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BOOK CHAPTER

Original citation: Magagna, Jeanne (2012) *Communicating without words*. In: *The silent child: Communication without words*. Karnac, London, pp. 29-46. ISBN 9781855755185

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At long last, Milo was well again!

Afterwards ... the conclusion

As soon as Milo began to make strides back into the world, we became supercharged with huge energy. Nothing seemed impossible and everything was worth a try. We could hardly believe that Milo was well again. We had never allowed ourselves to contemplate that he might not be, yet at the same time had not dared to think how he might be after the illness.

I still remember that when he was unwell, one of the most painful things was seeing his friends. Their wellness, his sickness; the contrast was unbearable. Now of course, he is like his friends, they all look wonderful and healthy and full of vitality. He is achieving great things at a top university, startlingly fit and he's always sensitive to supporting "the underdog". It is hard to believe he went through so much suffering himself. I still find myself wondering what on earth went wrong. Did something go wrong? Will we ever know?

As a family, and as a husband and wife I feel we achieved something enormous too. It was the worst eighteen months of my life. Undoubtedly, we are a strong couple, but having gone through this crisis, the family unit is extra strong and loyal, and we have deep family ties. We never discuss Milo's illness with other people, and people we have met subsequently do not know the history. As time passes, the experience of Milo being so very ill is often still in my mind yet gradually getting buried in my "annual rings". It will never really vanish. I am so thankful that we found the right specialist care and that we were able to do the work necessary for such a good outcome.

Postscript: Milo is now successfully completing his university studies.

CHAPTER THREE

Communicating without words

Jeanne Magagna

A little about me

I was born in America residing in my Italian grandmother's home. Everyone spoke Italian to each other and spoke to me in broken American words. During the endless hours I spent with Nona, my grandmother, I watched the look on her face, the gestures of her hands, the way she laughed, frowned, and walked around with her hunchback protruding. I loved her dearly and yet I only learned one word of Italian from her, "zitte", which means "be quiet!" I did not speak then, but I felt the feelings of the speakers, observed their gestures, listened to the intonations of their voices, and even joined in their laughs. Their personalities entered me in this way and became part of me.

Infant observation

Later, I did weekly infant observations under the supervision of Mrs Esther Bick, who was encouraged to initiate this pioneering work in 1948 by Dr John Bowlby at the Tavistock Clinic. I became utterly convinced of the therapeutic value of the observer who does not speak much, but simply observes and compassionately empathises with the child, through getting in touch with the flow of the child's gestures, the sound of her cry, the look of her eyes. Through the observer's compassionate observation of the infant-mother relationship there seemed to be a transformation of the child and mother's interactions. The observer's silent understanding was being offered to both the mother and the baby. It could only be experienced through empathic attunement between observer, mother and baby.

The application of infant observation to work with the silent child

As I did in my grandmother's home and in infant observation, I use this experience of understanding through observing as I work as a child and family psychotherapist with the eating disordered children who do not communicate with words, but only through gestures and projections of states of mind into me. After many years of working with non-speaking children, I have come to understand how essential it is to patiently hold hope and trust that a compassionate understanding rapport with the child will enable the child to reach out to grapple with life and try to understand his or her own emotional experiences.

As a result of this experience I can say, as you meet a mother/father/baby or a child, a question is being asked of you: "Can you understand me?" To understand you must reach into the depths of your own emotional experience at that moment to understand that which cannot yet be communicated in words. As you do this, I believe that both you and "the other" can repair some broken connections between the verbal self and the as yet unsymbolised self.

Exploring five states of mind of the child

I shall now describe *five states of mind* in babies, which might help you in your therapeutic encounters when working with a non-speaking child. My aim is to show you how infant observation will help you move beyond the symptom of the young person's not-speaking to understanding the child's *communication without words*. As Bryan Lask suggested in Chapter One, the child is not silent, he is simply not speaking!

I shall proceed by sharing brief observations of five different states of minds in babies relating to members in their families. I shall then link the discussion of each baby's different infantile experiences with five different states of mind, which may be present in the non-speaking young person. There are many more feelings present in a personal encounter and I am illustrating only some states of mind commonly experienced by the non-speaking child in psychotherapy.

The first state of mind: giving up

The following observation of a five-month-old baby described in *Intimate Transformations: Babies with Their Families* (Magagna, Bakalar, Cooper, Norman, & Shank, 2005, p. 25) shows how unnoticed sibling relationships affect a "sense of self".

Infant observation one: "Anna", five months; "James", twenty-three months

Anna, five months, is sitting in mother's lap, facing out, having her bottle. She has both hands around the top of it while mother holds the end of the bottle. Her brother James comes near with Anna's dummy. Mother tells James, "Don't do that!" but James continues to push the dummy into Anna's mouth until the bottle is forced out. Anna whimpers. James climbs into mother's lap. Mother faces Anna away from her body. Anna looks stupefied with her eyes glazed over and unfocused. Her fists are tightly closed, but the rest of her body is limp. Anna remains motionless and when mother puts the bottle into Anna's mouth again, Anna doesn't suck. Milk dribbles out of her mouth. Anna rocks herself. Her eyes are still blank and unfocused as she leans back onto mother.

There are repeated sequences of James doing such things as pushing Anna off her chair, taking her toys, taking the space on mother's lap, often leaving Anna excluded from mother's care and attention. As time progresses with this going on, when Anna's mother comes to her, Anna gradually has become rigid within her own body, rather than cuddling into mother's body. Anna is hostile to mother for not protecting her from James repeated physical intrusions into her personal space and her rapport with her mother. Now her relationship with her mother is an intensely ambivalent one.

Thinking about infant observation one

In trying to understand the meaning of a non-verbal gesture, it is important to do a process recording in order to find answers to the following questions:

1. What is the sequence of interaction?
2. What do you think baby is feeling over time and how is that shown?
3. What do you think mother is feeling over time and how is that shown?
4. How do you feel witnessing this? Does it resonate with any experiences you have in your therapeutic work with a non-speaking child?

1. *Let us look at the sequence of interaction:*

James pushes the dummy into Anna's mouth and repeatedly intrudes. Mother uses verbal remonstrations, but she does not protect Anna physically from James' physical intrusions.

2. *What is Anna feeling?*

Anna is feeling unprotected and misunderstood by mother. She looks stupefied, her eyes are glazed over, and she is not focused on anything particular. Her body has lost its resilience and hangs limp. Anna moves into "blanking it out", dissociation, a kind of not thinking. She does this for *she feels helpless* to change the situation. The only thing that Anna is able to use to keep herself feeling safe is the tightness of her fingers clenching into the safety of her palms. When she goes into these dissociated states, she seems to feel: "I am not experiencing this bad experience, I am not here." Physiologically, she is developing acute hypervigilant anxiety responses, which will continue later in life.

3. *What do you observe in mother's actions and how do you think mother is feeling over time?*

Mother seems slow to protect Anna physically from the intrusion of James. It may be that mother experiences the presence of Anna as a disturbance to mother's very intimate relationship with James, her older child. Mother has difficulty identifying with Anna. Often, mother ignores Anna as mother plays and talks with James. Mother seems to lack the capacity to *simultaneously* meet the emotional needs of two very young children. One wonders how mother's internalised sibling relationships might interfere with an empathic identification with Anna.

4. *How do you feel witnessing this scene? What is your countertransference as you identify with each of the three family members?*

You might feel sorry for all three parties as well as angry with James for intruding, angry with mother for not protecting and understanding Anna's experience, and worried about Anna. Anna's passivity also involves letting go of "her fight", and all her aggression gets projected

into James. He becomes "the bully" and Anna becomes "the victim". Anna is only five months old, but she is getting cast into a "helpless victim role".

Now let us link this infant observation with therapeutic work:

The first example of a clinical encounter: the silence of "giving up"

How might this state of mind present in an older child? Often, a young person with an eating disorder starts out by fighting against medical staff and parents who are threatening their omnipotent control of anorexia nervosa. The young person starts obsessively counting calories, not eating, being extremely controlling. At a certain point, if he becomes physically ill, or he is feeling no one really understands what he is experiencing internally, or if he is separated from his parents when he lacks the inner resources of good internalised parents, which allow him to be separate from him, the young person collapses into dissociation, bodily limpness, feeling helpless to make any change in the situation, giving up, not talking, not eating, and maybe not moving at all.

A child gives up and retreats into not-speaking in the context of family relationships. For this reason, it is essential to offer family therapy to understand what is not being acknowledged emotionally and spoken about in the family. The child's non-speaking might be linked with his own or the family's *denied* feelings which can not be spoken about and have just been sensed by the young person, with no inner freedom to speak about what is being sensed. There may also be physical, sexual, or emotional abuse, but not always!

"Giving-up", non-speaking Russian "Marina", eleven years old

Here is Marina, eleven, in a family session with two younger brothers and an older sister, Josephina, fourteen, and her parents. Marina is hunched over with her long, curly black hair completely draping over her face. She has not spoken to anyone for months, nor has she eaten. She is naso-gastrically fed. Marina sits immobile in a wheelchair for she also does not walk. No one in the family answers my question: "I wonder what you are feeling being here together in hospital today?" It is clear that Marina is in "not-speaking" mode. There is silence in the family. I position a little chair right beside Marina and I ask Josephina, the older sister to sit in it. I ask Josephina to speak as Marina in the first person, and I ask her, "What might be the matter?" Josephina says, "I am frightened. I don't want to be in hospital away from my family. I want more time together with my mother. I am worried about her."

I then ask mother to "be Marina" by sitting next to her in the little chair. I ask, mother, "being Marina, what else are you worried about?" Mother replies, as Marina, "My brothers are rough. They hit me sometimes when they are cross with me. It hurts." Mother looks very sad as she speaks for her eleven-year-old daughter Marina. I ask mother, who is still speaking "in the role of Marina", "Does your mother know any other reasons for your hiding away?" Mother, being Marina, says, "I am frightened."

Mother starts crying and wiping away her tears. I gently say to her, "Your tears are saying something to me." Mother says, now in her own identity as mother, "I cannot cope any longer. I miss my family in Russia." Father joins in and says to me, "The family has been very sad

since the paternal grandmother has died six months ago. That is when we moved here from Russia. Everyone is missing Russia. We have to speak English here. We miss our language, our family, and our life there."

As the sessions go on for a few months, the older sister, Josephina, bravely describes how her father drinks, gets furious with mother for not disciplining the children, shouts, hits when he loses his temper, and throws plates around.

Father defiantly says, "They need some rules. The children are all running wild, they are spoiled by mother who buys them a lot of things and doesn't discipline them." Mother is twenty years younger than her husband. She treats him like the parent and feels bullied by him, aligning herself with the children against the "bullying father". Father feels responsible for everyone in the family as though he is "the only parent".

What is unspoken is that the family is angry, terrified, feeling out of control, unsafe, and unhappy. The family's fear and unspoken shared sadness has been projected into the identified non-speaking child Marina. Marina is helpless and overwhelmed by the family's terror and sadness.

As I reflect on the pervasively refusing not eating, walking, speaking children who have given up hope, I become aware of intergenerational silences, family silences, the child's denial and the child's dissociation, withdrawal from unbearable pain, and retreat from "family secrets". Here are just a few of the family relationships which seem to be present when a child retreats from thinking. These family situations, if they are not accompanied by thinking, talking and dealing with what is going on, can drive a child into a retreat from the spoken word:

1. The grandfather has witnessed his Lithuanian Jewish family being murdered in front of his eyes, but has never spoken about it. The family style is to be strong, not speak about pain, and not talk about difficulties, for discussions regarding psychological or physical pain and/or difficulties might upset family members.
2. The mother in an Arabic family is being beaten by the father's mates, but the family can't talk about it because they are afraid of what father will do to them and afraid of losing any financial support to have a roof over their head. The non-speaking child finally lets me know.
3. There is severe bullying by the older boys and also by the American father in the family, but the mother and her non-speaking, anorectic daughter at times deny it. At times they are simply too afraid to speak about it, for fear dad will return to the United States and leave the family completely.
4. More commonly, there is depression in the parents accompanied by severe denial and fear of the painful emotional issues that the non-speaking child may be facing. The parents' transgenerational conflicts have led to weakened internal psychic structures, and it feels "just too much" for the parents to acknowledge how they are not understanding their non-speaking child's emotional needs. Denial and/or lack of resolution of intense conflictual feelings is often the family context in which a child stops speaking.
5. The identified patient knows about the homosexual or heterosexual affairs of the father and/or mother and does not speak, not just about this, but about all sorts of aspects of his family's

conflicts and unhappiness. Hiding painful issues from awareness, "not thinking about them" and using "distraction" gradually become a forceful eradicating mechanism, through which the child can lose parts of his capacity to be mindful and ability to speak about emotional experiences.

When the family has no system of interaction which involves holding feelings of family members, trying to make sense of them and speaking together about them, there develops an overload of overwhelming feelings, which drown the identified non-speaking child. One non-speaking anorectic young person living in a family in which all members relied on manic denial of feelings to cope said finally, "Inside I felt like the toilet pipes were bursting. I felt I was going crazy. Then I stopped eating, I turned away from others, my family, my friends." For her, there was a sense of accumulating traumatic, destructive experiences with no inner psychic structure, but also no family mentalizing structure to facilitate bearing, understanding, and putting a stop to destructive emotional interactions in her shouting, quarrelling family.

When they were young adults, some formerly not speaking, not eating, not walking (pervasively retreating) children contacted me. They made me aware that we were required to find a way of gaining a much deeper understanding of the family dynamics, involving the child in a retreat into helplessness and not speaking, walking, or eating. This was always so difficult when no one seemed able to speak about "the issues", which sometimes weren't fully apparent to anyone in the family.

In particular, the young people who came to talk to me as adults let me know that the mental health of the parents and siblings involving emotional neglect, abuse and violence, and sibling bullying seemed to be underemphasised when they had been inpatients. Often, we had been aware of these issues, but not aware of how ongoing and severe they were because all family members were "not speaking" to avoid family break-up, the prospect of which felt even worse than what they were currently experiencing. Some families of non-speaking children did break up, and some of these children went to boarding school, which was felt to better meet their best interests, even though the full details of their family situation had not been revealed.

Some children who originally did not talk, walk, or eat after they recovered from their illness went on to live quite happy, productive, normal lives. Not *all* the families of these non-speaking children had severe difficulties, and it remains a mystery as to why these particular children found it so difficult to stay connected to life. Perhaps "not talking" about things, because of a difficulty in bearing psychic pain and conflict, simply left them overwhelmed and drowned by unbearable feelings.

However, the child who "gives up" and feels "dead-alive" has *sometimes* experienced trauma from projections from the family or external people as well as having the internal trauma of being overwhelmed with feelings. Such a child has inadequate inner psychic apparatus (mentalizing, internalised parents) to think about the feelings and work out solutions to the difficulties which the child is facing. The non-speaking child often has feelings that cannot be symbolised, verbalised, described to others, or mastered.

There are major limitations to what can be achieved relying solely on ordinary verbal communication with such a child. The first therapeutic work involves receiving projections of the child's states of mind; holding the feelings inside oneself, trying to puzzle over the feelings and bodily experiences one has, giving the feelings some words or a drawing, and then thinking about what the child is feeling. Sometimes the clinician, as well as the child, might find it helpful to use drawings, sculptures, sand-tray representations, music, and later writing stories and poetry to process experiences in a therapeutic encounter.

The second state of mind: the silence of "I am afraid of being here - keep away!"

Showing a negative reaction rather than being passive and not emotionally present to external life is a sign of a self remaining emotionally intact. A fearful or angry flinch away from a therapist is progress from unfocused dissociation, for there is still hope that both the child and the therapist can notice and change something in the fearful situation.

Here is an example of a negative reaction, which is a sign of a mind facing a persecutory experience rather than denying it:

Infant observation two: "Tom", three and a half months

Mother anxiously holds the baby. Immediately, each time mother shows baby the bottle, he looks at it as though he doesn't recognise it. He then becomes serious as he looks at his hand and rotates it in front of his eyes. Then, with his left hand, he grasps his right wrist and brings his fist to his mouth. Saliva bubbles are coming out of his mouth. Baby then sucks his tightly closed fist. For six or seven times, mother takes baby's hand from his mouth to try to insert the bottle. Baby immediately puts his hand back in his mouth. Mother pushes the baby's hand away and inserts the teat of the bottle. Baby sucks once and spits out the teat. Each time this sequence is repeated, mother becomes increasingly insistent as she firmly presses the bottle hard into baby's mouth.

Baby grasps the bottle with both hands, pushes it away, and spits out all the milk from his mouth. Mother becomes more nervy, forceful, and angry as baby becomes increasingly strong-willed in rejecting both the bottle and mother. Baby vomits the milk, returns to sucking his thumb, looking away from mother, with his other fingers tightly clenched, near his chest.

(Magagna, 2002, p. 137)

What is important in processing this infant observation is to observe the specific sequence of interaction and put oneself in the shoes of each person in the interaction. Asking questions about one's emotional experience while observing deepens and more fully elucidates the observational process.

Thinking about infant observation two

1. What is the sequence of interaction?
2. What do you think baby is feeling over time and how is that shown?
3. What do you think mother is feeling over time, and how is that shown?
4. How do you feel witnessing this; does it resonate with any experiences in your work with a non-speaking child?

1. *Let us look at the sequence of interaction:*

The bottle is threatening. The baby retreats to the blockading thumb as a primitive protection against the anxiety. Mother takes away baby's self-protecting thumb used to armour himself against the persecutory bottle/mother.

2. *Can we now empathically identify with the baby?*

The baby is persecuted. He is frightened of the bottle's entry into his mouth. It has become bad through circumstances which we don't understand. He is turning to his own system of defence, putting his thumb in his mouth, clenching his fist, tightly closing his eyes. This is his armour to protect him from the anxiety of the horrible bottle.

3. *Can we understand now how it feels to be baby's mother?*

Mother is panicked because of her need to keep the baby alive through food.

She is not able to identify with the baby's persecution because she is so worried about what she is not doing; feeding him.

Mother becomes angry and frustrated because of her sense of impotence.

Mother then becomes controlling and intrusive. She is not able to think, not able to talk to the baby, not able to experience how threatened the baby feels if she takes away his thumb or inserts the bottle into his mouth.

Mother ultimately is feeling terribly persecuted by the baby who is refusing what she is giving him for him to remain alive!

4. *What is your experience in witnessing this, and does it remind you of any experiences in your therapeutic work with a non-speaking child?*

The experience of observing mother and child interacting like this is very upsetting.

If you are identified with the baby, you can get angry with the mother for being so intrusive.

If you are identified with the mother who is feeling so impotent, you can also get "fed up" with the baby. The anger can interfere with understanding the sense of persecution in both an impotent mother and a frightened baby who has lost a sense of the goodness in his relationship with the food/the mother.

The second example of a clinical encounter: "Keep away!"

A similar kind of scenario often occurs when parents first bring a non-speaking, non-eating child to an inpatient unit. Terror can also occur when a pervasively retreating child begins to again be *mindfully present* to his own feelings, from which he has previously been dissociated.

Our task with the non-speaking child gesturing through recoiling her body and turning away her glance that we should "keep away" is to understand the experience *both* in oneself and in the young person. We must understand the young person's transference to the therapist, and therapist's countertransference to the young person, just as we did in the previous uncomfortable baby-mother feeding interaction.

Then we have to think of:

1. Identifying with the young person's transference.
2. Understanding our countertransference; how we feel at that moment.
3. Thinking about how we speak.
4. Thinking about where we should locate the feeling: *in us or in the young person?*
5. Thinking about the feelings that are existing in each person in the encounter.

"Keep away" gestures of silent "Jane", fourteen years old

Jane wasn't told that she was being admitted into the inpatient unit. Her parents were afraid of what she would do if she knew beforehand. When Jane came with a strong, defiant stride into the therapy room, she averted her gaze and went to the window, where she stood with her back firmly positioned to keep me out. Her face, covered with long, blond hair, was invisible throughout the session as she looked out of the window.

"We need to find some quiet space within ourselves to understand the child, before we 'do' anything verbally. If we speak before we feel, the child becomes disturbed". (Dosamantes, 1992, p. 362).

1. *What is Jane saying?*

"Keep out! I don't want you to get in! I want to be out of here!" Her firm stride, her back to me, looking out of the window, indicate: "get out!"

2. *What is the therapist supposed to feel?*

I am to feel the rejected one, the pushed-out one. Jane is projecting into me "the bad unwanted feelings".

3. *Where should the therapist locate the feeling; in Jane or in the therapist?*

Like the baby who didn't want the bottle in his mouth, Jane is not wanting me to talk about the feelings *inside her*. She doesn't want me to come closer, she wants to push me out. For this reason, the interpretation has to be about feelings outside her, what John Steiner (1993) calls, "therapist-centred interpretations", which *locate feelings first in the therapist* and only later within child when the child has the capacity to think about feelings inside her.

What could we say? I am not wanted here. I should leave her alone and not offer this time to think with me. Could I say, "I should 'let you out' of this place that feels like a prison, keeping you here for 50 minutes?"

4. *How should the therapist speak?*

Jane is being firm, with her hard back pushing me away. When I speak, I need to keep attuned to the strength of her emotions as she "shuts the door" on this unwanted me.

5. Jane is feeling persecuted and rejecting my overtures, and I am feeling "no good" and that nothing I say will feel good to her at this moment. I can just understand that is how she feels.

Jane's protective, blockading thumb consisting of not speaking, not eating; keeping her hard back facing me represents her way of keeping away what she experiences as intrusive: a therapist trying to understand how she feels. Understanding threatens Jane's own protective armour of denial, of not-thinking about difficult emotions.

Jane had difficulty in sleeping, but had no access to her dreams. Jane was lonely underneath, but had no access to words for her emotions. Jane's body was cold, tired, but she seemed to have no sensation of heat, cold, or tiredness. She was in the armour, which was firm in relation to me, but also the armour separated her from her own vulnerable, emotional self underneath. She was using *primitive omnipotence* (Bick, 1968) as her protection, for she was insecurely attached to her mother and lacked internal mentalizing parents. For this reason, she was terrified that therapeutic understanding was going to "crack" her self-protective armour—all that she had to keep safe!

This understanding is all based on *countertransference*: the feelings I listen to silently within myself until I know what I feel inside while with her. I then need to consider what feelings I am holding in projected form for Jane and what feelings belong to me. I need to be firm in my voice because she is in her "soldier self" armoured against me. Work with the non-speaking child isn't about asking a lot of questions, for an unwilling child will feel that questions are intrusive. The task is to ask questions about what *you as a therapist* feel. The task is also to ask what is projected into you as the therapist at this moment. Therapy involves listening to the music of your soul.

What is healthy about this situation? Jane is struggling against that which persecutes her. She is putting up a fight. She *hasn't given up* trying to protect herself! Believe it or not, that is a strength. She still has some hope that she might get things working with people the way she thinks they should work, or she wouldn't be fighting. Passivity, when the child feels limp and helpless, is much more worrying!

This is what one can typically receive from frightened people newly admitted to an inpatient unit. They have had some difficult experiences or they wouldn't have stopped eating and wouldn't stop speaking in the session at this point. "I shouldn't be here..... my parents are the ones who have a problem. They think I have anorexia nervosa. They are just trying to make me fat." This would be what Jane might be saying if she were speaking rather than not-speaking to me. She said this later in the therapy. Jane was experiencing what a motivational therapist would call a *phase of denial*.

But wait a minute! If you take these statements metaphorically, perhaps it is true that the child's psyche is being saturated with undigested intergenerational conflicts, and conflicts of the immediate external family and her own internalised family. This is partly what is responsible for making her feel fat and visually perceive herself to be fat.

The third state of mind: silently using adhesive identification which can involve holding onto physical sensation, muscular rigidity, or the sameness of an object in lieu of having

an internal space to contain emotions

Third infant observation: Baby Eric, four months

"Baby Eric is lying on mother's lap. She isn't holding him firmly and in response to this lack of holding baby stiffens his body and back with his head pushing back. His back and neck are stiffly arched over mother's legs... Stiffening of musculature is baby's way of trying to make a stiff, holding container for himself with all the energy he can mobilize... At other times a colourful, striped, jump-suit, which always hangs nearby, is often used when baby is not 'emotionally held' by mother. He stares at it intently, 'holding on to it' with his eyes" (Magagna, 2002, p. 85).

These behaviours are described as using adhesive identification measures in lieu of a secure internal or external mother being present at that moment.

Holding the lips together and tightening of the stomach and body musculature are required when the infant is terrified and cannot trust the mother to attend to him. Spitz (1965) noted that babies in hospital who were nourished but did not have a primary caregiver attending to their psychological needs stopped crying and later died. Tightening of the lips, muscular rigidity, holding onto a physical sensation or an object is thought of as *adhesive identification* (Bick, 1968), which is used in lieu of both physical holding and psychological containment by the mother and/or an internal mental structure to contain emotions. Sometimes parts of the body get frozen in an extended period of muscular tightness and physical pain. The muscular contractions can cause both a feeling of paralysis and actual physical impairment to mobility.

The mouth is the bridge between internal experience and the outside world represented by mother. When the link with the mother is broken, the bridge to her, the mouth, stops opening to let out cries, sounds, or words for her (Rhode, 1997, p. 17). The mouth may remain closed with the lips adhesively stuck together, for to open the mouth can bring fear of everything, all of the self, falling out. Opening the mouth may bring the fear of crying and never stopping. Opening the mouth may also bring the fear of becoming trapped in emotional overload without any internal psychic structure for reflective functioning.

A mother who often fails to respond to a baby's cries can contribute to a child having an insecure attachment to her. The child will then stop crying for mother when in need of her. When a child expects to be understood, words can feel like a way of getting through emotionally and eliciting a response. When the expectation of mother's understanding is weak, words can feel like something that is concretely lost from the mouth, like losing a part of the self into the void. The lips adhere to one another as a protection, as a means of control to survive psychologically without falling apart.

The third example of a clinical encounter: using adhesive identification

Silent "Lara", aged fifteen, using adhesive identification to hold herself together emotionally

For several months, Lara, who was suffering from anorexia nervosa, was silent. Later on in her sessions, she cried out in pain. She had been suffering for two years from an abdominal pain for which the doctors could find no cause. She no longer walked because the pain was so

severe. Upon admission, she whispered to her mother that she did not want to talk to anyone because in her year-long previous hospitalisation, everyone kept saying her physical pain was not real. Feeling terribly disappointed that no one understood her, Lara stopped talking completely.

In the sessions when she started crying, she paused in her crying only sometimes, in order to hear my words. I stayed with Lara's crying about her pain rather than trying to explain it was nothing. Sitting alongside her, rather than facing her, I echoed her cries, taking care to pace and attune my cries in a way that matched her cries. Subsequently, I spoke in the first person, "No one understands me. Jeanne doesn't understand me. I am in too much pain to talk. The pain hurts so much it takes over my mind. Please understand how much it hurts inside."

As the sessions went on, I would create stories about "the pain" using made-up characters, talking about the hatred of the non-understanding therapist, the non-understanding doctors. I accepted the physical pain and how it felt to be overwhelmed by it. I was aware of a shared family system of denial of psychic pain. It was particularly obvious that Lara's mother would deny pain or get too upset if she acknowledged problems. I was also aware that I needed to accept the *pain as physical*, regardless of any medical diagnosis. Lara's soul was breathing through her body. Her body was reflecting the pain.

Gradually Lara used eye-blinking to signal to me. Later, she began moving her head to signal yes or no to my aspects of my conversation with her. She was like a strict teacher firmly signalling to me if I "got it right" or "got it wrong". Much later, when she found words again, Lara described her hallucination of a man's voice coming through a door and her nightmare of being stolen by a man and taken away from her home.

In a series of instances of non-speaking young people, holding onto a physical pain of an earache, a headache, a sore leg, seem to be unconscious protections against becoming conscious again of anxieties of a terrifying psychotic nature. Adhering to a physical pain can be a protection against losing one's mind!

Through my work with Lara, I have thought more about the infant left alone in her bedroom while the parental couple share a night together. The baby cries with the anguish of being separate from mother or separate from father and is jealous of the couple's togetherness. Also, the baby's body, if the baby is left to cry for some time, suffers the pain of physiological responses to prolonged panic and crying. This pain at a physiological level seemed to be re-experienced in the session and requires therapeutic containment through feeling the young person's terror prior to transformation from physical pain held onto adhesively in lieu of an inner psychic structure for mentalization to take place. Later, the physical pain became transformed into symbols of psychological issues. Much later, it was possible to talk to Lara about her psychic pain that had contributed to her unconscious retreat into illness.

In the hours spent with the non-speaking Lara, I continue exploring what is happening inside her and inside me. I imagine that somewhere there is a wish for a regeneration of a silent, encrusted part of my infantile self and of Lara, that has never been spoken to, never been heard. Somehow Lara, myself, and every human being probably entertains a wish for a dialogue with the encapsulated part of the personality, a part of the personality deeply buried in the unconscious that is isolated, lonely, and out of communication with both the conscious self and the unconscious dreaming self.

The fourth state of mind: the silence filled with hatred and subsequent persecution

Bowlby's book *Attachment and Loss* (1969) is essential reading to carefully distinguish the non-speaking child's sense of being persecuted by the therapist from the non-speaking child's hatred and rage towards the therapist. A therapist new to a child may be experienced as threatening to his defensive armour. The two phenomenon hatred and persecution are often confused because the child's hatred to the therapist creates a "bad therapist" who is then persecutory to the child. Hatred and persecution require disentangling through observation of gestures and body postures as well as through noting one's countertransference experiences. First, though, let us look at an infant observation where the child begins to experience anger, rage, hatred towards the mother, followed by a sense of persecution.

Infant observation four: "John", eighteen months old

This is an observation made by the Robertsons (1971): John, whose caring parents were having another baby, placed him for nine days in a residential unit. The nurses were young and friendly, but the system of group care does not allow any one of them to substitute for the absent mother. John tries hard to make a relationship with the matron to get the comfort he needs, but he is defeated in getting her attention, and he becomes increasingly distressed. The nursery nurse's work pattern prevents John's individual needs for substitute mothering from being met. He becomes upset and tearful. Then for a few days, he begins crying in a very strong, protesting way. The staff are used to crying children and don't respond to his cries. Their philosophy is that John will cry less if they respond in this way. He is angry with his absent mother, for she has left him and he is not protected from the attacks by the other children. Gradually, he becomes hopeless, listless, and depressed. When the mother returns, she feels a stranger to John. Mother has turned into a persecutory figure for she has been filled with all John's projections of panic, rage, and hostility towards her for leaving him in this unknown place, with unknown caregivers, in an unprotected situation. When mother says hello to John for the first time, he hostilely turns away from her. She feels rejected, for she has become John's persecutory mother, now perceived as a "bad object" filled with his bad projections of hostility.

Hostility to mother turns mother into a dead mother filled with bad 'stuff' of hostility. The mother has not been kept alive as a good mother inside. A child has to have a good and strong mother present, internally and/or externally capable of bearing hostility. When the internalised mother and external mother is uncaring, weak, or filled with too many projections of hostility, she is no longer a good mother; instead, she is a bad object. It will take some time for John to return his mother-in-his-mind into being a good mother who can accept his anger and hatred for leaving him alone and unprotected in the strange situation.

The fourth clinical encounter: The silence filled with hatred and subsequent persecution

Hatred and rage usually occur in therapy after the young person is less dependent on primitive protections against anxiety, such as omnipotently controlling intake through vomiting or starving or self-harming. Pseudo-independence is reflected in states of mind suggesting, "I can take care of myself, I don't need anyone else." Hatred and rage emerge when there is a grow-

ing dependence on the therapist and the therapist's reflective functioning offered to the young person.

Sixteen-year-old "Hanna"

Hanna came to the UK with her American family while her father was on a university sabbatical. She has long, dark, unruly hair. After six months of virtual silence accompanied by crying in therapy, Hanna is beginning to depend on me. Just before my frequently discussed two-week holiday, she says, "If I were really courageous I would really bloody myself." She adds, "How can I make anyone take care of me if I am not ill?"

When I return from holiday, Hanna is furious with me. She walks into the first session with her head down and hands clenched; she immediately walks out of the therapy room and does not return. She refuses to come to the second session. When Hanna arrived on the third session after my break, she does not meet my glance when I greet her, nor does she respond to my hello. She is silent for a very long time.

What can I do? I can interpret the need for safe space, a bodily position to hold herself together. With her body and her fingers tightly curled up, she feels better. I can acknowledge Hanna's sense that there is a split between her body felt as safe and the outside world, represented by me, felt as bad. On the other hand, I could create a story, sometimes with dolls or animal families, not speaking to her directly but rather to myself, so she won't feel intruded upon. She can feel free to be curious about what I say. She can choose to listen or not listen. She can think or not think with me. Creating a story to the side of her allows her to feel she has "to search me out" rather than feeling I am pushing my thoughts into her mind.

Despite Hanna's persecution, hatred and rage, a question is again being asked of me. She is asking, "Can you understand me?" Compassionately comprehending Hanna means that I must meet at least these six requirements:

First, I must pay rapt attention to the bodily experiences of both the young person and myself. This involves the following:

- Rapt attention to what I observe concretely, such as asking myself about the direction and feel of her eyes looking: Hanna's eyes are turned away from my gaze.
- Rapt attention to what Hanna's hands are telling me. For example, they may be tightly clenched, extended in tight musculature, spread out like spider legs, hurting each other, picking on nails, fidgeting on a mole, spot or pulling on the hair. In fact, Hanna's hands were tightly clenched.
- Rapt attention to what her feet are telling me. They may be tightly intertwined with one another, tapping the floor, kicking quietly outwards, holding toes clenched, while pressing them tightly onto the floor. Hanna's feet were pressing tightly against the floor, as though she were holding herself together psychologically by sticking to the floor in an adhesive way (Bick, 1968).

- Rapt attention to her breathing. For example, there could be relaxed breathing linked with sadistic phantasies of attacking someone, there could be constrained breathing trying to hold the rage in. Both Hanna and I were experiencing a shallow kind of breathing reflecting anxiety.
- Rapt attention to the tightened musculature used to hold Hanna's body firmly. I noticed that Hanna's muscular rigidity created an impression of an ice sculpture. There could also be aching pain in her body due to the muscular rigidity.
- Rapt attention to fluctuation of her bodily states and to the moments in our non-verbal/verbal dialogue when the fluctuation occurred.

Second, I must tolerate the frustration of not-knowing and not understanding. I must bear the frustration of feeling ineffective.

Third, despite the aggression in the room I must strive to be compassionately present, empathic and non-critical towards the feelings emanating from myself and Hanna in that present moment. That is the only way that I will lessen the cruelty of the harsh superego punishing Hanna by creating symptoms and guilt.

Fourth, I must make a decision to speak or not speak about the gradually forming thoughts about the present moment with Hanna.

Fifth, it is important that I accept that unprocessed anguish and suffering have contributed to a broken symbolisation and a broken verbal bridge to me. Hanna's missing the sessions is a form of *acting out* what couldn't be put into symbolic thought.

Sixth, and most importantly, Hanna has a right to be alone with her feelings. Only when Hanna feels sufficiently held together internally and trusts me will there be a sharing of the encrusted hidden parts of Hanna's self which require understanding, regardless of whether or not there is verbal conversation.

What could I do and what did I do in this situation?

I tentatively told Hanna a story of our time together before the break. I mentioned how she had felt she could count on me a little. I also described how she had also told me that she wanted to bloody herself before I left for holiday. I wonder if she was in a rage with me for leaving her just when she had thought I might understand and help her.

Hanna remains silent and immobile as though she hasn't heard a single word.

I then say it has been difficult for her to come back to see me. I suggest that she has struggling with the temptation to run away from me, but she came to the session. I add, "Even though you are here, you and I are confronted with these feelings, whatever they may be."

You may notice, I am not asking questions. I am making a tentative running commentary which implies curiosity and allows the possibility for Hanna entering the conversation through listening, thinking, feeling or words.

Near the end of the session Hanna haltingly decides to speak with me in a voice which is aggressively chopped up so that it is virtually mute. Hanna mumbles, "I feel really bad about myself. I have a very angry, nasty side." She, her parents and two brothers

have all been involved in hitting one another. "I am worried everyone will reject me for having it."

Hanna adds, "You feel different to me now you have come back. I don't like you. I don't like feeling I dislike you so much. You have become a stranger to me. Before I thought you liked me, but now I feel you don't like me."

I wait briefly and then suggest, "Maybe you have been very angry with me. You hated me for leaving you". I tentatively wonder, "It could be that now I am filled with your hostility. It feels to me that the hostility now in me is boomeranging back at you."

Hanna replies, "I felt like slapping you. I can't imagine that you can feel me disliking you and not dislike me." (Dislike is a mild word for her hostility!)

As I reflect upon this session, I realise that not coming for therapy, not speaking with me may have been Hanna's only way of modulating her out-of-control, violent feelings.

I discover subsequently that Hanna had filled the holiday by watching violent and sadistic films; one safe outlet for her aggression. Over time I realise that a very uncomfortable silence accompanies Hanna's hatred and rage when she feels completely misunderstood by me, or criticised by me. On these occasions, I again puzzle over my countertransference and talk about what has happened in these moments between us just before Hanna abandoned a verbal interchange with me. I mull over possibilities aloud to myself, wondering if I have understood anything about the hostile silence.

Alan Schore (2002a) suggests that the therapist's own bodily sensations in the therapeutic encounter are needed to provide a deepening of empathic connection with the child. The therapist's body is especially involved in the reception of transference projections of split-off parts of the self. Schore agrees that in order to transform the child's distress, the therapist must go beyond mirroring. More than the clinician's verbalisations it is his/her non-verbal activity, the bodily and emotional containment by the therapist of the child's projected and disavowed experience that needs to precede verbal processing (Dosamantes, 1992, p. 362). It could be argued that these spontaneous, emotional pre-attunements constitute a conversation between the limbic systems of child and therapist. The pre-attunement experiences create a safe holding environment promoting transformation of the personality (Hadiks, 1994).

I shall now describe another experience that has happened with several young people, including this time with Hanna.

Hanna is sitting with her head in her hands at the beginning of the session. I feel physically drained of life and then gradually become aware of a pervasive pain in my face. It is as though I have been and am still being battered. I use this experience to describe how there is something that seems to be battering the life out of this experience. Using third-person descriptions of an experience present in the room, I go on to describe how there is some pain, some lifelessness here.

After a very long silence, Hanna describes being assailed by inner thoughts saying, "You shouldn't talk to her, it's all useless, nothing will change. You shouldn't eat, you can't gain weight, you are horrible, you are just fat, that is all!" She reports this event factually with no

flicker of desire to challenge these thoughts. She is flattened. It is I who has to struggle to come to life, to release life from deadness, to feel her aggression against her life in therapy, against my work.

At times, I wonder if part of what is also essential for transformation through projective identification is my seeing Hanna's facial expressions of hopelessness, despair, terror, disgust, shame, excitement and rage, and her seeing my facial responses to her. I recognise Hanna's emotional state by seeing and experiencing her bodily and facially expressed, non-verbalised affective expressions. It is this seeing, receiving and responding to Hanna's non-symbolised emotional state, which is a central therapeutic component of the non-verbal communication in therapy.

The fifth state of mind: the silent loving communion between the child and the therapist

The therapist should enable the child who arrives to the session disgruntled like a lion to depart like a contented lamb.

(Meltzer, 1984)

Infant observation five: "Eric", one month old

I observe Baby Eric, one month old, sucking mother's nipple calmly while looking first into mother's face and then more directly at her eyes. The rest of his body is very still, with his arm resting against his waist. He moves his hand along mother's blouse, holding on it momentarily. He glides along mother's breast with his fingers. After a while, he stops sucking and he looks up at mother's eyes in a more intimate, attentive way than before. Then he smiles, and mother says he enjoys staying awake for much longer periods now.

By four months, you can see that the pleasure of being deeply understood fosters an ordinary dialogue as part of the mother-baby relationship. I observed Baby Eric when mother was talking with him. He takes his fingers out of his mouth, breaks into a smile and then a laugh, with a kind of "goo-aah-hi" series of sounds. He becomes more excited as he waves his hand in a flopping motion. As mother talks to him, he makes more sounds (Magagna, 2002, p. 86).

The fifth example of a clinical encounter: the silence in a more loving communion

Once the protective defences against intimacy have been lessened, the pleasure of being deeply understood creates in the young person in therapy the possibility of a similar psychological growth and happiness to what was experienced by baby Eric in his loving relationship with his mother.

Sixteen-year-old "Hanna"

Hanna had not spoken to staff, family, or me for several months of her admission to the inpatient unit. She had lived a kind of masochistic experience of life without any point. She didn't

talk for, in her words, "There was no point". When she did talk, she said she just wanted to run away from her life, but there was nowhere to run. Her family situation was very difficult indeed, and she spent a lot of time crying and saying she had had too much, she was worn out, she couldn't live.

At the end of her inpatient admission, Hanna said, "I hate to admit this, but this has been the best experience of my life." It seemed most appropriate to sit quietly together while meditating on Hanna's experience of the pleasure of being understood.

The psychotherapeutic experience requires some silence—silence for meaning to emerge and silence for meaningful insights to seep profoundly into the psyche.

T. S. Eliot in his *Four Quartets* (1940) helps us to understand when he says:

I said to my soul, be still, and wait without hope.
For hope would be hope for the wrong thing: there is yet faith
But the faith and the love and the hope are all in the waiting
Wait without thought, for you are not ready for thought:
So the darkness shall become the light ...

We must be still and still moving
Into another intensity
For a further union, a deeper communion.

(T. S. Eliott, 1940, pp. 123–129)

Conclusion

I have drawn the links between observing an infant with a mother, and therapeutic work with the infantile and mature parts of the non-speaking young person.

Five of the states of mind which may underlie silence have been illustrated: first, giving up; second, being afraid; third, silently using adhesive identification; fourth, feeling hatred and rage; and fifth, experiencing a loving, understanding and deep resonance with the other.

Most importantly, I have emphasised the importance of linking the internalised family relationships of the young person with the external context: the inpatient dynamics, the unspoken issues in the family, and the family's system of communication, as well as sibling, school, and peer dynamics.

Lastly, I have described how the therapeutic person's task is to be fully present to one's deep emotional and bodily experiences, one's countertransferences. Being with the child involves rapt attention to every nuance of the communication between child and therapist.

In each moment of your therapeutic encounter, a question is being asked of you. When the child is not speaking to you, *even more* is being asked of you. You are being asked to transform non-symbolised, inchoate experiences into thoughts suitable for shared understanding to emerge.

PART II

YOUNG CHILDREN