefly around Gina.

In the ninth session, the second last before the term break, Gina greeted me as I entered reception, climbed down the steep rockery in the rain on her way to the gym, checking all the time that I was watching her. She collected her equipment and, with easy confidence, sped around the room on the scooterboard, before pulling down the gym mat and pointing for me to sit and watch her. As I watched, I was aware of her physical attunement and enjoyment of her body. I reminded her that there was one more session before the holidays. Gina quickly responded with, ‘That’s okay. I’ll be away till school starts. Everything’s good except I felt really sad when my friend’s mother died.’ I offered the interpretation that the break ‘may feel like things had died between us’. Her puzzled look reminded me that I was on the wrong level. I needed to use her physical actions to explore her feelings. I did not have long to wait. Gina hopped off the board, and, hitting the ball into the wall, said, ‘I’ll miss these walls’. She hopped back on the scooterboard and began moving around the room with sudden trips to me. I said that she now knew how to move close, and away, and keep herself safe, which she had not been able to do when little. I said that I would be going away for the holidays, and that she may feel unsafe.

Gina picked up the tennis racquet. She directed me, by pointing, to sit and watch. She got the chalk and drew a target, a bull’s eye, with scores between each circle. As she hit the ball, she said the number and looked at me. She then hit again, said the second number, and added the numbers, looking at me. It took some time before I realized that she wanted me to add the scores. I began to add the numbers as she said them. A rhythm began to develop, with her smiling as I commented on her enjoying me watching her, and keeping the score. In contrast to her earlier sessions, she was rhythmically engaging me. At the end Gina put everything away, then reappeared with gold paint, which she applied to ‘my wall’, writing ‘G-I-N-A’ in the centre of the target, in the bull’s eye, and then to the lines along the mid section. I commented on her need to leave her mark on ‘our wall in the middle of the eye but not on top or bottom’. For me there was the sense of a central core being seen and developing in current time, and the fine outline of the past and future waiting to be consolidated.
Throughout the sessions with Gina I felt anxious. In supervision, I expressed my concern at my lack of words. I slowly became aware that Gina, while at times operating at a level of procedural recall (Fonagy, 1998), was describing her experience at a body level; that is, not at a level of what was observed to be done, but what was experienced at a psycho-biological level. Fonagy describes the clinician, when working with procedural memory, as being sensitive to the ‘multiple meanings encoded into a single verbal message using stress, speech pauses, intonation, and other features of pragmatics’ (1998: 348). My words or interpretations were offered at too high a developmental level. I had to learn to read Gina’s physical action to enable the meaning to be named both concretely and, later, emotionally; and then to be shared as a symbol common to us both. I was offering a ‘bodily thinking’ to create both a bridge to, and a boundary around, Gina.

Engagement with the therapist’s body is a taboo because of previous abuse, and the child may become over-excited or frightened. Ordinarily one shies away from lending one’s body (but very rarely one’s mind) to the child. I found myself challenged to think about how physical attunement may be needed in the therapy with these children to enable integration at the psycho-biological level.

My work with Gina and other children was encouraged as I read Schore’s (1994) description of his interactional developmental model. Schore describes emotional dysregulation due to the failure of affective development, and in his opinion the therapeutic task is to work through the primitive pre-symbolic sensorimotor level of the experience, to a mature symbolic representational level. I began to listen with a new understanding of infant development and communication. I heard Gina’s developing protoconversations (pointing, lilting, and adding to words to create rhythmic communication) and narratives (through prosodic movement and language). We played with joint attention (both to each other and to a common object); shared understanding (of the ‘tricky’ organization of the game); and mutual regulation (sense of fine-tuning the timing of each game interaction).

THE PROCESS OF CASE MANAGEMENT

Throughout the period of therapy, things were happening for Gina at home and at school. The case manager kept me informed of the
problems within the carer family, including a death, children leaving home, employment stresses and the loss of the family pet. Gina’s behaviour, though, had not been a major topic in meetings with the carers, and she had settled. At the time of the scheduled review there was an agreement by the carers to a further three months of therapy. The case manager noted that Gina was described as more tuned in, and she appeared able to verbalize the family’s emotions about the major incidents that had occurred. She was doing well at school, making friends, and concentrating in class. The attacks had ceased. I wondered if my blunt description of the severity of Gina’s behaviours had enabled the carers to put aside their rescue and idealizing fantasies and acknowledge her history, without feeling failures. In so doing, Gina’s own emotions were given space to develop, to be heard and to be reflected on by both therapist and child. Fonagy and Target (1997) emphasize the importance of this reflective function in the therapy of maltreated children.

Discussions were held with the placement agency and the case manager. We were reminded by the carers that there were often two to three weeks of settled behaviour, and this current extended period of settled behaviour was unknown. These anxieties were discussed and contained by the case manager. Any contact from the family was promptly responded to, and every one involved was informed of the outcome. Previous agency reports were shared across services in an attempt to put the full history together. Co-operation of this sort is indicative of a willingness to see the child honestly, with all the history, rather than denying the reality of the child’s experience. This open case management allows the child psychotherapist to operate on three levels: first, as an advocate for the child, and adviser on overall planning, within the case management model; second, in linking carers’ and workers’ responses to the child’s behaviour to positive management strategies through acknowledgement of the child’s experience of reality; finally, in ensuring that the case management structure is such that the total focus within the therapy sessions can be on the child. It is critical that therapy is not seen as open ended or, rather, without ending. The reality is that often the child does move to another region, the therapist leaves, or programme models change. The review sets a frame, and a time frame. Within this model, the child psychotherapist takes a more active role than in long-term psychotherapy.

Confidentiality of the child’s material is important, as always. Yet with such cases of pre-verbal presentation of experience, it is the advocacy of the child’s experience that provides both security in the child and understanding in the carers. The child is ‘before’ understanding,
and relies on the therapist to translate their actions so that the carers can understand. In conveying the message, the child needs to trust the therapist as translator, and the carers need to do the same. The acceptance of the complexity of communication is critical to paralleling and conveying the child’s experience. Rather than betraying confidentiality, the child psychotherapist is opening up the possibility for meaningful communication. This advocacy role is vital for the success of such short-term therapy, and the child must be aware of the therapist’s involvement and of the child’s own desperate need to have the therapist translate and inform significant others involved on the child’s behalf.

**DISCUSSION**

It was Alvarez (1992) who first focused my attention on the difficulties of communicating with children such as Gina, who have severe attachment difficulties, exceptional developmental histories and a limited expressive repertoire. In this work it is often the limited expressive repertoire that is the most confusing and challenging. Perhaps, for a child such as Gina, there had been few opportunities to co-operate in a mother–infant rhythmic dance of communication. In a setting of domestic violence, Gina may have experienced her mother’s physical and emotional damage as her own, with no intact ‘mother’ capable of containing her own bodily panic and dissolution. For Gina, attunement and holding appeared to be unknown and attempts to enter a rhythmic dialogue were responded to with fear and attack. The fear is of experiencing again both the internal and the external chaos. Being aware of this helps us to understand more fully why such children disrupt relationships and placements.

Communication by psychic snapshots is the special learning that this case provided for the therapist, and allowed integration of literature not previously internalized. Fundamentally Gina felt unsafe in relation to the maintenance and balance of closeness and distance. Therapy with Gina was about re-encountering early forms of emotional connectedness, such as are made physically in the rhythmic exchanges between mother and infant. However, to arrive at the point of being able to find such capacity for emotional closeness, there needs to be a willingness to be with the child in her most infantile expressions, and not distort these with more mature constructs. The body could be brought forward in rhythms, and the rhythms gave sense to early life experience. These were the snapshots developed from the negative film, which could then
be given mature commentary, and the fragments of her life experience drawn together.

In child psychotherapy it is usual practice to follow the child’s play, and make links between a series of images that can be given back to the child in a digestible form. However, by focusing only on images that link, one can edit out or rather not see the single snapshots that, if held as discrete images or negatives, will later make sense of the jigsaw of the child’s experience. Often these single snapshots are the entities with most emotional pain. By being able to demonstrate how the snapshots, or traumatic traces, existed in the physical postures and play within the therapy sessions for Gina, reality and truth could be engaged and repetitive blocks to integrated functioning removed. In this way there is an analogy to transference interpretation. Calling them ‘snapshots’ gives too visual a quality to them, although the idea does convey the spontaneous, transitory and elusive nature of the therapeutic perceptions. Without attunement and rhythm, these snapshots would remain as negatives, unable to be developed and brought forward into conscious thought.

Such children as Gina are usually not seen in therapy due to the complexity of the multi-agency involvement, institutional practices, or the belief that the only form of therapy suitable in such severe cases of abuse and neglect is on-going, long-term psychotherapy. The child psychotherapist, in working with these children, has to take a complex, multilevel role in case management, and balance interfaces, boundaries, and interests. Using Alvarez (1992) and Schore (1994), the developmental infant psychologists, and the recent writings on the role of affective body experience, including Orbach (1996) and Meurs and Cluckers (1999), I have found that it is critical in working with these children to provide a defined space, both physical and in time; to listen to the child’s experience through her body’s language (psychobiological); to name the experience with a word of understanding; and, above all, to allow one’s mind and body to be actively engaged in play (gesture, touch, movement, vocalization, mirroring and reflecting). The use of intuition and gaze are critical in engaging the child at the point of the earliest arrest in development. The normal baby is a bundle of gesture, movement, and vocalization, and as such understood by the mother through attunement. The multiply placed child is operating at this same infantile level but without the primary experience of bodily emotions being recognized, contained and processed; correspondingly, the therapist may experience continued hostility in the form of physical rejection. These children in therapy express at the affective
body level their needs, pain and history. The therapist must learn how to come into rhythm with such expressiveness, to slowly allow the child’s words to differentiate aspects of their experience.

A question remains as to whether such children are permanently impaired. Schore (1996) suggests that impaired maternal attunement sets up a lifelong vulnerability to psychiatric disorder. Clearly Gina’s capacity to attach was markedly impaired. However, her capacity for attunement was not lost. The stabilization of chaos, both internal and external, enabling the emergence of recovery through rhythmical exchange and attunement, may lessen what might otherwise be a lifelong psychiatric vulnerability.

CONCLUSION

In this paper I have presented an alternative model of intervention that is both brief and active, particularly with children who have histories of severe attachment difficulties and abuse and have experienced multiple carers and placements. The case material of one child was presented as typical of many other children I have seen. This work relies on new thinking about how the body enters into the therapeutic relationship, allowing the child to remember and the therapist to understand.

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