

STUCK CASES:

Understanding the experience of children, families and clinicians in a child and adolescent mental health setting when the helping relationship becomes stuck.

Andrew J Dawson
UEL 0436577

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STUCK CASES: Understanding the experience of children, families and clinicians in a child and adolescent mental health setting when the helping relationship becomes stuck.

ABSTRACT

Stuck cases in multi-disciplinary Child and Adolescent Mental Health Services occur when families attend for help but something in the helping process becomes a problem in itself, to the detriment of the child and the distress of parents and professionals alike. This research reviews the psychoanalytic literature in relation to stuckness and impasse and then samples the systemic literature, drawing comparison between them both. The literature review reveals that the study of stuckness has led to theoretical and technical developments in both fields. The thesis goes into detail to consider the appropriate methodology for studying stuck cases in a way that is robust and allows for the interviewer to use their psychoanalytic training in a reflexive way as a strength in the process and details the reasons for choosing constructivist grounded theory. The research itself is based on twelve intensive interviews with CAMHS staff from a range of disciplines in the Greater Glasgow and Clyde area. The research aimed to interview families too and there is a detailed discussion of ethical reasons which meant this was not viable in this study. The interviews with clinicians highlighted the close links between stuck cases and trauma, addiction, parental mental health problems, and psychological maltreatment of the child. The analysis of the interviews demonstrated that in every case there was a great deal of unconscious or unprocessed communication from the family that impacted on the progress of the treatment. Further study of the nature of the cases allowed for warning signs to be identified that can be used to alert clinicians that they should proceed cautiously. The warning signs are Taboo Subjects, Life and Death Anxieties, Blinding Trauma, Career Shaking Experiences, Compelled Care, The Insult, and a Crisis of Confidence in relation to child protection. Following on from the warning signs the research suggests that stuck situations can be conceptualized as a series of traps which follow a particular pattern. Some of these traps are possible because the clinicians want to maintain a view of themselves as helpful and benevolent, making experiences where they are dismissed or seen as malevolent particularly difficult to reflect upon. The benevolence traps are Hero to Zero, Zero, and Pandora' box where the clinician's curiosity and linking the child's problems to other family factors is seen as catastrophic. Other traps are described as professional traps as they involve services, teams or belief systems and these include Evidence Based Traps, Logic Traps, Professional Isolation, and the Parent Trap. The final trap is described as a Loyalty Trap and explores the anxious nature of the relationships in the families of stuck cases and how the child may be put in a cruel position of having to choose between the clinician's view of the problem and the family's view of the problem. Although the family view may be causing and prolonging the distress of the child, it is argued that the child will invariably choose the family view. This is conceptualized as Loyalty to the Toxic Breast. The research ends by recommending developments in CAMHS and across agencies in relation to training, support, team work, supervision, consultation and the management of psychological maltreatment of children in stuck cases.

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INTRODUCTION

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The experience of 'getting stuck' with a piece of work is a common one. In primary school children are encouraged to try to solve problems themselves and if they need extra help then to ask the teacher. When properly handled this can be a developmental experience as the child asks for help, receives help, learns something about the task but also learns that the helping relationship is responsive and trustworthy. Psychoanalytically this may be conceptualized as containment (Bion, 1962a) where the adult carer allows the child to work within his own limits (his tolerance for frustration) and assists before the experience becomes overwhelming. The prototype for this is after birth and at times of crisis when the mother enters a particular state of attunement with the infant where she has a heightened sensitivity to the child's anxieties. If things go well enough by the mother calming the infant, then the infant learns how to manage frustrations, how to interact with others and at the same time learns that the object of his communication is trustworthy, responsive and essentially helpful. Bion (1962a) suggested that as well as having an experience of being thought about, the child also takes in a little of the capacity to think.

In the late 1980s and early 1990s I was working as a dramatherapist and was part of a consultation group for Arts Therapists who wanted to discuss their work with a Child Psychotherapist. I found this extremely interesting and felt that it added depth and meaning to my work. The sessions allowed me to reflect on many difficult and stressful work experiences and I thought it improved my practice through improving my observational skills and facilitating reflective practice.

Some years later I had my first real experience of what I would describe as a 'stuck case', rather than a difficult case. While working with a group of young people with severe

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mental health problems I encountered a teenager who seemed to take pleasure from ‘rubbishing’ the sessions from within the drama and in the reflective space at the end of the session. I thought this young person manipulated the others during the drama to make it contain shocking sexual references, traumatic experiences and scenes that were embarrassing to others but particularly designed to be embarrassing to me. The young person managed to do this in a way that ‘sabotaged’ my working methods. By this I mean that the young person was essentially doing what I would want a group member to do: Turning up, joining in, expressing disturbance within the given activity rather than acting out, and the young person was able to reflect on the experience in the reflective part of the session. The problem for me was that I felt that the structures I provided did not contain the anxieties or offer a different experience, I felt that the material of the drama was so disturbing that it was actually damaging to the other group members to take part in it, and I felt that when the young person rubbished the session during the talking time it was me and the other people in the group who were being rubbished. I felt that the group was so intolerable that no one would want to come back, including me. The puzzling thing was that everyone in the group did turn up, week after week, and the same experience was repeated.

In response to this experience I arranged an individual consultation with a Child Psychotherapist who gave me an opportunity to examine the work in fine detail, think about all aspects of the work, ask what the young people were trying to communicate, and to reflect on different ways of responding therapeutically to the individuals and to the group as a whole. In order to understand the communication it was important that the consultation offered me freedom of thought and association in relation to the group. The consultation offered what I thought was a safe enough space for me to express my feelings of ‘stress’ in relation to the group, my ‘dread’ as the time for the group approached each

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week, my hope that no one would turn up, and my feeling that while I was trying to be helpful to this group of teenagers the drama was being used to re-traumatize and shock rather than heal, and that instead of being seen as a helpful figure I was left after each session feeling that I was useless, had been tricked or spoiled, and that I had done something which was in some way traumatic or damaging rather than helpful.

At that point in my career I had been working therapeutically for six years and had been actively using the concepts of transference and counter-transference as part of my practice. The counter-transference experience I was experiencing in this instance was so intense that it had affected my ability to conceptualize what was happening. All of my energies were going on trying to contain the extremes of the emotion I was experiencing and in making sure I survived the group and kept turning up. My experience of consultation with a Child Psychotherapist provided space for reflective practice to develop, allowing me to see that the feelings I was having were a response to receiving a powerful communication from a teenager in a desperate state of mind. This young person was struggling to find a helpful therapeutic figure who could make experience more tolerable and thinkable, rather than make matters worse. When reflecting in this way it became all too obvious that I was the object of emotions that would be appropriate for this young person to have in relation to the perpetrators of the abuse and neglect which the young person had experienced. In practice this allowed me to gently draw attention to something being acted out in the sessions, I was able to point out that it didn't have to be like this in the group, and even though this young person and the whole group found themselves involved in a certain type of traumatic drama and a certain way of possibly abusive relating, other more rewarding experiences were possible. The reaction to these changes was slow but clear. The young person continued to try to shape the drama in a particular way but the other group members reacted differently, moving to a state of encouragement and slight isolation of the

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young person. I was, with some difficulty, able to maintain an open invitation for this teenager to join in. In addition to being the focus for this young person's complaints I was now able to point out in a gentle way that it was difficult to see the positive things that had happened in the session. I continued to find this young person difficult to be with and to work with but I no longer felt 'stuck'.

Overall this experience increased my interest in psychoanalytic work with very disturbed adolescents and introduced me to working at a deep level with transference and counter-transference phenomena. I had an experience of a psychoanalytic intervention sustaining me at a difficult time in my practice and providing positive developments to a piece of work with which I was 'stuck'. To my mind the consultations were successful because they provided a safe space where reflective practice was possible. This involved the Child Psychotherapist promoting freedom of thought, providing a setting in which I felt secure and could bring work in which I felt I was failing, and using psychoanalytic ideas to inform practice. I found it fascinating that psychoanalytic supervision could be useful for work that was not necessarily based on psychoanalytic ideas.

I have now trained as a Child Psychotherapist and work in a multi-disciplinary Child and Adolescent Mental Health Service (CAMHS). My work is interesting and varied with a mix of intensive and weekly work, work with parents and families, work with complex cases and a significant amount of training, consultation and supervision. In addition to a Child Psychotherapist the multi-disciplinary team includes Psychiatrists, Psychologists, Family Therapists, Nurse Therapists, a Speech and Language Therapist, an Occupational Therapist, and Social Workers. My department works closely with local schools and the local social work departments. The consultations I offer are available to staff in all the associated organizations as well as to staff within my own team. Colleagues may ask for

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consultations for a wide range of reasons: sometimes to get a psychoanalytic perspective on their formulation of a case; sometimes to have time to reflect on practice; and sometimes when they feel 'stuck' with a case.

Child psychotherapy is both an intervention and a way of thinking about working with children and young people. The consultation service I provide is for people engaged with any type of work with a child ranging from family work, to cognitive behavioural therapy, to group work, to education. Sometimes the consultation leads on to a referral for psychotherapy but usually this is when all alternative interventions have been considered. Kam and Midgely (2006:46) describe research into the process of referral for child psychotherapy and their findings are very much in tune with my clinical practice. They say

*'When trying to explain why the participants in this study made a referral at a certain point in their ongoing work with the family, they often explained this in terms of certain feelings that were in them at this stage of their own work with the family. In particular, they explained how their own feelings of being **stuck** and/or confused could be a sign that a child may be ready for some form of psychotherapy.'* [Emphasis added].

This research is intended to explore just this type of case in CAMHS, where families and clinicians both feel 'stuck' with a high level of emotional communication involved. The research will need to establish what is meant by 'stuck', whether it is the best term to use and what it implies.

Within my own service most practitioners are very experienced and are skilled in joint working. When the initial intervention is felt not to have had the results that were hoped for, most practitioners manage this by re-formulating the problem, inviting a colleague to help co-work with the case, working more closely with an outside agency such as education or social work services, or by trying to engage the family in more discussion and reflection

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in relation to the problems. An ordinary part of multi-disciplinary work is peer supervision and case discussion and this is in addition to professional line management/ supervision.

In 2005, in response to clinical demands within the CAMHS service, a colleague (Mary Long, Systemic Family Therapist) and I started a joint Child Psychotherapy and Systemic Family Therapy sub-clinic, taking referrals from CAMHS practitioners who felt stuck with cases. We used systemic techniques alongside psychoanalytic concepts to offer ways of thinking about cases where families were having a high emotional impact on the clinician and the work was not progressing to anyone's satisfaction. We discovered that often there was an intolerable power relationship between the clinician and the parents of the child referred and the parents often did not trust the clinician. From a psychoanalytic point of view we wondered if the stuck intervention was beyond this family's tolerance for frustration as they were firmly holding onto an intense negative transference to the clinicians they had encountered. As a group of staff we agreed to change our approach to these families by developing interventions that shifted the power balance. This would involve me as a Psychoanalytic Psychotherapist working with psychoanalytic concepts and with family therapy techniques in a way that was only possible with a close collaborative relationship with the Systemic Family Therapist. To start the work of the joint clinic, instead of asking the family to be screened by unknown possibly judgemental people, we decided to alter the balance of power by asking the family if they would consent to watch as I interviewed the referring clinician, with whom the work had become stuck, about their story so far. This would involve the family going to the viewing room and me interviewing the clinician in relation to the reason for referral, the assessment process, what the difficulties were, and points of agreement and disagreement between the family and the clinicians. In this way we pioneered an intervention we described as 'The Screened Clinician Interview'. (This innovation was presented at the 6th Congress of the European

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Family Therapy Association (EFTA, 2007) by the researcher and Mary Long, Systemic Family Therapist.) This change in the power balance allowed the family to attend the clinic and engage in a meta-dialogue that involved thinking about the process as well as the content of the work (Andersen, 1987) and this involved a high level of transparency in the work and close collaboration between professionals and families. The aim of the interview was to allow the story of care seeking to be told, including all the frustrations involved and to highlight the benign efforts that the clinicians had been making in trying to help, even if they had not been successful. In psychoanalytic terms it was to try to re-establish a positive transference and de-toxify the intense negative transference.

In one of the sessions following the Screened Clinician Interview we repeated the same process but this time the Child Psychotherapist interviewed the child while the family and referring clinician screened the process. This was done using video recording if the child struggled to understand the screen. We found that this was a powerful way of giving the child a voice and bringing the different views held by the child into focus for discussion. In this way we developed what we have called the 'Screened Child Interview' (also presented by Dawson and Long at EFTA 2007). The aim of the interview is to give the child a voice and to allow their point of view to be expressed in such a way that their parents and the clinicians can be put in touch with their needs.

This work in the joint Child Psychotherapy and Systemic Family Therapy sub-clinic stimulated a great deal of discussion, thought and clinical innovation among the practitioners involved which included a Nurse Therapist, Consultant Psychiatrist and Clinical Psychologist as well as other visiting staff. Along with the Screened Clinician Interview and the Screened Child Interview which we pioneered, we used the technique of the Reflecting Team as described by Andersen (1987:415),

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'A 'stuck' system, that is, a family with a problem, needs new ideas in order to broaden its perspectives and its contextual premises. In this approach, a team behind a one-way screen watches and listens to an interviewer's conversation with the family members. The interviewer, with the permission of the family, then asks the team members about their perceptions of what went on in the interview. The family and the interviewer watch and listen to the team discussion. The interviewer then asks the family to comment on what they have heard. This may happen once or several times during an interview.'

These interventions responded to the needs of a small proportion families referred to the CAMHS team and we developed a number of descriptions that would help clinicians to identify stuck cases to refer. We would usually see families who had attended for some time, or had a long history of being 'stuck' with relationships with social services, education or other health agencies. These were families where the clinician may have felt that interventions that 'ought to work' were sabotaged by a family member/ dynamic. From the family perspective the clinician may have been seen as or experienced as a negative influence and the intervention not trusted. The practitioner may have felt a 'dread' at the thought of the next appointment that would be consistent with a 'nameless dread' of powerlessness as described by Stephen (1941) and developed by Bion (1962a). Also these are likely to be cases where the parents' view of the child did not match with clinician's view, leading to disagreements about treatment and resentment or blaming between professionals and parents. It may also be that in relation to these families, services, professionals and networks were 'split' and different agents held different views of the child and family. The family may also have enlisted professionals against each other, so that situations arose where there were 'goodies and baddies', i.e. good social worker /bad CAMHS professional, or vice versa, and this split was making it even harder to provide coordinated assessment and care of a child. While we used the above descriptions to guide clinicians referring to the sub-clinic, we kept an open approach to referrals, responding to the needs of families using the service and our colleagues in the CAMHS team and we were flexible about taking cases that were felt to be 'stuck' even if they did not exactly fit the criteria above.

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From this experience of creating a way of working that we felt was useful to staff and families who found themselves in 'stuck' positions, I found I became increasingly interested in thinking about the compatibility of systemic and psychoanalytic ways of thinking and in exploring further how families and clinicians came to find themselves in this stuck situation.

RESEARCH QUESTIONS

What is a 'stuck' case, can it be thought about in different ways? Are the different ways of thinking compatible and complimentary? What sense do clinicians from different backgrounds and professions make of this? How do families, parents and children, experience becoming 'stuck'? And can studying the different ways of thinking about this material (i.e. psychoanalytic, systemic, clinician reports and family reports) help us to understand the phenomenon and ways out of the situation toward more successful work?

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Questions for the Literature Review

When did the terms 'stuck' and 'impasse', first come into use as a category?

What situations are these terms describing?

Do the terms derive from previous ways of conceptualizing the problem?

How are the concepts changing and adapting in response to practice?

What developments in practice are stimulated by this way of conceptualization?

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Within the psychoanalytic literature there are three main sources that are organized around the theme of impasse, Meltzer (1968), Rosenfeld (1987) and Parfitt (2006). Of all the literature, the work by Rosenfeld stands as the central source of thinking about theory and development of technique in relation to impasse. As the rest of the literature is so limited it has been necessary, for the purposes of this review to try and uncover literature that is connected to the theme but may not make direct reference to the terms 'stuck' or 'impasse'. This has been achieved partly through focusing on articles already known to the researcher such as Britton (1981) which looks at 'Re-enactment as an unwitting professional response to family dynamics' and following the literature supporting these articles and trying to follow the theoretical and technical development noted in the literature to the modern day. While the literature is almost exclusively discussing individual adult work deep into analysis, it becomes clear that the study of stuckness is central to the development of psychoanalytic theory and technique. The study of stuckness or impasse consistently leads to developments in practice and it seems that engaging with the themes is an essential part of keeping psychoanalytic thinking developing and adapting as we continue to deepen our understanding of human relations.

DISTINCTION BETWEEN IMPASSE AND RESISTANCE

It is important at the start to distinguish between resistance and impasse or stuckness. Resistance refers to an ordinary part of psychoanalytic practice where the patient's defences are used to stand in the way of development. This is appropriate and has to be understood and worked through. Some resistances may be intractable and yet this remains different from a stuckness or impasse where by implication there will be no move by either party. Resistance refers to an activity on the part of the patient alone, whereas stuck or impasse refers to a situation where both parties are involved together.

Meltzer (1968) drew a distinction between impasse and other types of 'intractable resistances' in psychoanalysis. His discussion draws attention to a particular phenomenon involving a mutual drive to idealization between the analyst and patient and his approach anticipates future writers who, like him, also suggest alterations to technique in response to resistance.

Meltzer (1968:153) says,

"The scientific nature of the analyst's work will convince him that every resistance is potentially open to relief, and any intractability must be taken as an analytic failure, regardless of the personality defects in the patient- call them what you will- defective drive toward integration, inadequate cooperation, dishonesty, folie à deux with an external figure, overwhelming persecutory or depressive anxiety, inadequate drives, split-off psychosis, etc. This conviction, to my mind, forms the fundamental bulwark against countertransference acting against the patient and should, in all cases of intractability, be further strengthened by supervision with a colleague prior to a decision regarding termination, interruption, or partial interruption."

Detailing the analyst's response to resistance and intractable defences allows Meltzer (1968) to then separate out the impasse from other resistances. Meltzer describes one particular type of impasse that develops when an analysis is well established and Meltzer (1968:153)

himself reports not seeing it before the fourth year of analysis and describes it as an *'impasse at the threshold of the depressive position.'*

IMPASSE AT THE THRESHOLD OF THE DEPRESSIVE POSITION

Meltzer (1968) suggests that a point is reached when the patient is less subject to narcissistic functioning and has adapted in life outside analysis to a point where infantile functioning does not dominate. Meltzer (1968:154) says,

"The general point about adaptation is that the patient is content, or relatively so, in his egocentricity and feels ready to stop analysis from the point of view of the conscious motives that first brought him to the couch... The analyst is therefore felt to be holding on to the patient for various reasons of his own and attempting to press him in a direction that is foreign to the patient's nature, aspirations, and 'condition of servitude'.

An extraordinary and powerful campaign therefore builds up over the period of impasse to terminate the analysis in an atmosphere of mutual idealization..."

Meltzer (1968) suggests that a well-planned and co-operative interruption to the analysis is an important option to allow the patient to go away and come back with a clearer view of the position they had been in. It requires the analyst to be cognizant of his or her own part in the impasse and to have gathered detailed descriptions of the pattern of relating that is preventing further progress. It requires the analyst not to agree to the mutual idealization despite the pressure from the patient and the pressure in the countertransference. Meltzer (1968:159) suggests that the patient will be co-operative but not sincere and the agreed interruption must be held to otherwise it will,

'...lead to the prolongation of the impasse to the point of mutual exhaustion and render a technique of interruption feeble, if not completely unfeasible. I consider procrastination in the face of such evidence to be dangerous as well as wasteful.'

Meltzer notes two other types of impasse. The first is one linked with a trauma (Freud, 1914), and the other where there is catastrophic anxiety. He does not go into detail about these other types of impasse because they do not benefit from the use of an interruption in analysis.

BRIDGING THE GAP: PSYCHOANALYTIC THEORY AND FAMILY WORK

Britton (1981) helps to bridge the gap between individual psychoanalytic work and family work. This paper has helped to shape the researcher's clinical work as it describes a type of situation that I would call 'stuck' and engages directly with the psychoanalytic view of this. Although it could be included in the systemic literature review this article is undoubtedly written from a psychoanalytic perspective. Britton (1981:48) says,

'... contact with some families may result in professional workers or their institutions becoming involved unknowingly in a drama which reflects the relationships of the family or within the minds of some of its individual members; and that this is not recognized but expressed in action....This may eventually call attention to itself by its repetitious nature or by the impasse which seems to follow a variety of initiatives.'

Britton (1981:48) says that indications of the unconscious processes involved may be seen in a range of 'professional symptoms':

- The intensity of feeling aroused by the case
- The degree of dogmatism evoked
- Pressure to take drastic or urgent measures
- Inappropriate unconcern
- Surprising ignorance
- Undue complacency
- Uncharacteristic insensitivity
- Professional inertia.

Britton (1981) makes an important point that the dynamic may represent an interpersonal or an intra-psychoanalytic situation. In other words he is describing situations that are both systemic and psychoanalytic.

Britton (1981:49) uses case examples to demonstrate situations that can be thought about as 'repetition compulsion' where events are repeated but the situation is essentially static

and he describes this as a 'homeostatic system' and Britton goes on to argue that this is compatible with the conservative nature of the death instinct as described by Freud (1920).

Britton (1981) names implicit psychoanalytic concepts that can be used in this type of family work:

- Repetition compulsion (Freud 1914).
- Transference (Freud 1914).
- Projective identification, Melanie Klein (1946)
- Reality of projective identification and its effects on countertransference, Bion (1974)

Britton (1981:50-51) notes that the same dynamics displayed by families can affect colleagues and different agencies, and can result in quarrels, quick and heavy handed decisions by managers and supervisors and breakdowns in communication. He discusses the nature of disagreement and uses the terms 'stalemate' and 'intransigent problems' which both relate to ideas of stuckness. Britton (1981:53) says,

'The implication is that families whose mode of mental operations are characteristic of the 'paranoid-schizoid' position¹... rather than the depressive position are not only unlikely to see themselves as the agents in their own disturbances but are likely to evoke unconsciously determined action in those around them.'

Britton goes on to describe the difficulties of members of families functioning in Paranoid Schizoid mode and not in the Depressive Position in a way that is very helpful for the therapist to understand as I think it clarifies the nature of the difficulties with stuck families.

Britton (1981:53) says these family members,

¹ Klein (1946)

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'...are likely to feel persecuted rather than guilty, ill rather than worried, enmity rather than conflict; desperation rather than sadness, they are likely to be triumphant or if not to feel squashed and to see others as either allies or opponents. Their tendency to take flight (e.g. by moving, changing partner, changing schools, etc.,) is linked to their belief that psychic experience can be split off and left behind; by the same token there is a sense of being hunted and a fear of being cornered.'

Britton (1981) suggests that the professional response to these families can involve either being provoked or paralyzed and the professional is faced with the limitations of the help they can offer. He suggests that accepting small significant changes is important and this also requires giving up hopes for a transformation. Britton (1981:54) says,

'The thesis which is argued here is that 'realization', and a change as a consequence of 'realization' rather than change as an alternative to 'realization' may prevent patterns which cross not only individual but generational boundaries.'

Britton's way of thinking is on the borderline between psychoanalytic and systemic thought, drawing attention to the inter-generational patterns of relating and the qualitative nature of changes that are possible.

In reviewing the literature it seems that Britton started an important line of thought about the use of psychoanalytic concepts in relation to systemic practice and family work and that in doing so he found himself discussing cases that could be seen as stuck. Britton's article is not explicitly about stuckness in work with families. However, like Britton, some articles in the literature do seem to be addressing the problems of stuckness in an implicit way. An example of this is Alvarez (1985) addressing 'The problem of neutrality'.

NEUTRALITY

Alvarez (1985) begins by stating that certain types of work challenge traditional ways of working in psychotherapy, specifically that work with borderline and psychotic children who test the notion of neutrality to the limit. She details the importance of the setting in making sure that the work with these children is possible and then challenges the psychotherapist to think about the internal setting of the analyst's mind. Alvarez (1985) suggests that the child psychotherapist may have to bring life to the interpretation to make it meaningful for some children and for others they may have to build a 'fortified neutrality' to put limits in place for the child. This has to be carefully monitored to ensure that the therapist has not become closed off to the communication made by the child. Alvarez (1985) traces the concept of neutrality to the 1890's and the beginning of psychoanalysis when Freud moved from active interventions to the method of free association that Alvarez (1985:89) suggests was a move from "*analytic authoritarianism to relative analytic passivity*". Alvarez (1985) goes on to discuss the movement from neutral reflection as suggested by Freud to the more active and dynamic response suggested by the container-contained communication put forward by Bion (1962a). Alvarez (1985) specifically focuses on Bion's two phases of work in containment and then transformation.

While this may not initially seem to be a paper on the theme of stuckness Alvarez is implying that work with borderline patients requires a change in the attitude of the therapist otherwise the patient is unable to receive the intended communication or the analyst becomes overwhelmed by the emotional demands of the patient. She seems to be describing the need to maintain a balance, which could be another way of describing

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avoiding becoming stuck. This balance refers to being close enough to the patient to maintain contact while being distanced enough to be able to think (Alvarez, 1985:101)²

Alvarez (1985:101) describes three variations on the theme of neutrality.

1. *'...the therapist may resort to extra fortifications to maintain his or her capacity to think'*.
2. *'diplomatic missions', "...that is, where the distance is too great, and where the chronically ill autistic, schizoid, or deprived patient's ability to feel and think is severely limited, the therapist may thus be forced temporarily to carry the patient's auxiliary self."*
3. *'advanced listening posts', "...for signs of reparation and of budding ego development in certain borderline children and improving psychotics'.*

These themes explored by Alvarez resonate with the one major source in the literature that is explicitly about impasse. Rosenfeld (1987) links the development of an impasse to the breakdown of communication between the analyst and patient, leading to increased anxiety. This differentiates an impasse from a resistance as it involves misunderstanding and a loss of connection as a cause of difficulty rather than the avoidance of development due to a fear of mental pain. To fully understand the importance of Rosenfeld's work it is important to see it in its historical context and to look at the development of theory and technique suggested in his book.

HISTORICAL PERSPECTIVE

Rosenfeld (1987) begins by describing his early attempts to treat psychotic patients that went against established psychoanalytic tradition. To understand the context in which Rosenfeld developed his ideas it is useful to refer to Meltzer (1978) who took the view that Freud's later writing and particularly the article *Analysis Terminable and Interminable* had a negative effect on the development of analysis. I think Meltzer was suggesting that Freud was reviewing his life's work rather than reviewing psychoanalysis as a developing methodology. Meltzer (1978:137) says,

² This resonates with the systemic idea of a meta-dialogue (Andersen, 1987)

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I suggest that the pessimism about analysis that pervolates through 'Analysis Terminable and Interminable'³ is of a very peculiar sort. It seems to me that it is an outgrowth of Freud thinking of the analytical method and analytical theories as if they were complete (although he would absolutely deny this in theory); as if the method had now been brought to its perfection, and its efficacy could be evaluated in some final way. The weight comes down very much on the side of what psychoanalysis can not do, because of the 'quantitative' or 'economic' factors. These economic factors were felt to be connected with the death instinct and destructiveness (primary sadism, primary masochism, secondary sadism and masochism); and the strength of these impulses was felt to create the negative therapeutic reaction in analysis. It manifest itself as what he calls 'inertia' or 'stickiness' in the transference, and created the opposition to cure and the clinging to guilt. These three link together: the stickiness or the inertia of the libido as it is manifest in the transference; the tendency to negative therapeutic reaction to any step forward in insight; and the factor of the patient clinging, rather masochistically, to the repetition of his experiences of guilt.'

It is worth noting that Freud's use of the terms 'stickiness' and 'inertia' in the transference also resonate with the theme of stuckness. Meltzer is suggesting that Freud is pessimistic about the impact analysis will be able to have on patients who display this in the transference. Meltzer suggested that Freud had repeated experiences of seeing his colleagues attempting analyses that would 'grind to a halt' and that this led Freud to see the limitations rather than the possibilities for development in psychoanalysis. Meltzer (1978) goes on to discuss Freud's focus on the Structural Theory of the mind in Analysis Terminable and Interminable. Meltzer (1978:137-8) says,

'The implications of that paper had a rather bad effect on the development of analysis. First of all, they [the theories] tended to discourage character analysis; secondly, they tended to encourage analysts to restrict themselves to curing symptoms; and thirdly through the tone of the paper, to discourage technical innovation or experimentation.'

Despite being theoretically correct in Meltzer's view, the focus on the economic category of Freud's meta-psychology (the preoccupation with the quantitative relationships) is not of clinical use. Meltzer (1978:141) says it,

³ Freud (1937)

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'...tends to serve for analysts the function of an escape hatch or rubbish bin into which the analytic failures may be dumped. It discourages a more pugnacious attitude toward analytical failures; dissuades the analyst from full responsibility for his own failures; and encourages a tendency to blame the patient and assume that the failure of analysis is that of the patient and not of the analyst. One unsavoury manifestation is the emergence of the term 'unanalysable', which comprises a sort of political conviction, a relegation to a psychoanalytical Siberia. This seems to me to have arisen in direct relation to the paper 'Analysis Terminable and Interminable', and to be the most unfortunate part of the legacy that we have received from Freud, glorious as it is in other ways.'

If we are to accept Meltzer's view, which I do, then it seems that psychoanalysis has itself gone through periods of inertia and it is only when practitioners such as Rosenfeld question the limits of the application of psychoanalytic work that new developments are possible.⁴ That is not to say that Rosenfeld did not recognize the anti-therapeutic factors in the functioning of the analyst and the possibility that patients will not respond positively to traditional analytic work. His book tells the story of his perseverance in trying to understand how to understand the negative reactions and to adapt technique accordingly.

Rosenfeld (1987:10) describes work with a schizophrenic patient saying,

'To my surprise these transference interpretations unfortunately made her very much worse; her delusions increased and she had to go into hospital for a long time.... it eventually helped me to realize that interpretations of openly Oedipal material were very dangerous in schizophrenia. This was an important discovery which eventually enabled me to formulate ideas about the concrete nature of psychotic thinking and feeling and its influence on the way the analyst's interpretations can be distorted so that they are misheard as actual suggestions.'

Rosenfeld (1987:12) then went on to focus on the study of the communication with patients, both verbal and non-verbal, paying particular attention to how the communication was received by the patient. He states the importance of making a good enough contact with the patient and empathising with the patient to such an extent that the analyst is able to feel and experience what is going on in the patient. This is in conflict with the traditional view of analytic neutrality as discussed by Alvarez (1985) and is in stark contrast to the systemic views of neutrality that will be discussed in the systemic literature review.

⁴ It is interesting to note that Rosenfeld (1987:153) is unsure of Meltzer's use of interruption or reduction in frequency, showing that the debate about technique is not always agreeable.

EMOTIONAL INVOLVEMENT OF THE ANALYST

Rosenfeld (1987:15) states that at times the therapist's emotions become entangled with the projections of the patient and it is necessary to take time to differentiate between the two. He recommends the analyst takes time to reflect on the emotional experience so that the patient's communication is not blocked by the analyst's defences. Once the analyst is aware of the projections, Rosenfeld recommends that the timing of interpreting the projections is considered and he maintains that some patients will experience an interpretation that is too quick as the analyst expelling the feeling. Rosenfeld's view is that the projections may have to be contained for a considerable time but he sees this as an act of containment rather than in-action. There may be a process of the analyst interpreting the communication internally to himself but waiting for the right time and an appropriate way to deliver the interpretation to the patient. This reflective functioning and internal dialogue, taking a close up and a distance view at once is an essential part of psychoanalytic practice and is something that resonates with some of the family therapy literature, notably the literature relating to the reflecting team and establishing a meta-dialogue (Andersen, 1987). While the family therapists may try to use a team to achieve this position the analyst develops an internal live supervisor in his own mind.

DEFENSIVE AND DESTRUCTIVE FUNCTIONING

Rosenfeld (1987) suggested that to understand impasse it was necessary to explore themes such as envy, narcissism, the death instinct, and projective identification. Rosenfeld (1968) drew attention to the pain, anxiety and envy that is stirred up in patients when they become aware of their need for and dependence on the object. Then Rosenfeld (1971) made a distinction between libidinal (loving, caring, interdependent) and destructive aspects of narcissism. In destructive narcissism the destructive aspects of the personality are idealized. Other more libidinal aspects are '*devalued, attacked and destroyed with pleasure*' (Rosenfeld (1987:

22). Rosenfeld spends much of his book pointing to the importance of distinguishing between a patient operating through destructive narcissism and one operating through defensive narcissism and highlighting the importance of the analyst not interpreting destructive functioning when the patient is in a desperately defensive state of mind. In particular Rosenfeld (1987:33) warns against the analyst misinterpreting the patient's realistic criticism as sadistic attacks. Rosenfeld (1987:32) says,

'A corner-stone of my view about therapeutic change is my belief that even the most disturbed and tricky patients, whose pathology may cause them time and time again to defend themselves against anxiety by distorting and undermining the analytic process, not only to seek to communicate their predicament but also have a considerable capacity for co-operating with the therapeutic endeavour, if the analyst can recognize it.'

Rosenfeld (1987:34) returns over and over again to the central importance of the analyst being able to recognise the motivations behind the patient's actions and not to act defensively. He then describes anti-therapeutic factors starting with aspects of the analyst's personality that have not been sufficiently analysed. He goes on to highlight three particular anti-therapeutic issues:

- Adopting a particularly directive role toward the patient
- Badly timed and vague interpretations
- The tendency to rigidly and restrictively pursue a particular line of interpretation.

All of this builds up to Rosenfeld describing the high degree of difficulty the analyst has in working successfully with highly disturbed patients. Rosenfeld builds up a picture of the patient who attacks not only the analyst but also aspects of his own mind. When this happens Rosenfeld (1987) believes that the patient is left in a confused state of mind. Here the idea of an impasse is useful as when the patient is confused there is no point in interpreting resistance as he feels helpless and unaware. Rosenfeld (1987:90) suggests,

'On the other hand, interpretations which can make the patient aware that there is a force at work inside him, which is powerfully suggestive and prevents him from thinking and observing what is going on, are experienced as helpful and ego-supportive.'

PSYCHOANALYTIC LITERATURE REVIEW

I believe that the study of impasse has made a major contribution to the development of psychoanalytic thought through the quality of observation and thought about the patient's response to an alteration in the interpretive approach. Rosenfeld (1987:111) goes on to suggest that when the time was right, frequent and firm confrontation of the narcissistic aspect led to change for patients. However he went further in the study of the destructive aspects of the mind and suggested that the narcissistic defences tended to operate in a similar way to a gang mentality which the patient may want to avoid but in the end it feels safer to join or collude with the gang functioning. His approach suggests that it is possible to take an honest look at this with someone, collaboratively.

DIAGNOSING IMPASSE

Rosenfeld (1987:139) says that impasses are of different kinds: Firstly, those in the final stages of analysis (perhaps similar to the impasse on the threshold of the depressive position outlined by Meltzer, 1968). This is seen as a positive development and allows the patient to work through material and reinforces the process; Secondly, when a patient has been making good progress but has a sudden negative reaction, Rosenfeld suggests that more envious and destructive aspects of the patient are active at these times and have to be studied carefully as the type of difficulty being presented will respond to different approaches; Thirdly Rosenfeld (1987:139) makes a distinction between a true negative therapeutic reaction from one where the negative reaction does not follow a period of progress. In all of the above cases the analyst has to be sensitive to the type of impasse that has been encountered and consider the patient's needs and the best technical response before proceeding. Rosenfeld gives detailed clinical examples to demonstrate each of the situations and stresses the importance of understanding projective processes and the analyst's need to avoid becoming caught up in returning projections too quickly or too forcefully as this only increases anxiety.

ACTIVE CONTAINMENT

Rosenfeld (1987) goes on to describe the quality of the difficulties in relating to patients with borderline and psychotic states who may be struggling with confused and contradictory feelings and thoughts. The receptive analyst may find themselves having strong physical responses to these patients and may be required to contain powerful projections. Rosenfeld (1987:159-160) discusses containment saying,

'The word 'contain' can imply a rather passive attitude which might mean that an analyst should remain silent or inactive. While this is occasionally a necessary function of the analyst (as of the mother in normal development), I want to stress that the containing function in fact requires a great deal more than passivity. Essentially, the analyst has to be prepared to enter into an intense relationship and to retain his function of putting experiences into words..... The analyst has empathically to follow the patient's descriptions of both real and phantasised events, which are often re-enacted by being projected into him. Most patients, particularly psychotic and borderline patients, usually require a great deal of active thinking on the part of the analyst because they themselves lack the capacity for thinking.'

While stressing the need for the analyst to be able to recognise and work with projective identification Rosenfeld (1987:161) refers to the danger when projective identification is excessive that verbal communication breaks down and a process of active misunderstanding takes place as the capacity for abstract thought vanishes and words are experienced concretely.

Rosenfeld (1987:166) describes a case where he uses the term deadlock to describe an impasse where the communication broke down as the patient felt that they had lost a part of their mind and needed the analyst to be sensitive to this and interpret in a particular way.⁵ If the analyst is sensitive enough even the most disturbed patient can find within himself or herself a hidden safe part that is able to work in the treatment. Rosenfeld (1987:

⁵ In the case example this appears to have been done in quite a humorous manner with Rosenfeld (1987:166) suggesting that they look for the lost aspect of the patient under the couch.

200-217) highlights the central role played by fear for many patients and sometimes the analyst. Examples of fears explored are: Fear that part of their mind is dead, to which Rosenfeld suggests responding to an 'alive' part of the patient while responding to and staying in touch with the dead part (p.200); Patients who say they have arrived back at the beginning and Rosenfeld suggests there may be aspects of the self that can not be integrated and can only be destroyed or protected (p.205); Fear that the patient has damaged the therapist (p.212); A fear that the patient is using the clinical setting where the therapist's behaviour is curtailed to torture the therapist (p.217).

Rosenfeld (1987:217-9) suggests that analysts need to be honest and they also have to face deeper levels of scrutiny, emotional attack and feelings of hopelessness and helplessness. The analyst has the continuing task of understanding these experiences and showing the patient how everything fits together in the whole situation. At the same time Rosenfeld reiterates the importance of detailed interpretations that allow the analyst to be re-established in the patient's mind.

Returning to the reasons for an impasse developing, Rosenfeld (1987:265-6) says,

'...I have come to accept the existence of several varied causes (not just the eruption of psychotic processes) and believe that in each case what has been going on in the treatment has to be examined in very great detail in order to understand as specifically as possible how the problem has arisen. It is with the prevention of impasses and their working through that many of my ideas are concerned.'

This would suggest, in relation to this research, that we may find that impasse and stuckness have a wide range of causes.

THICK SKIN AND THIN SKIN

Rosenfeld (1987:274-5) differentiates between thick and thin-skinned narcissistic patients. Thick-skinned patients, who are insensitive to deeper feelings, need firm management and confrontation with their narcissistic attitude and envy, frequent repetition of interpretation

and confrontation. Thin skinned patients are hypersensitive and easily hurt. If treated as if he is thick skinned then a thin skinned patient will be severely traumatized. Rosenfeld (1987:274) suggests that often thin-skinned patients were severely traumatized as children and feel “*inferior, ashamed and vulnerable and rejected by everybody.*” With these patients Rosenfeld suggest that it is important to make them aware of the conflict between positive and destructive aspects of themselves. Rosenfeld warns that unfortunately it is very difficult for an analyst to remedy mistakes in technique that might be made with thin skinned patients.

DEVELOPING THEORY IN RELATION TO CONTAINMENT

Rosenfeld’s work has had a major impact on psychoanalytic thinking in Britain and the developments in theory and technique have been studied and developed since his book was published in 1987. While the theme of impasse has not had an organizing function on the psychoanalytic literature there is an implicit follow up to this theme. For example Carpy (1989) who refers to Rosenfeld (1971) in distinguishing between the use of projective identification for communication and for the denial of psychic reality, pointing out that an interpretation will be experienced differently: either in a meaningful way or as a forced re-entry. Carpy (1989:289) says,

‘Another way to look at this is to consider the extent to which a patient retains within himself some vague awareness of whatever is projected. The more a patient retains an awareness of what he projects, the more he will be able to recognize it as his when the analyst interprets it to him. A more disturbed and borderline patient tends to use projective identification in a more complete form, so that he often divests himself entirely of his projections, seeing it as entirely foreign to himself, and retaining no awareness of it whatsoever. It is here that the therapeutic task is rendered particularly difficult....’

Carpy develops Rosenfeld’s view that the analyst has to hold onto projections sometimes for a considerable period of time by suggesting that it is impossible for the analyst to do this completely and that there is an inevitable partial acting out on the part of the analyst.⁶ Carpy (1989) suggests that this partial acting out (which is not deliberate but is inevitable)

⁶ This is not the unwitting re-enactment of the professional described by Britton (1981) but a partial acting out as the analyst struggles to contain forceful and disturbing projections.

allows the patient to observe either consciously or unconsciously that she is affecting the analyst and allows the patient the opportunity to witness the analyst struggle to deal with the feelings that they too have struggled with. Much of this is non-verbal. Carpy (1989:293) says,

'...I believe it is the inevitable partial acting out of the countertransference which allows the patient to see that the analyst is being affected by what is projected, is struggling to tolerate it, and, if the analysis is to be effective, is managing sufficiently to maintain his analytic stance without grossly acting out.

I believe it is through this process that the patient is able gradually to re-introject the previously-intolerable aspects of himself that are involved. He is also able to introject the capacity to tolerate them which he has observed in the analyst.'

Carpy (1989:294) suggests that interpretations can only become meaningful as the patient gradually recognizes and introjects those aspects of himself, and that this happens through mutual understanding of the qualities shared with the analyst. The analyst's ability to tolerate the countertransference is therefore central to the development in analysis for these patients.

Carpy (1989) extends his thinking to the need for the analyst to make links in his mind, which allows the patient to do the same where before the links would be attacked through projective identification in the way described by Bion (1959).⁷

Thinking about these issues prompted Carpy to look again at the concept of containment, the central concept in modern psychoanalysis. Carpy suggested that previous theory had not acknowledged that mothers and even analysts can not completely contain the anxieties involved in parenting and in analysis. Carpy (1989:294) believes it is the infant's knowledge that the mother is struggling with the emotion and still providing for the infant that brings out the '*goodness of the milk*'.

⁷ Attacks on Linking.

PSYCHIC RETREAT

Another major publication that builds on the work of Rosenfeld is Steiner (1993) who introduces the idea of psychic retreats. Steiner builds on the idea of defensive narcissistic functioning outlined by Rosenfeld (1987) and details the concept of the psychic retreat, as an alternative to functioning in the Paranoid-Schizoid or Depressive position. The retreat describes the way a patient can take a certain position which avoids meaningful contact with an analyst for an extended time or even permanently. Steiner develops this theme through detailed clinical material and goes on to look at two types of defensive functioning, turning a blind eye and evading the truth. Steiner explores both of these by referencing the story of Oedipus and he links these particular defences with perversion of the truth. He then examines the problems of technique looking to the grammar of interpretations that include *patient centred and analyst-centred* interpretations. Steiner also argues that with these patients containment is necessary but not sufficient and the patient also has to show some motivation to understand themselves. Steiner refers to the work of Joseph (1975, 1983, 1985) exploring the ideas behind the total transference, seeing all communication associated with the session, including non-verbal communication, as important and needing to be observed and where necessary interpreted. Implied in this is the idea that the patient is also studying the total situation of the analyst in relation to all activity in a session including non-verbal communication, tone of voice and choice of interpretation. Steiner's discussion of the technique of interpretation resonate with other psychoanalytic developments in relation to this by Alvarez (1983,1985) who explores the need for the child psychotherapist to consider the grammar of the interpretation as well as the tone of voice.

Steiner (1993:3) suggests that retreats are common and that,

'All gradations on the retreat are found clinically, from the completely stuck patient at one extreme to those who use the retreat in a transient and discretionary way at the other... One of the points I will emphasize throughout this book is that change is possible even in the analysis of very stuck patients. If the analyst is able to persevere and survive the pressure he is put under, he and the patient can gradually come to gain some insight into the operation of the organization and to loosen the grip and range of its operation....I am impressed by the power of the system of defences which one can observe operating in these stuck analyses. Sometimes they are so successful that the patient is protected from anxiety, and no difficulty arises as long as the system remains unchallenged. Others remain stuck in the retreat despite the evident suffering it brings, which may be chronic and sustained or masochistic and addictive. In all of these, however, the patient is threatened by the possibility of change and, if provoked, may respond with a more profound withdrawal.'

Steiner's development of the idea of a psychic retreat leads to some technical developments in relation to patient-centred and analyst-centred interpretations. Steiner (1993:131) says,

'Patients who withdraw excessively to psychic retreats present major problems of technique. The frustration of having a stuck patient, who is at the same time out of reach, challenges the analyst, who has to avoid being driven either to give up in despair or to over-react and try to overcome opposition and resistance in too forceful a way. The situation is one where the patient and the analyst can easily be at cross purposes. The patient is interested in regaining or retaining his equilibrium, which is achieved by a withdrawal to a psychic retreat, while the analyst is concerned to help the patient emerge, to help him gain insight into the way his mind works, and to allow development to proceed.'

Steiner (1993) goes on to suggest the analyst has to find a balance between patient-centred and analyst-centred interpretations and that a containing setting is required before a patient can gain insight.

REFERENCES TO IMPASSE IN THE CHILD PSYCHOTHERAPY LITERATURE

Frick (2000) briefly discusses an impasse that may occur when a child develops in therapy but the parents do not. Frick (2000) suggests that technical considerations are very important in this work and suggests that interpretation is kept to a minimum. Frick (2000:82) says,

'Defences in parents are often stronger and more rigid than in children, and their changes are more gradual. The parallel treatment therefore often raises special demands on the parental therapist. The often difficult countertransference processes may make the task especially trying.'

IMPASSE AND COLLABORATION

Other articles in the child literature that are worthy of note include Shuttleworth (1984) who describes a very long analysis of a child with learning difficulties and describes a move from thinking at to thinking with the child as a means of overcoming barriers to development. Although Shuttleworth (1984:101) does not use the term 'impasse' or 'stuck' he describes his attempt to, '*stay afloat in Mathew's 'whirlpool'*'. Shuttleworth (1984:107) refers to Bion's grid (Bion, 1963) to suggest ways of getting into "*a thinking relationship with the patient about his material.*" Shuttleworth (1984:114) says the optimal situation involves,

"...a commensal K link; in which case, first, therapist and patient are able to think together about the patient's material in a way that feels fruitful to both of them and in a way which raises the possibility of further exploration in both their minds.....

But it may be that such linking is, for whatever reason, felt to be too persecuting to bear and it may then come under massive attack...."

IMPASSE AND AN EMOTIONAL HAND GRENADE

Teicholz (2006) refers to other articles where therapists have experienced periods of difficulty alongside periods of development and proposes that these can be thought as stuck periods and that change is brought about by the therapist's enactment and emotional honesty. Teicholz (2006) uses the term 'therapeutic hand grenade' to suggest that the emotional honesty has an explosive impact on the stuck territory and the stuck relationship. The metaphor of an explosion suggests a dive for cover away from the stuck territory however Teicholz suggests that this is the very time the therapist has to stay in place and be seen to tolerate the explosive nature of the experience.

IMPASSE AND PERVERSION

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Parfitt (2006) is one of the rare articles in the child psychotherapy literature to organize itself around the idea of impasse, in this case focusing on clinical work with perversion. This article demonstrates that concepts developed in response to impasse are being applied by the child psychotherapy community in practice. Technique and theory continue to be developed by paying close attention to understanding the patient's position, the nature of the interpretation required and the way of delivering an interpretation so that the patient can hear it.

Parfitt uses the concept of impasse as developed by Rosenfeld (1987). Parfitt (2006:49) develops one particular type of impasse identified '*where episodes of negative therapeutic reaction are evoked by progress*'. Parfitt (2006) illustrates the impasse through clinical examples of work with two adolescent patients. Parfitt (2006:53) explores the ideas of perversion and fetish, making links to the idea of a '*combined object*' and he suggests that a fetish combines good and bad objects in a confusing way that holds the patient in an impasse. Parfitt (2006) also links the ideas of the impasse and the fetish to the psychic retreats described by Steiner (1993). Parfitt (2006) ends by suggesting two qualifications to Steiner's advice, the first in relation to interpreting the pressure that the personality may be put under to collude with destructive forces, the second to suggest that some insight is not simply avoided but is blinding.

Parfitt (2006: 59) develops Steiner's (1993) description of the psychic retreat saying,

In other words, the patient has a confusing 'it's good but it's bad' experience of retreat. One reason is that the retreat is organized in relation to an object which is 'good but bad', possessing qualities which mutually attract and repel. This seems to be due to some healthy and helpful parts of the patient's personality as well as some deluded and destructive parts being combined. How are good, helpful and sane features combined, tantalizingly and confusingly, with bad, destructive and deluded characteristics?

Parfitt (2006:59) suggests that these parts of the personality form a combined object of a sadomasochistic kind that,

“...operates exactly like a fetish. It has the power to evoke worshipful horror, or horrified worship..... Objects like this are not straightforwardly good as well as bad. Nor, under their influence, are the patient’s motives. Instead, the patient finds it hard to distinguish accepting his emotions from rejecting them, and seems neither straightforwardly to accept nor to reject what he thinks or feels. He tends to misrepresent thoughts and feelings, unconsciously, in such a way that it becomes hard to distinguish thinking or feeling two things, together in a confused combination, from thinking and feeling one confused thing.” (p.59)

Parfitt (2006) suggests two qualifications to Steiner’s (1993:103-4) suggestion that it is necessary to address the patient’s complicit part in remaining ill rather than receiving help. He agrees with Rosenfeld’s (1987) view that it is very disturbing to be trapped in an impasse, and Parfitt (2006) suggests that it is essential to interpret the defensive function the retreat provides while at the same time recognizing the attractiveness of the retreat and the power the draw of the retreat has on patients. The second adaptation of technique suggested by Parfitt (2006) when perversion is active in an impasse is to acknowledge the immense pressure the patient is under to collude with the perversion, not through choice but through fear of death of the personality. Parfitt (2006:63) says,

‘An internal protection racket would be ineffective without threatening destruction of the personality if its demands are not met, or if escape from the persecution is attempted, or if it is betrayed from within by double-agency. The patient’s sincere fear for his sanity and self-preservation, however illusory, has to be acknowledged..... Being weak, letting it win or giving in may then be recognizable. But these are not the same as perversely seeking, let alone preferring, to be taken over by it. Even when the collusive sense of ‘turning a blind eye’ [Ref to Steiner 1993] is apt, there can still be genuine fear that insight might be blinding.’

Parfitt (2006:64) discusses the possibility of blinding insight and says,

‘It is useful to distinguish a shallower sort of self-deception from a deeper sort. There is a shallower sort, according to which ‘turning a blind eye’ lets the patient prevent himself knowing something despite the fact that he would know it if he tried to look and see. There is a deeper kind, which prevents the patient knowing something by making him unable, temporarily, to look and see even if he tried.’

OVERVIEW

The depth and quality of the psychoanalytic literature under review makes it difficult to generalize but there is a clear engagement of psychoanalytic thinkers with the theme of impasse and stuckness, developing from Freud's initial views on intractable resistance toward an understanding that when communication has not been fully established or has broken down then the process of analysis has entered an impasse where psychoanalysis is not happening. This is especially true if the therapist does not share responsibility for the breakdown in the communication. While different types of impasse are described each article reviewed suggests a development in theory or technique, which demonstrates the powerful nature of this material and the progressive attitude the problem forces onto the motivated therapist. Thinking about impasse and stuckness has led to a range of challenges to traditional technique including thinking about neutrality as something to be worked towards (Alvarez, 1985), recognizing the activity of projective identification in work with families and the resulting professional symptoms (Britton, 1981), distinguishing between destructive and defensive narcissistic functioning (Rosenfeld, 1987), focusing on communication at a verbal and non-verbal level (Joseph, 1983, Rosenfeld, 1987), altering interpretive styles in response to the thick skinned or thin skinned qualities of the patient (Rosenfeld, 1987), re-examining the process of containment and considering the inevitable partial acting out of the mother or the analyst as part of what makes the process of containment something that can be introjected (Carpy, 1989), the concept of psychic retreats as an alternative to Paranoid-Schizoid or Depressive Position functioning and the development of sensitivity and flexibility on the part of the analyst to assess the need for and to deliver analyst centred and patient centred interpretations (Steiner, 1993), and the need to pay attention to the delivery of an interpretation through use of tone of voice, considering the grammar, balancing the need to talk to the alive aspect of the patient while

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keeping touch with the dead aspect, and generally continuing to observe the response to an interpretation in order to continue to develop the quality of the communication with the patient (Britton 1981, Joseph 1983, Shuttleworth 1984, Alvarez 1985, Rosenfeld 1987, Carpy 1989, Parfitt 2006).

SYSTEMIC LITERATURE REVIEW

SYSTEMIC LITERATURE REVIEW

This review is restricted to Family Therapy Literature and articles published in English.

The writer wants to acknowledge that, as a psychoanalytic psychotherapist, I am approaching this review as an interested outsider rather than as a Systemic Family Therapist. For this reason the review can not be completely comparable to the Psychoanalytic Literature Review as I am not in a position to fully judge or apply the theoretical constructs in the Family Therapy Literature. The systemic literature that is reviewed here is designed to raise the writer's sensitivity to systemic phenomena but of course can not take the place of a systemic training or, ideally, a research partnership with a systemic practitioner.

QUESTIONS FOR THE LITERATURE REVIEW

In the selected articles, what situations are the terms stuck and impasse describing?

In the selected articles, what developments in practice are stimulated by considering the concept of stuckness?

INTRODUCTION

When Family Therapy was first practiced in the UK the main approach was to apply psychoanalytic techniques and theories to work with whole families. One way to look at the development of Family Therapy is to suggest that over time there was an increasing tension among practitioners who felt that the field was becoming stuck due to a reliance on a psychodynamic approach and that other innovations were necessary. Since then there have been different movements within the family therapy field, for example Structuralist, Milan, Post-Modern and Narrative approaches. Family Therapy therefore, in common with many other professions, is not easy to define and certainly involves a wide range of approaches, techniques and theories which are selected and applied by individual

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practitioners. While Family Therapy is therefore an umbrella term, there is a convergence in relation to systems theory.

Put basically, the idea of systems theory is that when a number of objects are related to one another in a system then a change in any part of the system affects the whole system. I do not intend to classify or discuss the diversity of the Family Therapy field or to give a coherent description of the history of family therapy. This literature review looks at the use of the term 'stuck' in the family therapy literature, exploring the way the term has been used and the developments in theory and technique that have happened in relation to it.

OVERVIEW

A search of the Family Therapy literature quickly demonstrates that 'stuck' or 'stuckness' as a category does not appear as a consistent organising theme in the literature. For this reason I have selected three articles that I think are significant as they have influenced my own practice when working alongside a systemic family therapist (as outlined in the introduction) and also one recent article that includes a reference to systemic practice including the work of a child therapist.

The first article which is specifically about stuckness appears in 1982 (Treacher and Carpenter) and this was followed up in another article by the same authors along with others the following year (Carpenter et al, 1983). Another key paper was written by Andersen (1987). This paper is a little more general, taking the view that all families who seek help are stuck. The differentiation between a stuck family and a stuck case is made when the therapist becomes stuck too. Then as recently as 2008 Van Lawick and Bom wrote a paper about professional help reaching a 'deadlock'. An examination of the

experience of deadlock seems identical to the stuckness described by Treacher and Carpenter in 1982 but neither they nor Andersen are referenced or listed in the bibliography.

STUCKNESS AS A THEME

Treacher & Carpenter (1982:286) say that

'Stuckness is an ugly, and perhaps unhappy, term, but it at least avoids some of the linear connotations of 'resistance'. We understand resistance to imply that it is us the therapist that us being resisted by the family. Stuckness for us implies that it is the family and the therapist who are stuck with each other; both are likely to describe the feeling of 'going round and round in circles' and both to punctuate the sequence by blaming the other as being the cause of the failure to achieve change. Hopefully, the term stuckness also draws attention to the fact that it is the therapeutic system that is the focus of the problem and not the family, as the use of the term 'resistant family' obviously implies.'

This move from a 'resistant family' to a 'stuck system' is not just a conceptual shift but is a rejection of the power relationship suggested by the concept of resistance. This involves a fundamental change to the social construction of the therapeutic relationship. The systemic literature makes frequent explicit reference to the ideas of post-modernism and I would see the shift from resistance to stuckness as a post-modern shift in practice. This is an example of the ability of the family therapy approach to develop, 'morph', or incorporate ideas from a wide range of sources and bring them to bear in practice.

Treacher & Carpenter (1982) make a link between stuckness and disadvantaged families referencing the work of Skynner (1976) and Lorion (1978) who took a view that therapists who view families as unmotivated may actually be describing their own unmotivated or resistant state. However, the article by Treacher & Carpenter (1982) represents a sea change in conceptualization as they also reject the idea that the problem may belong to the

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therapist. They begin to conceptualise a system that is stuck and use a table to demonstrate the therapist and family position, they later develop this to show the likelihood of change.

TABLE 1. TREACHER & CARPENTER (1982: 287) SYSTEMIC VIEW OF STUCKNESS

Therapist's position/Family Position	Motivated	Unmotivated
Motivated	Therapeutic change likely to occur.	Possibly stuck
Unmotivated	Probably stuck	Very stuck

Treacher & Carpenter (1982) go further by adding the therapist's professional system's motivation and also drawing attention to the complex range of systems that have to be considered in a full formulation.

In thinking about dealing with stuckness Treacher & Carpenter (1982) advocate openness and transparency and also encourage the clinician to be aware that an intervention may actually cause deterioration in some cases (Gurman & Knistern, 1978). They stress the importance of not blaming the family for the stuck situation and insist it is the therapist's responsibility to 'unstick' the therapeutic system. Treacher & Carpenter (1982:290-91) say,

'...our first responsibility is to determine where and how we and the family are stuck. It is only when the stuckness has been adequately diagnosed that it becomes appropriate to begin to think of new tactics and strategies to deal with the stuckness. The attraction of empirically trying 'something new' on a 'suck it and see' basis is very tempting and we feel that in the past we have been too ready to seek this type of attempted solution which immediately becomes the next problem that we tackle. We are therefore beginning to see 'stuckness' (if it is recognised and correctly diagnosed) as an ally rather than an enemy.'

DIFFICULTY OF SYSTEMATIC ANALYSIS OF STUCKNESS

Treacher & Carpenter (1982: 291) tried to develop a framework for systematically analysing 'stuckness' and discovered '*major difficulties in developing watertight analytic categories*' and indeed felt that the phenomenon was too complex for any system to encompass the richness. Instead they assume 'stuckness' and ask a number of questions that help to evaluate its nature. Treacher & Carpenter (1982) ask a series of questions around the possibility that stuckness develops because of technical errors or failures the therapist makes so that the solutions have themselves become new sticking points. They take each of these questions in turn and show the different situations and techniques which may be of use in dealing with them. These situations include the following possibilities: There is a basic disagreement between family and therapist about whether there is a problem and the therapist wants to change or rescue a family that does not want to be changed or rescued (the therapist may conceptualize this as the family being in denial); The family keeping a secret (Byng-Hall, 1978); The family avoiding a more stigmatised experience i.e. court; Some family members and possibly the therapist feeling lonely and the therapy is a solution to the loneliness; The family may identify a problem but not connect this to whom it is a problem for; The family may see the problem as being that their child is on the child protection register while the social worker may be concerned about non-attendance at school; Hoped for solutions may be very different with for example one party looking to reconcile relationships and the other wanting (perhaps secretly) for a divorce; The therapist may be intent on making changes to the family that are unacceptable to the family Watzlawick et al (1974); Evangelising therapists may not have checked out what other solutions the family has sought; Families with psychosomatic problems are particularly difficult to work with if they believe that a 'medical' approach is the only way to achieve a solution; The family may seek to prove that their problem is impossible to solve and wants

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to stay in charge; A family system that seems bent on the well members banishing the ill members into an institution (Scott & Star, 1981); Families only referred or attend at times of crises; The therapist may not have the theoretical knowledge or technical skill to deal with the problem; The style of therapy does not suit the family; the pace of the therapy is wrong for the family; The timing of the sessions is wrong so that there is a confusion toward the end of the session.

TECHNICAL RESPONSES TO STUCKNESS

Treacher & Carpenter (1982) believe that unless the above reasons are addressed then the therapy will not succeed. They see the following techniques or interventions as useful in trying to regain some manoeuvrability in the system Treacher & Carpenter (1982: 293-302):

- Greek chorus. Papp (1981) (similar to the reflecting team described later by Andersen, 1987).
- Convening a wider family system, Spark (1974), Guerin and Guerin (1976), Sluzki, (1978).
- Establish role of neighbours and lodgers.
- Invite the children to draw their house or their family.
- Establish whose advice they have taken in dealing with their problem.
- Are there other agencies involved with different goals? (Roberts 1979, Zuk 1976).
- When many agencies are involved then a case conference is essential.
- Ask the family to set a minimum goal which would indicate to them that wider change is possible and then wait to see if this goal is sabotaged.

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- The therapist may have to make their own value system explicit and state why she can no longer work on central issues with the family (advocated by Minuchin and Fishman, 1981).
- The therapist may adopt a *mea culpa* stance and admit to doing a bad job. The family may then mobilize to rescue the therapist.
- When taking on a case referred from another worker who has become stuck be sure to check out what went wrong, even though everyone was trying hard.
- Adoption of an 'as if' technique to let family members express their own view.
- If families can not accept a non-medical intervention then offer them the medical checks first.
- Use a geneogram to establish whether a position is informed by a family script or myth.
- Gain manoeuvrability by establishing advantages and disadvantages of changes, paying attention to the gains of not changing.
- Accept the position of the family and help them to think about how to advance it, perhaps with letting go of a family member.
- Ask the family if the pace and frequency of meeting is meeting their needs, Palazzoli (1980).
- Pay close attention to the timing of the session, leaving enough time to set an achievable but useful task for the family.
- Positive connotation, Palazzoli et al (1978).

It is clear from the above that the Treacher & Carpenter (1982) are focusing on identifying a clinical situation and generating a range of techniques that may be useful. The theory develops as they explain the usefulness of the techniques. The development away from 'resistance' toward 'stuckness' allowed greater freedom for reflection on the practitioners

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experience of being stuck, the dread of working with particular families and opened up the possibility of working with the 'stuckness'. They developed the ideas a year later in, Carpenter et al (1983) in a paper titled 'Oh no! Not the Smiths again! An exploration of how to identify and overcome 'stuckness' in family therapy. Part II: Stuckness in the therapeutic and supervisory system?.

MANOEUVRABILITY

Carpenter et al (1983:82) introduces the concept of 'manoeuvrability', saying it

'...seems to us to be particularly useful in understanding the therapist's experience of being stuck. Essentially families come to therapy because they are stuck: stuck in repetitive cycles of behaviour, thoughts and feelings and unable to find a way out.'

This is an interesting thinking point and for me resonates with psychoanalytic ideas of repetition compulsion (Freud, 1920), ghosts in the nursery (Frailberg et al, 1975), psychic retreats (Steiner, 1993) and the claustrum (Meltzer, 1992). The article does not reference Britton's (1981) article but does seem to be describing the same phenomenon of re-enactment without direct reference to psychoanalytic literature. Carpenter et al (1983) are stressing the lack of manoeuvrability, the way in which the helper or helping becomes part of the problem and that the same mistakes (or failing attempts to help) may be made over and over again and they suggests that rather than working within and without the system, the therapist may get stuck in it. They may have joined the family in the stuckness.

Technically, Carpenter et al (1983:85) prefer to focus on communication as part of the solution to stuckness, saying, *'...our preference is to acknowledge openly the difficulty and to attribute the responsibility for being stuck to ourselves as therapists.'* There is an emphasis on the importance of the family not being blamed. If the therapist claims to be stuck this paradoxically puts her in a position of power. If the family feel blamed then the therapist seems to taking a

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superior position. This connection to ideas around power are consistent with Andersen's later work and this is an issue which is consistently voiced in the systemic articles in relation to stuckness.

Carpenter et al (1983:89) give a detailed example of a 'double bind' and a 'paradoxical injunction' as a response to a stuck case. The practitioner finding themselves stuck with a double bind may also be one of the key descriptors of stuckness. In detailing their clinical example these writers again demonstrate the strength of the systemic school's focus on recognising technical problems and developing techniques to counter them.

THE DIALOGUE AND META-DIALOGUE

Andersen (1987) begins by stating that in a sense, all family therapy is about families who are 'stuck'. His paper is essential in conceptualizing stuckness in relation to the context of family work, issues around systemic practice and particularly the use of systemic techniques. In the paper Andersen (1987:415-417) draws attention to a process whereby the '*family interviewer*' (clinician) could become '*repeatedly drawn into the pessimism of the family he was interviewing.*' Child psychotherapists might recognise this phenomenon and suggest it might involve projective identification (Klein, 1946) and again this was described by Britton (1981). Andersen does not explore the mechanism for this but makes a clear and direct link to techniques that may help the interviewer and the family to reflect on this process. In particular he describes the use of a reflecting team, not directly involved in the interview, who are able to spot the patterns and interactions that the family interviewer is subject to. In child psychotherapy this process, of taking a more distanced view alongside a close view, is a major part of the work and the extensive training takes a number of approaches to

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help the child psychotherapist develop an internal supervisor.⁸ It seems to me that Andersen's actual team is an equivalent resource that may be necessary when dealing with live systemic issues and the presence of a number of members of a family. Andersen (1987) uses the term 'meta-dialogue' to describe the discussion facilitated by the reflecting team, who are out with the face to face therapeutic session and are therefore able to observe the process of the therapeutic encounter as well as the content.

From Andersen's work it seems that an important dynamic in relation to stuck cases is the practitioner being caught up in something along with the family. Central to the intervention is seeking outside or additional help. It is worth noting that Andersen's focus is repeatedly on developing techniques that allow a different level of thought, freeing the interviewer from the burden of being caught up in the system. In this sense it can be seen as a development of technique rather than theory. He focuses on the idea of change for the family and talks of different ways of introducing change and different types of change. Andersen (1987:418) says,

First, a system that is standing still contains too many repeating samenesses (Watzlawick et al, 1974) and too few new differences. A helper must basically respect the sameness because it represents where and how the present system is and has to be.... It is important to respect the stuck system's resistance to that which is too unusual.'

This is reminiscent of the description of catastrophic change given by Bion (1967) where the patient fears that things must stay the same or he will face annihilation. This in turn resonates with Bion's (1957) differentiation of psychotic and non-psychotic thinking. Specifically that the psychotic aspect of the personality can not tolerate any difference.

⁸ The training for this involves intensive psychoanalysis, designed to allow them time to develop an active reflective function in a clinical setting; also years of sharing the details of sessions with supervisors, fellow trainees or peers. The child psychotherapist may often work on their own but draw from the experience of training to have their own internal reflecting team.

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When only the smallest differences can be tolerated Andersen suggests that we must use our imagination to think of questions that are just different enough from the ones the system usually asks itself. Technically the use of questioning is seen as a crucial way of engaging families in the process of change. Psychoanalytic practitioners have tended to use reflections on observations and to wonder about these, with patients, and to offer interpretations which in current practice are designed to be collaborative. In other words, if put properly an interpretation is a type of question and if the timing is right it may be tolerable enough for new thoughts and understandings to develop into emotional growth. In contrast, the questioning used by Andersen has more of a curious drive behind it (referencing Blount 1985) oscillating between getting a picture, explanations and alternatives. Andersen also uses time to explore changes in the picture and imagined/possible futures. In this way one part of the intervention can be seen as future oriented. This presents a technical or perceived technical point of difference between the systemic practice and the psychoanalytic practice which is usually thought of as historically oriented. Ironically, in current psychoanalytic practice and even since the days of Freud psychoanalysis has strived to free people from the constraints of the past and from re-living past negative experiences in the present.⁹

⁹ The work of Bion (1967) continues to have practical and theoretical repercussions for modern psychoanalytic practice when he describes the task being with people without memory or desire, focusing on being in the moment, which family therapy colleagues have told me is also consistent with systemic thinking.

NEUTRALITY AND THE META-POSITION

Neutrality as a defence against getting involved in the acting out is an important idea. Practitioners using a neutral stance perhaps wisely try to avoid getting into the difficult or 'stuck' position in the first place but it has the disadvantage of not allowing the practitioner to experience the difficulty with the family. It seems, with the developing techniques that Andersen discusses that even with the defences which neutrality brings it is still possible to get caught up in the problem with the family and to get stuck. It may be that one of the qualities of the families we are discussing is that they manage to create an experience of being stuck regardless of the efforts which clinicians put in to preparing for them.

This meta position that Anderson discusses is also referred to in psychoanalytic literature and on a more day to day basis in terms of reflective functioning and is seen as central to change. Andersen (1987: 421) believes in quiet listening and respecting each member of the reflecting team to create their own ideas and he states that the team's reflections are '*speculative*' but based on verbal or non-verbal observations, working within the family's tolerance for challenge, to open up flexibility of thought through the use of '*both / and*' rather than '*either/ or*'. Andersen (1987: 421) says, '*The reflections must have the quality of tentative offerings, not pronouncements, interpretations or supervisory remarks.*' This care over how to offer a thought is in line with current psychoanalytic practice, particularly the work of Alvarez (1985, 1997) who might focus on the grammar of the interpretation. This also builds on the work of Meltzer (1978) and in current psychoanalytic practice an interpretation would be considered to be a collaborative act. Andersen (1987:426) says,

'Our new way of working makes us feel that we are participants in a process in which family members become our equals. We do not feel we can or should control the therapy process and we accept that we are merely part of it.'

Again this links to the work of Bion (1967) who wrote about working without memory or desire, not trying to control the therapy or the outcome, allowing it to happen. It can also

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be seen as a re-distribution of power, making the helping professionals appear less threatening, avoiding in part the difficulties which families and individuals may have with authority and authority figures.

Technically Andersen draws similarities between the reflecting team and previous family therapy techniques such as the 'Strategic Debate' and 'Greek Chorus' described by Papp (1980). Again I think this is important as the organisation of the material is around technique, which is well referenced in the systemic literature.

Andersen, then, creates a formulation of the needs of a family around the idea that the system is stuck. In response to stuckness change has to be tolerable and respectful of the existing order and neutrality and collaborative ideas about working with families are stressed. This is similar to previous interventions, uses some concepts already existing in Family Therapy but moves philosophically away from a paternal view of the expert to a collaborative model and technically provides a new set of voices that are outside of the system, allowing the family to hear their view without direct interaction. The focus therefore seems to be one of providing thoughts, ideas, observations and questions that are tolerable to the system and can be digested by the system.

Andersen's work has had a profound impact on the practice of systemic family therapy and many articles respond to his work, but again the focus is on technique and philosophy and does not pick up on the theme of stuckness.

DEADLOCK

The final article I want to refer to in detail is by Van Lawick & Bom (2008). I have included Van Lawick and Bom (2008) in this review even though they do not refer to stuck, stuckness or impasse. Instead they refer to a situation where professional help has reached a 'deadlock'. This re-phrasing of stuckness is helpful as it describes families where professionals have sought additional help, or felt the need to refer onto more specialised teams. Van Lawick & Bom (2008: 504) also link the situation of deadlock to what they describe as '*multi-stressed families*', a term described by Madson (2007) (and implicit in the work of the other authors featured in this review) who suggests that it is important to be aware of how these families cope with all stress factors. Van Lawick & Bom (2008:504) say,

'These stress factors are connected to each other and concern all areas of life: lack of resources, social stress in the environment and with housing companies, school and work problems, debts, integration and language problems and illnesses. Reactions to these types of stress often increase the stress and involve interactional escalations with psychological and physical violence, alcohol and other substance abuse. These families often have a history of frustrating experiences and they have developed an attitude of distrust to the outside world. Professionals want to help and often take a condescending educational stand in order to control the situation. The family feels blamed for the situation and this triggers more distrust. Professional helpers feel powerless and start blaming the family for not being cooperative.'

In this way Van Lawick & Bom (2008) take a view that the core problem is stress and a pattern of functioning that increases the original problem. Professionals who take a superior or authoritative stance find that they enter a relationship with increasing dissatisfaction and increase the level of the problem. Van Lawick & Bom (2008) also suggest that with this type of family it tends to be the least qualified and most poorly paid staff who are asked to do the most work, with the most experienced professionals rarely getting directly involved. Their article discusses their attempts to change this situation in their workplace and details a number of techniques and strategies that they used. It

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fundamentally stresses the importance of trying to work collaboratively with the family, starting with a home visit, asking the family directly about what went wrong when they sought help before and on building on the strengths which they find in the family. They have integrated a lot of systemic ideas into their practice and stress their preparation as a team in discussing their work with a family using multi-dialogues (linked to ideas of a reflecting team and circular questioning, and taking a meta-position, Seikkula et al, 2003) to make explicit the ideas and theories that were being applied to the work. In the direct work with the family the same technique is used, starting with the family being asked to set the agenda and responding using techniques designed to stimulate reflections.

COLLABORATION AND FEEDBACK

Van Lawick & Bom (2008) conceptualise their work as building bridges between themselves as professionals and the multi-stressed families. They use this metaphor as the idea is that the bridge is built from both sides, in a collaborative partnership. To do this Van Lawick & Bom (2008: 506) try to avoid the '*expert role*' and take on a '*position of not knowing*' which they say,

'...does not mean that we do not know anything. We are experts in asking questions that stimulate reflection. We are experts in shaping a context for new initiatives. But we do not know which direction these initiatives will take in the particular lives of the people with whom we work. Therefore we try to establish a form of collaboration with our clients because collaboration is something one does together; each participant is equally important.'

Van Lawick & Bom (2008:507) take the idea of collaboration forward by rejecting the term '*resistance*' (which Treacher and Carpenter did in 1982) but they also alter their language and do not use '*dysfunctional communication, or concepts of pathological diseases*'.

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Van Lawick & Bom (2008) give detailed case studies about the work, identifying ways of avoiding or reflecting on the deadlock position. They identify one aspect of the development in the family as being able to accept tragic and painful aspects of life, and they link this development to the family's experience of empathy from the therapists.

One of the reasons I have included the Van Lawick & Bom (2008) article is because it advocates two technical developments that are not mentioned in the other articles reviewed here and are closer in practice to my own experience of working in collaboration with a systemic family therapist: Firstly, in addition to the multi-dialogue Van Lawick & Bom (2008:511),

'...also try to hear all the voices within a person. Often one inner voice (e.g. 'I am a loser, I will always be one') is a dominant voice that silences other voices, like 'things can change, the future can be better' or 'some people like me'. And the different voices within the therapist: 'I feel stuck', 'this family is a mess', 'aren't these people resilient!', 'this son needs help with his drug addiction', 'I am worried about this girl' and 'how courageous.'

I think this obviously relates to object relations although this link is not specified and the aspects of the self are utilized differently in a technical way; Secondly, they utilize a child therapist to work with the child and to ensure that the child's voice is heard and that the child is given opportunities to see the world in different ways.

In their conclusion Van Lawick & Bom (2008) stress the importance of feedback in facilitating positive working relationships and change for the family. Van Lawick & Bom (2008:515-516) say,

'Home visits to multi-stressed families where professional help has become deadlocked can open up new possibilities, especially when the therapists work from an egalitarian and collaborative position. The therapists start to learn from the family; they want feedback from the family about professional help: What do they think went wrong, was not helpful? What do they think could be helpful? This starting point helps the family to move from a defensive, paralysed, hopeless and isolated position to a position of initiative, re-engagement, hope and connection. In this process a culture of ongoing feedback is crucial. This feedback helps the clients keep a sense of agency over the process of change and can formulate the core values they want to be met in their lives.'

CONCLUSION

The articles by Treacher & Carpenter (1982) and Carpenter et al, (1983) are excellent examples of the care and consideration given to the positions that professionals find themselves in and they clearly show the complexity of the stuck situation and the wealth of techniques that can be developed to address the problem. The article by Andersen (1987) is an example of the strengths and weaknesses of the systemic field in relation to this subject: it does not reference the earlier articles on the theme of stuckness but it does take the philosophical and technical aspects of the work further, stressing the collaborative nature and the importance of the meta-dialogue. Twenty years later Van Lawick & Bom (2008) are again engaging with the theme without reference to the previous articles but building on their technical and philosophical foundations. They take the intervention further by stressing the need for home visits, collaboration, paying attention to internal voices in addition to multiple perspectives and involving a child therapist and getting a robust system for feedback in place between the family and the professional group.

DISCUSSION OF LITERATURE REVIEW

There is a great deal of energy and excitement in the articles reviewed in both the systemic and psychoanalytic fields. It appears that the subject of impasse or stuckness appeals to some clinicians in both fields as the subject provokes questions in relation to theory and technique. There is quite a different feel to the literature in each field and it is notable that the psychoanalytic literature focuses only on alterations to interpretation rather than on other techniques (the notable exception to this is Meltzer (1968) who suggested an interruption to the analysis). On the other hand the systemic literature responds by suggesting many and varied techniques to try. Both literature fields increasingly broach the idea that there is a deprivation and understandably intense defensive function on the part of the individuals and families involved. The need to bear the high level of fragility in mind and to be sensitive to this is an essential requirement in working with these individuals and families. Both fields stress the need to find space to think and to work with the patient in a collaborative way while not being overwhelmed by the material.

It was interesting to note that there was a technical move in each field that involved an awareness of the importance of communication. I noted a difference in the two fields that may characterise their different ways of working and thinking in that the systemic field appeared to focus on the language used and was aware of avoiding certain terms or ways of thinking while the psychoanalytic field seemed to focus more on the grammar and delivery of interpretations. I thought this was interesting and perhaps could be a theme that is explored in further research.

DISCUSSION OF LITERATURE REVIEW

Although both fields are quite different in their approaches there is an increasing theoretical agreement that the family needs a diverse range of techniques and interventions that are sensitive to the communications that are being made at many levels, including levels of unconscious functioning and acting-out. Both fields crucially report the need to work with colleagues and the network in a sensitive and supportive way, accessing supervision and carefully studying the work with these families.

AIM OF THE INVESTIGATION

To discover how families and clinicians find themselves in stuck positions (where the helping relationship has reached an impasse) and begin to build theory that will help clinicians and managers make decisions on how to improve interventions in these circumstances.

DISCUSSION OF THE SELECTION OF RESEARCH METHOD

Dare (1988:174) says,

Psychoanalysis and family therapy can come together more now, twenty years on, by agreeing that both activities are preoccupied with the therapeutically useful, ethically apt re-creation and telling of stories.'

In choosing a method to investigate the research question it is important to select an appropriate approach which will generate the most appropriate data. The most obvious place to look for relevant research data that can be collected is from CAMHS professionals who can tell their stories about getting 'stuck', how they experienced this, and from families who have been through the joint Child Psychotherapy and Family Therapy Sub-Clinic.¹⁰ Consulting people with different experiences i.e. professionals, parents and children can provide a triangulation within the data. There is therefore a potential in the CAMHS setting to gather some very appropriate data but how should this be done and how should it be analysed?

¹⁰ As discussed in the introduction.

DISCUSSION OF SELECTION OF METHOD

It would be possible to look at the data from a psychoanalytic view, in the manner which happens in work discussion seminars taught as part of the psychoanalytic observation courses and in the manner child psychotherapists are skilled at through training and writing of their qualifying membership paper. However there are some methodological difficulties in relation to this including the risk of exposing the research to criticism of imposition of a viewpoint on the data, and potentially forcing theory into the material in the way described by Ekins (1998) when he describes the problem as 'grid-reading' or imposition of theory onto data. He draws a distinction between the psychoanalytic methods used for clinical work and the methods required for research, preferring to use an approach which does not filter data through an imposed framework of theory.

I do not completely agree with this criticism of psychoanalytic methods for research purposes but I do think Ekins (1998) is drawing attention to a potential lack of rigor in the reporting of psychoanalytic research to date. When reading psychoanalytic articles readers are often left to accept that the theories proposed are based on extensive observation but are presented with only the briefest of examples, or selected facts (Poincare, 1908). This has possibly led to an alienated audience of 'scientifically minded' practitioners from other fields, who have at times been very dismissive of psychoanalytic methods. Gomez (2005) wrote about the 'Freud Wars', mapping a debate about the scientific standing of psychoanalysis. Gomez charted criticisms of psychoanalytic research methods starting with an outright attack from Crews (1995) who maintained that psychoanalysis was a pseudo-science unable to meet the standards of scientific reasoning. Crews presented a powerful argument that historically can be traced back to Popper's (1962) assertions in relation to science, and a movement in the middle of the twentieth century to promote a very narrow definition of 'legitimate' science. From this narrow perspective it is claimed that if psychoanalysis cannot function within the field of 'legitimate' science to explore causes in

DISCUSSION OF SELECTION OF METHOD

an empirical sense then it is not science at all. These criticisms are long-standing in relation to psychoanalysis and tend to focus on some very narrow aspects of psychoanalytic literature i.e. an interpretation that is disagreed with remains 'true' and it is the patient who can not accept the truth or 'resists' the truth. The unassailable correctness of the analyst is repulsive to the empirical scientist and often leads to an enthusiastic rejection of psychoanalysis. This particular debate was explored in detail by Ricoeur (1981) who used it to draw our attention to the unique position of psychoanalysis in studying the defensive process of repression. Ricoeur pointed out how analytic practice has developed and involves a more mutual exploration of meaning, using narrative, and psychoanalysis is moving past this problem form within its own methodology. Ricoeur's prediction has certainly been borne out over the last decade with the increased emphasis given to research in Child Psychotherapy training and the realization that in teaching Work Discussion seminars we were not only finding ways to observe clinical relationships, children's developing minds and moments of emotional growth but we were also teaching a research method that gathers high quality data. Psychoanalytic practice and research is inherently reflexive, which is increasingly being acknowledged as a desirable element to social research rather than an impediment to it, (Charmaz, 2006).

Most parties involved in the debate on psychoanalysis as a science now agree that what is being described and discovered in psychoanalysis is not a 'cause' in the empirical sense suggested by Popper (1962) and Crews (1995), but a different type of enquiry that often leads to further complexity. Indeed, in psychoanalytic practice the complexity of findings has led to different schools of thought, debates and schisms but despite all this there has been a convergence in some aspects of the psychoanalytic method. In child psychotherapy this method relies on observational material, careful process recording, clinical supervision (identifying the emotional communication through the study of transference, counter-

DISCUSSION OF SELECTION OF METHOD

transference and session content) paper writing and peer review. Also there is an organised body of work in psychoanalysis that stretches back over 100 years of clinical practice. The child psychotherapy literature describes details of emotional development and consistently draws attention to findings that a certain type of development is healthier than another, and we can provide evidence of this in relation to nurture, empathy, deprivation and trauma. This rich qualitative field has been ignored by empirical scientists because they claim it has not been organized in a planned, constructive and predictive fashion. The knowledge has 'emerged' from work over time. The empirical scientists claim that this body of evidence is not the same 'sort' that has been gathered using more empirical methods. As a professional group Child Psychotherapists have 'failed' to come up with good enough measures for the development of the human mind. What we have instead is an organised body of knowledge in our journals and books, a methodology, detailed qualitative access to multiple single case studies. There is a logical flaw in criticisms of psychoanalysis from both within the field and externally: We study the human mind in relationship with an emphasis on the unconscious and the logical flaw in the move to expand from this base through research is that it immediately becomes something other than psychoanalytic practice or research. Instead it falls into the wider fields of psychology, attachment, psychiatry or sociology. The findings thus 'fall' from one field into another. If the research methods chosen are not compatible with the psychoanalytic method then the danger is that the whole field 'falls' away from its own methods and towards something else. Psychoanalysis has suffered from its own success in stimulating awareness, ideas and research in areas as diverse as attachment, clinical psychology, family therapy and even cognitive behavioural therapy. An advantage of developing more rigorous and transparent research methods is that the findings will not fall in a way that the source of discovery or inspiration is lost.

DISCUSSION OF SELECTION OF METHOD

Since Ricoeur (1981) expressed his view that psychoanalytic research has been developing its own methods, there has been a sea change in the field of qualitative research, most notably because of the emergence of Grounded Theory which was first described by Glaser and Strauss (1967). Broadly emerging from the phenomenological school Grounded Theory achieved its impact from its positivist connections. Glaser and Strauss (1967) showed that methods could be used in qualitative research that looked at experience and yet were repeatable. The research could be replicated by a different researcher and the data could be re-examined to look for alternative ways of theorising. They made the process of theory making explicit by describing a detailed examination of the data, word for word, line by line, incident by incident, coding material in a focused way and allowing theory to emerge. In this way the findings could be 'grounded' in the material in directly demonstrable ways. This rigour in the method can be seen as complimentary to methods in psychoanalysis, the difference being primarily in the transparency of the process.

Since 1967 Grounded Theory as a research strategy for gathering and interpreting data has grown enormously, impacting on a range of fields from sociology to nursing, to marketing, and to psychoanalysis. Grounded Theory has also developed and split into different schools which opens it up to a criticism of not being one clear method for research but rather a license for researchers to do what they want with very limited rationale. This has been changing recently however with the publication of 'Developing Grounded Theory: The Second Generation' Morse et al, (2009) which presents a diverse field of researchers who have developed Grounded Theory in many directions but who remain respectful of this divergence and understand the positions which each other have taken. In its first chapter Morse (2009:17) maps out the different directions taken since 1967 and makes it clear that each alteration in method is coherently thought through and responds directly to the demands of different types of research question.

DISCUSSION OF SELECTION OF METHOD

It is important for Child Psychotherapists to be clear about the specific nature of Grounded Theory they are using. In psychoanalytic research Ekins (1998), Anderson (2003, 2006) Midgely (2004) and Hindle (2007), and have all shown how Grounded Theory methods compliment psychoanalytic research. Anderson (2006) demonstrated the way in which the psychoanalytic thinking operates at the stage of data gathering and again is in operation through the researchers sensitivity in the coding and theory building stages.

One of the biggest changes in qualitative research over the past 40 years has been the development of the understanding that reflexivity is a strength and not a weakness. While perhaps not recognised by the wider research community, this has been something that is inherent in every psychoanalytic endeavour and child psychotherapists have a high level of expertise in reflexivity because of their training. Using grounded theory allows the child psychotherapist to use additional techniques and even formats for presenting their work in a transparent way which until recently has not been so impressive in the literature. Charmaz (2006:188-9) describes reflexivity as,

'... the researcher's scrutiny of his or her research experience, decisions, and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interests, positions, and assumptions influenced inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports.'

This transparency and reflexivity in the method of Constructivist Grounded Theory compliments psychoanalytic approaches. The method allows for the strengths of the psychoanalytic research to be set free while at the same time providing safeguards against the grid-reading described by Ekins (1998), or the criticisms that the researcher has not provided enough detailed data to back up their claims.

DISCUSSION OF SELECTION OF METHOD

Charmaz (2006) has developed Grounded Theory in a way that is consistent with a constructivist philosophy which I think is very compatible to psychoanalytic thinking, and indeed must have been influenced by psychoanalytic thinking. Charmaz (2006:187) describes constructivism as,

'...a social scientific perspective that addresses how realities are made. This perspective assumes that people, including researchers, construct the realities in which they participate. Constructivist inquiry starts with the experience and asks how members construct it. To the best of their ability, constructivists enter the phenomenon, gain multiple views of it, and locate it in its web of connections and constraints. Constructivists acknowledge that their interpretation of the studied phenomenon is itself a construction.'

In time the research methods used by child psychotherapists may come to incorporate the techniques and method of Grounded Theory in a way that could be conceptualised as Psychoanalytic Grounded Theory and indeed I think the developments in Work Discussion seminars are approaching something which is substantial and unique and acceptable to both fields. Anderson (2006: 334) entertains this idea but then dismisses it out of respect for the writing of Glaser (1978). However, recent developments in the field of Grounded Theory, as detailed by Morse et al, (2009) indicate that developments like this are possible as long as the thinking about the methodology is rigorous and transparent. For this research into stuck cases I propose to use Constructivist Grounded Theory as described by Charmaz (2006) as to date I consider this the most compatible method to compliment the question while including the psychoanalytic sensitivity and training of the researcher. This method allows the researcher to be proactive during data sampling and rigorous in the methods of coding and theory building. Mostly, however it is the approach which is best suited to the research question, how do families and clinicians find themselves in stuck positions and what helps them out of them? Constructivist Grounded Theory allows for the gathering of data from multiple perspectives, interviews with staff and families and the reflexivity of the researcher who brings psychoanalytic practice to the interviews and theoretical sensitivity to the coding and theory building.

DISCUSSION OF APPROACH TO INTERVIEWS

Methodologically a decision had to be made about whether to look for information that involves a detailed gathering of case material, background details about age, family composition, developmental history etc., or alternatively to look for what Grounded Theorists call rich data, Charmaz (2006:14), where the researcher attempts to allow participants to, ‘...reveal views, feelings, intentions and actions as well as the contexts and structures of their lives.’ Given that this research is about how groups of people find themselves in a situation they were invited to tell the story of how this happened. I therefore decided to use Intensive Interviewing rather than a semi-structured interview.

INTENSIVE INTERVIEWING (Lofland & Lofland, 1984, 1995)

Charmaz (2007:25-26) says that,

‘The in-depth nature of an intensive interview fosters eliciting each participant’s interpretation of his or her experience.the interviewer’s questions ask the participant to describe and reflect upon his or her experiences in ways that seldom occur in everyday life. The interviewer is there to listen, to observe with sensitivity, and to encourage the person to respond.’

Charmaz (2007: 26) goes on to explain the ways in which an intensive interview allows the interviewer to:

- *‘Go beneath the surface of the described experience*
- *Stop to explore a statement or topic*
- *Request more detail or explanation*
- *Ask about the participant’s thoughts, feelings and actions*
- *Keep the participant on the subject*
- *Come back to an earlier point*
- *Restate the participant’s point to check for accuracy*
- *Slow or quicken the pace*
- *Shift the immediate topic*
- *Validate the participant’s humanity, perspective, or action*

DISCUSSION OF SELECTION OF METHOD

- *Use observational and social skills to further the discussion*
- *Respect the participant and express appreciation for participating'*

This approach to interviews was much more adaptable and compatible with a child psychotherapy training. It was also more directed toward gathering the information required to compliment the research question. The intensive interview therefore was designed to stimulate reflection on the factors involved and the ways in which clinicians conceptualise and construct the situations they have found themselves in with families.

METHOD

METHOD

The research was divided into two phases, the first phase interviewing experienced CAMHS practitioners, the second phase interviewing a family with a shared an experience of being stuck.

PHASE ONE, SECTION A: PARTICIPANTS

‘Stuck’ cases are largely identified through the reports of clinicians. To gather clinician viewpoints the researcher approached experienced staff working in Child and Adolescent Mental Health Teams in Greater Glasgow and Clyde Health Board.

NUMBER OF PARTICIPANTS

The research interviewed 12 out of a target of 18 practitioners. This represents around one tenth of the Child and Adolescent Mental Health staff in the Greater Glasgow and Clyde NHS area and as such was designed to be large enough to include practitioners from various disciplines and geographical areas, allowing for a wide range of experience and also scope for protecting identities.

SELECTION PROCESS

The researcher contacted all appropriate staff through circulating an opt-in letter or email, inviting them to opt-in to the research.

METHOD

Inclusion Criteria One: Practitioners were qualified professional used to dealing with a wide range of cases in a CAMHS setting. Participants came from one of the following professions:

Child Psychiatry

Clinical Psychology

Nurse Therapy

Systemic Family Therapy

Arts Therapy/ Play Therapy

Liaison Social Worker

Speech and Language Therapy

Inclusion Criteria Two: Practitioners had been working in a CAMHS setting for at least two years. This was to ensure that they could differentiate between an ordinary difficult case and a case which might be regarded as 'stuck'.

MEANS OF HANDLING REFUSALS/ NON RETURNS

The research aimed for eighteen practitioners but a review of the twelve interviews was felt by the researcher and supervisor to be a sufficient sample.

PHASE ONE, SECTION B APPARATUS/ MATERIALS

Interviews were audio recorded using a digital audio recorder, then transcribed into a Word Document by the researcher.

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INTERVIEW STRUCTURE

The research used Intensive Interviewing as described by Lofland & Lofland (1984, 1985).

The initial aim of the interview is to prepare the participant to identify and discuss an experience of a stuck case.

SCRIPT:

Stage one: The research is about stuck cases in CAMHS. This is different from difficult cases or complex cases. The research is looking at cases where a child or a family has attended asking for help, you have tried to deliver help in the way you think best, and somehow the process of delivering help and receiving help has become the problem, and the original problem, the reason for referral, is not getting any better.

Stage Two: Clarification about which case may be appropriate and helping the practitioners to tell the story by appropriate questioning and exploration.

Stage Three: A reflective discussion about the case including the researcher's view of the material and links to the literature search.

CODING

The material was examined using constructivist grounded theory techniques as described by Charmaz (2007).

PHASE ONE, SECTION C: PROCEDURE

INTERVIEWER

The researcher conducted all the interviews. The researcher is a qualified Child and Adolescent Psychotherapist with twenty years of experience working in a child and

METHOD

adolescent mental health setting. He is experienced in clinical interviewing and has extensive training in observation skills and reflexive practice.

MEASURES TO ENSURE RICH DATA

The intensive interview aimed to elicit CAMHS clinicians' views on the situation of being in a stuck position in relation to a piece of work. Some difficulty in gaining a completely honest account of this situation was anticipated as the clinicians may have felt that they got 'stuck' because of a number of factors which could include missing something important or they may have felt the research was focused on what they did 'wrong' and they may not have wished to be seen as someone who could not cope with difficulties. To ensure that some of these factors were addressed the practitioners were asked to opt-in to the research and they were given detailed information about the research, the methods used for protecting identities and that the cases they are discussing were not named. The researcher ensured that anything identifiable was removed from the narrative before transcribing the interview into a Word document.

It may be that practitioners still provided a version of events where their part in the process of getting stuck was misrepresented or underplayed but the use of reflexive practice, and open ended questions provided a rich descriptive narrative where the participants reflected on their construction of all parties involved in the narrative. The researcher considered all participants to be engaged with the question and honest in their accounts, including their own struggles with the difficulties in the cases.

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SETTING

The research was set in a Child and Adolescent Mental Health Clinic in the West of Glasgow. Interviews took place in a private clinical room with no telephone and an engaged sign on the door.

DURATION AND TIMING

The interviews lasted no more than one hour. Practitioners were not asked to participate more than once.

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PHASE TWO: CLINICAL EXAMPLES FROM MULTIPLE PERSPECTIVES

The research initially planned to include family perspectives on being stuck.

As there was only one family who successfully took part in the research the interview has not been included due to reasons of confidentiality. The method for approaching families is included in Appendix 1.

REFLECTIONS ON THE ETHICAL ASPECTS OF THE RESEARCH

The process of seeking ethical approval for this research has both limited the research and shaped it in ways that I had not anticipated. In many ways this has been to the advantage of the research as it has narrowed the scope of the study and allowed a deeper focus on the social construction of the experience of getting stuck, from the clinician's point of view. The process of getting ethical approval was arduous but enlightening and an area of the research where I felt I learned a great deal, in particular I learned that ethics and research methods are not separate but intertwined.

INITIAL EXPERIENCE

My initial experience of looking for ethical approval at my local NHS Ethics Department was very positive and very humbling. The administrator advised me to write the initial application from a viewpoint that the research was not an act of kindness to the participants but that it involved them agreeing to something as an act of kindness to the researcher. This standpoint gave me an opportunity to really reflect on what I was going to ask people to do and how to make sure that the participants gave truly informed consent. My application was re-drafted twice in response to the local ethics committee and I took part in a forty minute interview where I explained the research and the process involved. This opportunity to address the committee directly was welcome and the project was approved with some alterations to the method of seeking consent. It did draw my attention to the fact that it was easier for me to communicate the ideas behind my project verbally than in the written application. This led to me reviewing the initial proposal and

REFLECTIONS ON THE ETHICAL ASPECTS OF THE RESEARCH

concluding that it was difficult to understand because of the complexity of what I was attempting to do and the detail of the procedure was underwritten.

CHILD CONSENT FORM

In advance of seeking ethical approval I worked with a visual artist, Rachel Mimiec, to discuss ways in which the research could be explained to children in a meaningful way so that they could make an informed decision about whether to take part (see Appendix 2). I thought that the resulting consent form was superior to the seven page patient information sheet that was given to practitioners and parents. Of the three children who responded two of them had spent some time colouring in the drawings and they had agreed to take part.

VULNERABILITY AND TRUST

This research project invited staff to come along and discuss areas of work practice that did not show them off in their best light. The cases tended to be very distressing to staff and at times staff shared areas of practice where they felt lost, confused, impotent, they may have been acting out, and generally struggling to help the families in question. Why on earth would anyone volunteer to take part in such a study when it would put them in a very vulnerable position? In order to make this project something that staff would not just consent to but opt-in to, it was necessary to provide some protection for the practitioners and the families they discussed. These included sampling staff from a very wide geographic area, asking staff to opt-in, not using family names, child names or clinician names at any

REFLECTIONS ON THE ETHICAL ASPECTS OF THE RESEARCH

point in the interview or if names were mentioned not transcribing them, not noting the gender of the practitioners, where possible concealing the gender and any other identifiable details about families or practitioners. If at any point in the interview a respondent said 'don't put that in' then the information was not transcribed. The researcher transcribed the interviews personally to ensure anonymity.

At this point it is also worth noting that the method also impacted on the ethical dimension as I had conducted a trial interview with my family therapist colleague using a semi-structured interview. Examining the data that this yielded challenged me to think about different ways of gathering the information as the initial response was very factual but very cold. A semi-structured interview did gather information relating to the practitioners emotional response but got this information separate from the narrative and social construction that the later method of intensive interviewing yielded. The intensive interviews also protected the interviewees as it allowed a high degree of reflexivity and allowed them to explain the context of the experience and give their own version of events.

The researcher benefited from being part of a wide network of CAMHS teams in the Greater Glasgow area and was known to most if not all the participants. All of the steps above coupled with the personal knowledge of the researcher meant that enough practitioners in CAMHS responded to make the research viable.

Being ethically aware of what we require respondents to do is essential and I feel I benefited from taking a considerable amount of time to consider ways to protect the confidentiality of interviewees while at the same time make the information they provided available for detailed examination in a potentially quite public forum.

LIMITATIONS AND DEVELOPMENTS.

Initially I had hoped to interview 18 clinical practitioners in CAMHS with access to the case notes on the ‘stuck’ cases they had chosen. Through the discussion with the committee it became clear that they felt if the case files were to be used then the families involved would have to be consulted and give consent. I thought it would be highly unlikely that any of the families would agree to this, given the nature of the difficulties they would have experienced with the practitioners. I also thought that the staff would be reluctant to volunteer and nominate families to contact if there had been difficulties or if the treatment had ended badly. The first stage of my research was crucial as all stuck cases inevitably come through clinical staff and it was essential to get the practitioners views on what constituted a stuck case and the experience of becoming stuck. I therefore had to think of a way to get the practitioners’ views without making the research overly formidable so that no one opted-in. I was fortunate at this time to also be researching the methodology of grounded theory in more depth. As I did this it became clearer to me that the data I wanted to gather was not necessarily in the files of these cases or of a quantitative nature at all, instead I wanted to focus on the social construction around stuckness, and focus on the experience of the practitioners and explore how they constructed the experience. This allowed a breakthrough to happen in the method and in the ethical approach to the interviews. I suggested that I meet with volunteer practitioners in CAMHS and ask them to think of a case, not necessarily an open case but one from any point in their career and to tell the story of becoming stuck. The practitioners were asked not to name the family or the child and refer to ‘the boy’ or ‘the girl’ and ‘mum’ or ‘dad’ and in this way the interviews protected the identity of the families and focused on the practitioners’ view of the story. This was a positive development as it allowed me to focus on the data that was of most use to me. Even though I had anticipated the need to examine

REFLECTIONS ON THE ETHICAL ASPECTS OF THE RESEARCH

each case file in detail in hindsight I think this would have been distracting and would not have complimented the research method.

The second stage of the research was originally planned to be an examination of the case files and interviews with up to six families who had been seen explicitly because of becoming stuck. I had thought this would be a straightforward approach to the families that I had worked with over the past three years. Ethically this was not so straightforward. I first of all had to get legal permission to use the database of cases seen at the joint child psychotherapy and systemic family therapy sub-clinic, then had to go through a very detailed approach to families. The ethics committee stated that I was not to approach families directly to discuss the research but could write to them asking them to opt-in for a discussion with me. It was agreed that I could send one opt-in letter and one reminder. While I was disappointed in this I could agree with the committee that this would lead to motivated families responding and meant that no families were pressured or persuaded to participate. In practice this was something of a disaster for the second stage of the research as only three families responded and there were complications for two of these families. One family was in the middle of a clinical crisis and I felt that this excluded them from the research at this time. Another family were split in their motivation with the child and one parent keen to participate and another parent refusing. This left one family where all parties gave consent. I did not think that one family was sufficient to gather themes across a range of work and therefore have not included the interview with the family. This was very disappointing and I do feel it curtailed the scope of the research.

The committee also said that all parties in the index case, which was used for the European Family Therapy Association conference presentation in 2007, would have to opt-in to the research, despite having previously given consent for their case study to be used for the

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conference presentation. This was also disappointing as previously members of this family had been enthusiastic to have the case used for training. At this current time the family has re-organized and it was impossible to get the consent from all parties, although the ones that could be contacted remained enthusiastic. This had a particular impact on the introduction to the research and would have allowed an exploration of the application of many of the themes discussed in the literature review. I had actually already written this part of the thesis when I realized I could no longer use the material and I did feel that this was disappointing.

CONCLUSION

Despite major disappointments in relation to material that could not be included in the research and the passive nature of waiting for people to opt-in, there were positive aspects of having a thorough process of ethical approval, notably the confidence that I now have as a researcher in this aspect of the project. This confidence alongside the meaningful consent from the children involved (because of the children's consent form) and the positive developments to the methodology helping to focus on the social construction of stuckness have meant that the process of seeking ethical approval has been a very positive one.

FINDINGS: OVERVIEW

Each of the twelve CAMHS practitioners offered a detailed account of a case they considered to be stuck. The cases ranged from recent cases to cases that were seen over ten years ago. All cases were presented from memory, without access to a case file and the quality and quantity of information showed a very high level of emotional and professional engagement with the cases discussed. The interview took the shape of stimulating the idea of stuck cases and facilitating the practitioner to tell the story of what happened in the case. This was then followed by a discussion of the case with the researcher, which included some psychoanalytic concepts such as transference.

All names and professions have been removed from the account of the case at the point of transcribing and practitioners are referred to by a code P and a number (i.e. P1 or P7). Any identifiable material in relation to a practitioner or family was removed at the point of transcribing while as much of the sense of the case material was protected. The gender of the practitioners has been concealed. Where possible the age and gender of the child has been concealed by using the term 'the child' even if this refers to a young person in their teens (this was not possible in all cases without losing the sense of the narrative).

For purposes of clarity any summary written by the researcher is in a plain font and any quotes directly from the interview with the practitioner are presented in *italics*. All of the practitioners are working in a Child and Adolescent Mental Health Service and the identity of the service and the clinicians' professions have been withheld.

FINDINGS: NARRATIVES

The following results are summarized accounts of each interview. Five of these are presented in some detail as they demonstrate a particular type of experience. The other seven accounts are presented in a more highly summarized form designed to draw attention to their unique features. The focus of the findings is on the narrative and social construction and the experience of the case and therefore the practitioners own words are used whenever possible.

Footnotes are used to demonstrate some of the coding in relation to the material. The narratives can be read without reference to the footnotes but they are included as samples of word-by-word, line by line, and theme by theme codes as they emerged in the analysis. At the end of each narrative there is a short paragraph on the codes used and this allows the reader to cross-reference each case with the detailed coding and the emerging theory.

After the narratives there are a number of charts which presents some characteristics of the cases in a visual form.

FINDINGS: NARRATIVES

CASE ONE

P1 was asked to see two children from the same family while the mother saw P1's colleague (C1). P1 felt that the children attended reluctantly¹¹ and were pre-occupied with being loyal¹² to their mother and concerned about what the mother was doing in her own session¹³. P1 felt that the intervention that was being offered was unwelcome¹⁴ and actually the children were anxious about it rather than feeling helped by it. P1 reported this to the mother, who was very disappointed.¹⁵ P1 thought that the mother hoped P1 could *fix*¹⁶ the children. In the mother's parallel work with P1's colleague (C1) she had disclosed a very abusive childhood¹⁷ and while C1 wanted to refer the mother to adult services,¹⁸ the mother felt that C1 had invited the disclosure¹⁹ and was the mother's preferred therapist.²⁰ P1 and C1 were aware that the mother had chronic pain from a medical condition, enduring mental health problems²¹, and was bringing the difficulties of the children and the limits of what she could provide to the attention of P1 and C1²². P1 was aware of just

¹¹ Reluctant receivers of care

¹² Loyalty to parent in distress

¹³ Children pre-occupied by parents relationship with professionals and adult activity.

¹⁴ Clinician felt to be providing unwelcome care.

¹⁵ Parent disappointed initial help fails.

¹⁶ Parent hopes the children's problems are internal to the children, not linked to parent.

¹⁷ Parent traumatised as child and discloses this in Child clinic.

¹⁸ Perceived rejection follows on from disclosure.

¹⁹ Parent feels invited to disclose personal material.

²⁰ Preferred therapist selected by parent.

²¹ Parent with complex physical and mental health problems.

²² Parent draws clinicians' attention to the limits of what parent can provide.

FINDINGS: NARRATIVES

how difficult the children's lives were and wanted to help²³. A great deal of effort was put into arranging additional supports for the children and for the mother²⁴, including services to help the mother manage pain, and involving the children's father (who did not live with them) in providing increasing amounts of care²⁵. This took a great deal of time and involved *seeing through* the hostile and angry (and occasionally lewd) behaviour of the father²⁶ (which was displayed to multiple agencies and initially in the clinic) and persuading adult services to stay involved despite the initial non-engagement of the mother²⁷. P1 also facilitated the mother engaging with a practitioner from another service to help the mother's anxiety so that she could attend hospital for a life saving operation²⁸.

P1 has a vivid mental image of the children depending on P1 and C1 to make a difference to their lives²⁹. They did a home visit on a couple of occasions and P1 said, *We were met by the children standing in the garden waiting for us and we went in and saw the mum, and we had a conversation with her. And when we left, the kids stood and waved us off and both my colleague and I felt that they had invested a lot in us to help them by helping their parents*^{30,31}.

P1 and C1 continued to work with the mother with the idea of helping her to *shelter*³² or *shield*³³ the children from her needs, including stopping the mother from getting the boy in

²³ Clinicians have empathy for children and want to help. Link to Hero functioning.

²⁴ Clinician reaches out to other agencies

²⁵ Clinicians instrumental in involving the wider system to elicit care for children and distressed parent.

²⁶ Clinician has to 'make good' care figures that are perhaps frightening.

²⁷ Clinician persuades other agencies to act differently in relation to parent in the interests of the children.

²⁸ Life or Death anxieties in the system, in relation to the parent.

²⁹ Clinician is affected by strong visual image of children depending on them. Clinician in the Hero position to the child.

³⁰ Children aware that their parent needs help

³¹ Children invest in Clinician.

³² Clinician Shelters children from parent's needs.

³³ Clinician Shields children.

FINDINGS: NARRATIVES

the family to lay out her medication for her each day³⁴, getting the *mother not to shout, scream and swear at them*³⁵. P1 encouraged the mother to be available to the children³⁶. P1 had a good understanding of the mother's difficulties saying,³⁷ *She was in a lot of pain,*³⁸ *she was very tired and she was unwell, she had never really had very constant or affectionate parenting herself*³⁹ *and her partner was the same.*

P1 detailed the relationship between the children's parents having been very ambivalent, the mother hating the father but loving him at the same time.⁴⁰ He no longer lived with the family and had his own relationship.⁴¹ While he was willing to offer more help for the children the mother could not tolerate⁴² this and P1 said that the mother would, *...withhold the children*⁴³. *She needed him to take the children but she would withhold them to get at him, to punish him.*⁴⁴

P1 and C1 arranged for intensive social care workers to support the family by providing practical help and also providing social supports for the children⁴⁵. P1 said, *But interestingly*

³⁴ Clinician attempt to prevent children taking on a carer function.

³⁵ Clinician working to prevent angry and abusive behaviour from parent to children.

³⁶ Clinician requests that parent in distress re-prioritises needs toward meeting children's needs.

³⁷ Clinician understands parent difficulties and child difficulties.

³⁸ Parent in pain.

³⁹ Inter-generational absence of good enough parenting.

⁴⁰ Parental relationship ambivalent.

⁴¹ Family had reorganised.

⁴² One parent not able to tolerate offers of help from another parent.

⁴³ Children withheld from alternative carer.

⁴⁴ Children used as means of punishing.

⁴⁵ Clinicians organise additional care from other agencies.

FINDINGS: NARRATIVES

one of the things I had been trying to do was say we need to let the children grow up⁴⁶, become more independent, access clubs, have a bit of a life, but she was too frightened⁴⁷ to do that...

The case then became *stuck*.⁴⁸ In addition to all of the work detailed above P1 said, *I had done behavioural parenting stuff with mum but actually she knew a lot of it and dad was actually quite good at it too⁴⁹, but she still came in every week and said, ‘I fuckin’ hate this you know⁵⁰, the kids are the bane of my life,⁵¹ I am going to run away, the kids hit me over the head, they are beating me up⁵². Every session started like that. It never seemed to get any better and we would try to do practical things, try talking about why it was difficult for her, she would start to feel a little bit better, we were looking at her looking after herself.... But nothing seemed to get any better⁵³. The kids were still killing⁵⁴ her, you know, and she kept threatening to run away⁵⁵ and at points my colleague and I would say, you keep talking about running away but why aren’t you?⁵⁶ And you are saying things that are making us worry.⁵⁷ I don’t think she said that she was going to kill⁵⁸ them but there was lots of heat and emotion⁵⁹ and I think she said to the kids that she was going to put them into care and things like that⁶⁰. And we couldn’t work out why it wasn’t getting any better⁶¹ and also why she kept coming back⁶² because in a way my colleague and I had got to the*

⁴⁶ Clinician supports development for children and separation from parent.

⁴⁷ Parent frightened of children’s development and independence.

⁴⁸ Clinician identifies case becoming stuck.

⁴⁹ Parent capable in relation to the treatment offered.

⁵⁰ Parent in intolerable situation.

⁵¹ Children cause of misery and distress.

⁵² Children perceived as aggressive and reported to be violent to parent.

⁵³ Despite parent showing capabilities the situation does not improve

⁵⁴ Children reported to be damaging, killing, parent.

⁵⁵ Parent threatens abandonment.

⁵⁶ Clinician responds to parent threats to abandon with questions rather than pleading.

⁵⁷ Clinician feels that parent is trying to induce concern.

⁵⁸ Clinician concerned about parent killing child.

⁵⁹ High expressed emotion.

⁶⁰ Anxious attachment promoted.

⁶¹ Clinician struggling to understand lack of improvement.

FINDINGS: NARRATIVES

end of what we could offer them as a couple, although they weren't a couple but she wouldn't let him speak⁶³.... Toward the end we started to say, look if you feel like this then you can't look after them, you can't make them feel safe and they are hitting you and hurting you and maybe they need to spend more time at their dad's⁶⁴. And she could not abide that.⁶⁵ So we referred it to the Reporter⁶⁶ because we felt the kids needs, physical and emotional needs, just weren't being met and they were hearing a lot of stuff about her putting them into care⁶⁷.... And that was really hard for mum because in lots of ways we felt she was actually a very committed parent⁶⁸ who (voice changes) kept coming for help.

P1 said that she and her colleague felt that, *we were almost torturing⁶⁹ her because we were being firmer and firmer⁷⁰ with her, laying it on the line,⁷¹ referring it to the Reporter⁷². But she would come back and tell you the same story⁷³ and that went on and on... for years⁷⁴.*

P1 was frightened that the firmer intervention was hurting the mother⁷⁵, as her sense of herself was connected to being a mother⁷⁶ and despite limited resources she made a big

⁶² Parent attending puzzling to Clinician.

⁶³ One parent dominates discussion

⁶⁴ Clinician promotes separation between parent and children and promotes alternative care.

⁶⁵ Low tolerance for children's needs being met by others. Priority given to maternal tolerance over children's needs.

⁶⁶ Children's needs not being met linked to low tolerance to treatment plan, linked to Child Protection.

⁶⁷ Anxious attachment promoted.

⁶⁸ Incongruent functioning of parent.

⁶⁹ Treatment as torture.

⁷⁰ Clinician gets firmer and experiences this as torturing.

⁷¹ Clinicians make the Unwelcome Link very obvious.

⁷² Clinician links lack of improvement to child protection and refers to a higher authority.

⁷³ Parent repeats story, no sign of learning from experience of the treatment or previous discussion.

⁷⁴ Clinician finds parent attending to be interminable.

⁷⁵ Paradox for Clinician as way of managing felt to be hurtful/ harmful.

⁷⁶ Parent presents as a mother not an individual in own right.

FINDINGS: NARRATIVES

effort to seek help and never missed appointments⁷⁷. P1 felt that the mother was really committed to her children but at the same time paralysed by her commitment⁷⁸.

The mother's own past was so disturbing⁷⁹ that P1 and C1 again thought she should attend adult psychotherapy⁸⁰ but despite the referral being accepted and offers to help the mother attend, she did not take up the opportunity, preferring to look to C1 and P1 to help her with these issues⁸¹. P1 felt that the mother knew *at one level that she needed that kind of resource* (adult psychotherapy) *but she was terrified of it*⁸².

P1 and C1 went through two phases of seeing the family together and there was a shift of responsibility depending on which of them was the case manager.⁸³ The case ended very suddenly⁸⁴ from P1's point of view when C1⁸⁵ was the case manager and decided that continued meetings weren't making any difference and closed the case⁸⁶. P1 felt unprepared for this, *shocked*, but P1 reported being *grateful* to C1⁸⁷ for doing this, and felt that C1 had more confidence in dealing with the system used by the Reporter⁸⁸. At the same time P1 felt they were witnessing a type of torture by C1⁸⁹ to the mother as the

⁷⁷ Parent's diligence in attending seen as part of her identity.

⁷⁸ Double-bind for parent who is committed and paralysed by commitment.

⁷⁹ Parental trauma from childhood.

⁸⁰ A clinician attempts to refer parental trauma to another service.

⁸¹ Parent chooses Clinicians as preferred care givers, putting them in the Hero position.

⁸² Parent terrified of receiving care in own right

⁸³ Shift of responsibility between colleagues.

⁸⁴ Sudden end of treatment.

⁸⁵ Colleague acts without consultation.

⁸⁶ Clinicians not being successful in making a difference is reason for closing.

⁸⁷ Clinician shocked by end but grateful.

⁸⁸ Confidence in child protection procedures linked to reason for discharge.

⁸⁹ Clinician witnesses torture.

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referral to the Reporter⁹⁰ involved the possibility that this mother would have her children taken away from her.

At the time P1 did feel that the sessions ended without adequate explanation for the mother and P1 wanted to reclaim something positive about what had been achieved together⁹¹. With hindsight P1 feels that more explanation was not necessary and wonders if the need for thinking positively was for P1 not the family. P1 said, *The mum left, she didn't stomp out but she didn't give us a second look*⁹². *I think she felt, maybe a bit let down, dismayed. Toward the end of our time together she almost threatened self-harm*⁹³ *if we pushed things too far*⁹⁴ *and... we would both be worried about her and we involved the GP in that and the GP said, "Oh, she is as tough as old boots, she will survive us all!"*⁹⁵ *And that was actually quite helpful.* P1 felt it was one of the most unsatisfactory endings they had ever had and linked this to the term *stuck* case.

In discussion about the case the term *torture* was explored further and P1 felt that there was a *mutual torture*⁹⁶ with referral to the Reporter from the practitioners and from the mother P1 said, *Well I suppose I could see that she was in a huge amount of pain and she was very keen*⁹⁷ *to make my colleague and I feel some of that pain.... And my god she put her ex-partner through it as well, I mean she was good at putting pain out there and really my colleague and I didn't want to feel that bad about anything*⁹⁸.

⁹⁰ Child protection and possible accommodation of children linked to torture of mother.

⁹¹ Clinician wanted positive ending for family and for self.

⁹² Clinician not given second look, possibly put in Zero position by parent.

⁹³ Threat of self-harm.

⁹⁴ Clinician disengage following threats by parent.

⁹⁵ External view sought of parent.

⁹⁶ Tortured feelings shared.

⁹⁷ Keen for others to experience pain suggests sadistic functioning making it hard for Clinician to respond with care giving.

⁹⁸ Professional task of receiving communication from parent is personally high and to be avoided.

FINDINGS: NARRATIVES

P1 linked this case to another case earlier in P1's career where a similar set of experiences had occurred with a family and when P1 had met with a mother who repeatedly reported terrible accounts of the mother's own sexual⁹⁹ abuse when she was a child. They were so connected in P1's mind that sometimes P1 called the mother of Case One by the wrong name.¹⁰⁰ The link to the other family is important as the first family was one seen early in P1's career and was an experience that shook P1's personal and professional boundary as P1 found the sessions intolerable and could even remember the smell of the room after the mother had left.¹⁰¹ P1 did not find Case One's mother's pain intolerable but had found the other woman's pain intolerable. It was clear that P1 did not want to experience the same level of pain again.¹⁰²

P1 was asked if the set of feelings they had in relation to the case were ever thought about as a transference communication. P1 said yes and linked this to the mother wanting others to feel the pain that she was in.¹⁰³ P1 did not feel that the mother received the message that P1 was aware of her pain and felt that what P1 could offer was a *bit...insubstantial*,¹⁰⁴ *probably*. P1 then linked the idea of just being with the mother, with the idea of the pain she was in, to unbearable states of mind¹⁰⁵ associated with the previous case. While being aware of the transference relationship it was the painful nature of the communication that was avoided for fear that it would be unbearable for either the practitioners or the mother herself¹⁰⁶.

⁹⁹ Link to other case and link to sexual abuse and trauma.

¹⁰⁰ Confusion around identity.

¹⁰¹ Memory of cases involves different senses in this case olfactory.

¹⁰² Clinician emotionally avoidant.

¹⁰³ Transference linked to painful experiences.

¹⁰⁴ Insubstantial, linked to Zero not Hero.

¹⁰⁵ Link between professional tasks and personal capacity to work with the distress in the case.

¹⁰⁶ Fear of engaging with issues as too difficult for Clinician or Parent. Link to Pandora's Box, in this case the parent wanting to open the box and the Clinicians trying to avoid that.

FINDINGS: NARRATIVES

P1 puts the family of Case One into a category of people with *intolerable lives*¹⁰⁷. P1 did report seeking additional training, opportunities to reflect on the case, and feels that over time the stuck cases have stimulated a great deal of thought.¹⁰⁸ P1 also reported an understanding that CAMHS workers have the potential to help and to harm people,¹⁰⁹ which is something that they have grown to understand over years of practice.

P1 said, *I suppose I think, that wasn't my finest moment in therapy, you know?*¹¹⁰ *I am not ashamed as I think that is what it is like at times, you know? Sometimes you can't, maybe you don't have it in you at that time in your life to help, and sometimes people can't use¹¹¹ what you can deliver to them, the stuff you have got to give.*

NOTES ON CODING CASE ONE

This is a case that was dominated by parental needs. If the Clinician wanted to help the children they had to help the mother. The mother did not present as an adult in distress but as a parent in distress and refused to be seen by adult services. This was coded as a Traumatized Breast or Toxic Breast, a mother seeking help because of their desire to nurture their children while being aware that they are having a negative impact on the children's development.

Clinician aware of transference relationship but not working with it. This was coded as 'Unreceived Communication'.

¹⁰⁷ Intolerable lives. No way out. Link to traps.

¹⁰⁸ Case stimulated further development for the Clinician.

¹⁰⁹ Intervention may be harmful.

¹¹⁰ Career Shaken and philosophy developed to manage this.

¹¹¹ Families may not be able to use the service Clinicians offer.

FINDINGS: NARRATIVES

The Children put their hopes into the therapist and the mother chooses the colleague as preferred clinician to disclose personal history, putting the Clinicians into Hero mode. While the Heroic role was taken on, the Clinicians felt unable to help and despite heroic efforts they remained limited to looking on to distress, torture and remained unable to make a difference and therefore in Zero mode. This was coded as Hero to Zero.

The Clinicians made an Unwelcome link between the children's needs not being met and the need to suggest alternative care. They also involved other agencies in trying to see the situation in this way. This was experienced as torturing the mother rather than protecting the children. This was coded as an Unwelcome Link or a Cruel Link moving to a Persecuting Link.

CASE TWO

P2 reported an instant negative reaction from the mother of a boy referred for assessment. P2 felt that this negativity lasted throughout their whole relationship and that any efforts made to provide a thorough assessment of the child's needs, timed in the best interests of the child, were felt by the mother to be P2 withholding treatment or being negative about the child.

P2's memory of the case was very vivid despite the passage of many years.¹¹² P2 and a colleague attended a nursery meeting for a boy referred for an ADHD assessment.¹¹³ P2 said, *My opinion was that they may need assessment but this wasn't the right time¹¹⁴ as he was due to start school and there were signs that he was settling at nursery.¹¹⁵ I felt he should start school and if people were still concerned, there was a paediatrician and an educational psychologist involved, if they were still concerned, they should contact us again come Christmas.¹¹⁶ That didn't go down very well¹⁷ and immediately there was a stuck feeling¹¹⁸ about it and everybody didn't like this stance I was taking about it.¹¹⁹ I got a feeling that my colleague didn't agree with me either¹²⁰ but I felt this boy's needs were out with Tier 3 CAMHS at that point¹²¹.... I had the feeling (my colleague) was thinking about the distress¹²² that was in this big*

¹¹² Case stays in the mind of the Clinician over time. Unresolved case.

¹¹³ Case referred for specific assessment. Parent perhaps anticipates outcome.

¹¹⁴ Opinions about timing differ.

¹¹⁵ Clinician begins by seeing improvements rather than problems.

¹¹⁶ Other agencies and professionals given a role in timing and judging if referral necessary.

¹¹⁷ Opinion not agreed with or difficult to digest.

¹¹⁸ Stuckness develops quickly.

¹¹⁹ Clinician faces universal dislike of position, therapist as symbol of stuckness.

¹²⁰ Opinion splits colleagues.

¹²¹ Clinician holds to opinion.

¹²² Clinician imagines colleague's thoughts without checking or discussing.

FINDINGS: NARRATIVES

room with ten, fifteen people¹²³, and the mum crying¹²⁴. It felt as if I had closed the door on them somehow, in a way that was cruel¹²⁵, or uncaring somehow¹²⁶. I was giving him the opportunity¹²⁷ to start school and an assessment wasn't valid at that point.¹²⁸ So, as I say, there was a sense of stuckness and a sense of being unhelpful,¹²⁹ trying to make a helpful suggestion that was received as a cruel and unhelpful one.¹³⁰

There was then another referral to the clinic that was accepted without consultation with P2¹³¹, and P2 felt this was done because colleagues felt sorry for the boy and the mum.¹³² P2 still was of the opinion that the timing was not in the boy's best interests.¹³³ There was then a period of assessment by other colleagues and the mother was informed that the boy had neuro-developmental difficulties but not ADHD.¹³⁴ The mother did not accept this.¹³⁵ The assessment was then *distorted* by the mother and other professionals in other agencies¹³⁶ and the boy was re-referred again,¹³⁷ with the referral stating that he did in fact have ADHD. P2 felt that it didn't matter what action the service took,¹³⁸ the referral for ADHD kept coming in. P2 said, *Several years went past and his (the boy's) name became significant in the*

¹²³ Clinician taking unpopular stance in large forum.

¹²⁴ Parental distress expressed in large group. Parent experienced as leader of emotional gang. Parental distress dominates.

¹²⁵ Closing door. Cruelty. Clinician imagines they are being seen as cruel but can not reconcile this with motivation or opinion.

¹²⁶ Clinician representing uncaring figure.

¹²⁷ Clinician own view of opinion and actions is benevolent and incongruous with the group view.

¹²⁸ Clinician thinks that to respond to request would be an invalid action, not in best interests of child.

¹²⁹ Stuckness linked to sense of unhelpful Clinician.

¹³⁰ Clinician feels message is misunderstood in a negative direction.

¹³¹ Referrer does not accept first view and makes another attempt at seeking assessment, implying the Clinician was incorrect in not accepting it the first time. Colleagues accepting the case without consultation suggests a perceived split among service. Code as Clinician Out-manoevred.

¹³² Clinician feels that emotions have influenced decisions in an unhelpful way.

¹³³ Clinician sticks to view.

¹³⁴ Colleagues who provide requested assessment have alternative view.

¹³⁵ Parent does not accept professional opinion.

¹³⁶ Parent and agencies distort clinical assessments.

¹³⁷ Parent tenacious in seeking specific diagnosis.

¹³⁸ Clinician feels helpless. In the Zero position. It is fated that the referral will be accepted.

FINDINGS: NARRATIVES

clinic, a 'jimmy' type of case, a criteria if you like, let's not get into that again.¹³⁹ And I think that is what happens, we don't learn from our experience.¹⁴⁰

Another referral was accepted by the service and again P2 felt that it had been a bad decision to accept the case again,¹⁴¹ feeling that the mother did not trust the opinion of the therapists in the clinic. P2 then met with the mother and the child for an initial meeting to discuss further assessment and reported *...his mum remembered me from the first meeting which was now 2-3 years ago and she commented that I was the person who locked the door to her son's ADHD assessment saying he did not have ADHD, which is not what I had said at all.¹⁴² I felt that I could be professional, I could be a clinician and I could help this boy¹⁴³. And again this mum was crying, clearly very distressed, feeling that wherever she went there wasn't any help, despite the fact that out there was an army of people trying to help.¹⁴⁴ So we go through her tears and her anger¹⁴⁵ and I made an agreement with her that I would have an assessment completed by the autumn.¹⁴⁶*

P2 reported that anxieties around this case and making sure that the assessment was completed on time interfered with P2's functioning in relation to diary appointments, and other cases suffered because of this.¹⁴⁷ P2 said this anxiety spread to the secretarial and admin staff in relation to the case.¹⁴⁸

¹³⁹ Case represents a type of case where responding to other people's distress in a way that does not match the pace of a psychiatric assessment is not advisable.

¹⁴⁰ Link to Bion (1962a) Learning from Experience

¹⁴¹ Repeated pattern of accepting without consultation. Clinician pessimistic.

¹⁴² Parent remembers negative relationship and fixes this in relation to the Clinician, restricting movement to a more positive relationship.

¹⁴³ Clinician in the face of negativity resorts to professionalism and benevolent view of own practice.

¹⁴⁴ Clinician and parent have different views on availability of helping agencies. Clinician sees an army, parent sees an absence.

¹⁴⁵ Anger and tears as an environment to go through.

¹⁴⁶ Clinician strikes a deal with parent.

¹⁴⁷ Clinician functioning is affected across caseload.

¹⁴⁸ Anxiety spreads to other staff in supportive role to Clinician.

FINDINGS: NARRATIVES

P2 also noted that all questionnaires and reports that were necessary to complete the assessment were received in plenty of time except the material from the child's mother.¹⁴⁹

P2 attended another multi-agency meeting at the school and felt that there was a level of hostility directed toward P2 by the mother and the professionals at the meeting.¹⁵⁰ People gave their reports on the child's progress and said how poor his concentration was. P2 said, *I felt that there had been a lot of positive things said in the meeting, about the child, and I just wanted to question it a bit and I asked for some examples or proof or evidence or support about how much development he had made. I realized once I had asked that question that what they meant was, well he had made progress for him, in fact the child had made very limited progress for someone of their chronological age¹⁵¹. And I was beginning to feel that he might have a learning disability that was affecting his development along with other neurodevelopmental difficulties¹⁵². P2 then felt that P2 had put a *spoke in the wheel¹⁵³* by not focusing on progress. However, P2 felt it was in the child's best interest to fully assess the boy's needs and recognizing a learning disability would be an important part of this.¹⁵⁴ P2 reported, *And the mum very clearly said, and in a very attacking way¹⁵⁵, so you don't think my boy can make any progress? To which I said that wasn't what I meant, wasn't what I said. And she made another couple of remarks that were really hostile, really attacking, to the extent that some of the other people in the room, including one I hadn't met before, said 'that isn't what P2 said'¹⁵⁶.... I felt**

¹⁴⁹ Parent does not provide material necessary for Clinician to be successful. Coded as keeping Clinician in Zero mode.

¹⁵⁰ Parent as leader of professional gang.

¹⁵¹ Clinician exposes professional jargon of other agencies.

¹⁵² Alternative views of the child suspected.

¹⁵³ Clinician stopping movement.

¹⁵⁴ Disagreement in relation to the child's best interest.

¹⁵⁵ Parent has hostile attacking style in relation to the Clinician.

¹⁵⁶ Other professionals, previously unknown come to the rescue. Code as Clinician's Hero.

FINDINGS: NARRATIVES

there was nothing I can say that this child's mother will accept or even bear in the way I try to deliver it¹⁵⁷, so that something becomes distorted in the way that this sense of movement, the sense of trying to establish some kind of clarity in communication just continues to get stuck, and stuck, and stuck.¹⁵⁸ No matter what the setting, in a big multi-disciplinary meeting, in a clinical room..., in a school review, whatever the setting, something happened to make it awful¹⁵⁹. And you know, such feelings in me, I got anxious,¹⁶⁰ I had to really hold myself together to ask the simplest of questions¹⁶¹ as if I was speaking not just out of turn but saying things that really shouldn't be said.¹⁶²

P2 reported further dissatisfaction with colleagues who, P2 felt, should have anticipated the difficulties and listened to P2 as it went along.¹⁶³ While other colleagues were assessing the child and agreeing with P2's view it was P2 who had to face the mother's hostility and anger at any finding other than the ones she wanted.¹⁶⁴ Even when other colleagues took on a more central role P2 found that the mother expressed her dissatisfaction with the other colleagues through P2. P2 also felt that colleagues looked on but did not help, did not seem to see the distress that this case was causing,¹⁶⁵ and P2 was exposed to accusations from the mother of bad practice¹⁶⁶ and held accountable for the work of the whole service. In one instance the mother reported to P2 that a colleague had said P2 had

¹⁵⁷ Clinician in impossible situation. Messages misunderstood. Minus K.

¹⁵⁸ Sense of movement and no clarity in communication related to getting stuck.

¹⁵⁹ Unrelentingly awful. Clinician can not escape awfulness by changing setting.

¹⁶⁰ Clinician physically and emotionally distressed.

¹⁶¹ Freedom of thought curtailed.

¹⁶² Clinician as blasphemer or heretic. Taboo.

¹⁶³ Cassandra who foresees disaster but is not listened to.

¹⁶⁴ Clinician focus of parent's hostility to service. Clinician as sacrificial lamb or scapegoat.

¹⁶⁵ Coded as Professional By-standers.

¹⁶⁶ Negligence suggested in relation to Clinician. Threat to professional standing. Coded as a Career Shaker.

FINDINGS: NARRATIVES

a problem with the mother. At that point P2 felt completely isolated. Any formulation that was presented to the mother was mocked and laughed at as ridiculous.¹⁶⁷

P2 reported, *...you get stuck cases, you get difficult cases, but this one just seemed to get completely bogged down, it felt like quicksand, you couldn't get out of it.*¹⁶⁸ P2 felt professionally challenged by the mother, personally affected by the case, and isolated from colleagues.¹⁶⁹ P2 reported going over and over the case wondering about their own functioning, even after the case was closed. P2 said, *Sort of thinking about my behaviour, going over it, going over it, but not being able to make it work.*¹⁷⁰

The mother eventually withdrew the child from the clinic before the assessment was complete and sought an assessment elsewhere.¹⁷¹ P2 later heard that the mother had been successful in getting her child diagnosed with ADHD.¹⁷²

P2 used the following descriptions to describe the feelings that this family evoked: *anxious, furious, bewildered, and disorganised.*¹⁷³ When asked if they had thought of these emotions in terms of a transference relationship. P2 reported being aware of that but having to prioritise the needs in the case, feeling that the assessment for the medical condition came

¹⁶⁷ Parent attacks links that are unwelcome through ridicule and mocking.

¹⁶⁸ Bogged down, quicksand, no escape. A natural trap preventing movement and causing suffocation.

¹⁶⁹ Clinician shaken professionally, personally and institutionally in relation to colleagues.

¹⁷⁰ Unresolved emotional and professional issues in relation to the case, despite passage of time. Rumination.

¹⁷¹ Parent prevents Clinician from feeling of satisfaction by completing of work.

¹⁷² Diagnosis elsewhere raises doubts for Clinician about the assessment.

¹⁷³ Researcher suggests link with disorganised attachment.

FINDINGS: NARRATIVES

first and the other aspects of the work could be addressed following that.¹⁷⁴ P2 thought this could be done by involving other colleagues at a later date.¹⁷⁵

P2 raised the difficult question of boundaries when the transference type phenomenon is coming from the parent and not the child,¹⁷⁶ and the difficulties weren't confined to that relationship they *...spiralled into the network so that there are difficulties connected in relation to colleagues, how the clinic operates, how other professionals try to get information or keep information because they think it is confidential, because it all makes a difference in terms of a network¹⁷⁷..... all of these linked, interdependent opinions knocking on each other, affecting each other and I think that is when it becomes even more difficult. Stuckness is not just therapist, client/patient, it involves other agencies.¹⁷⁸*

P2 reported that *I think if I didn't have many years experience....it (the case) would have been a very destructive experience.¹⁷⁹ Comparing it to other assessments I have done, I remember, there was something about that case that didn't work that must, must, be coming from somewhere other than me because I have evidence, years of evidence, that actually the way I do things, the way I process things usually works, and if I didn't have that it could have been a very damaging experience without much support in the clinic, because I feel very alone and actually that became clear that you are quite alone and out on a limb most of the time.¹⁸⁰*

¹⁷⁴ Clinician aware of transference phenomena but unable to prioritise it.

¹⁷⁵ Clinician looks to involve others to consider transference material.

¹⁷⁶ Under discussed area of practice in Child and Family work. Clinician not confident of professional remit.

¹⁷⁷ Case spirals into network.

¹⁷⁸ Stuckness as a systemic problem.

¹⁷⁹ Professional experience provides some security from destructive aspects of the case for the Clinician.

¹⁸⁰ Clinician feels isolated from colleagues following the case and questions support in relation to other cases.

NOTES ON CODING CASE TWO

In this case the Clinician was treated like a villain from the very first meeting to the time when the family withdrew from the service. The mother was unrelenting in a single minded demand for a diagnosis and felt that the process of providing this was an obstacle rather than a path to full assessment. This meant there was no room for manoeuvre for the Clinician to have questions, freedom of thought, or to have a different clinical view of the child. The Clinician felt that any communication that was made was distorted or misunderstood in an active way by the mother who somehow managed to involve other agencies and professionals in this view. This is reminiscent of minus K as described by Bion (1962a). The Clinician also felt their expertise and experience was ridiculed resulting in professional distress along with personal distress that the Clinician may be seen as withholding and cruel rather than benevolent. Coded as: Clinician held in Zero position; Network Gang Functioning; Professional Isolation; Career Shaking Experience; Personal, Professional and Institutional Trap.

CASE THREE

P3 had been working with a family of a ten year old child for some time to help the child manage a range of distressing behaviours and to assess the child for OCD and social communication difficulties,¹⁸¹ when the mother *disclosed*¹⁸² that the child was soiling. Around the same time the mother *disclosed*¹⁸³ a very distressing childhood with many traumas. The descriptions of the trauma were so horrific that they were hard to believe.¹⁸⁴ The parents reported that they thought they were doing the right thing by attending the clinic for help with their child but they felt the therapist was opening Pandora's Box¹⁸⁵ by making a link to the parental history and family functioning rather than just treating the child.¹⁸⁶

P3 felt that the family dynamics were interesting and worth exploring. P3 said, *It was a difficult case to work with because the mum and the dad held a very different attitude toward the service.*¹⁸⁷ *The mum felt that she wanted to come here and she wanted the boy to come here and then you also got the feeling that she didn't really want things to change*¹⁸⁸ *because she had a very ...intense relationship with him (the child)*¹⁸⁹ *and it felt that it (the relationship) was on one level quite functional*¹⁹⁰. *And the dad just didn't feel very connected to the whole process at all,*¹⁹¹ *he didn't feel connected to the mum and the boy's relationship, felt quite an outsider... I think he saw the problem in more of a behavioural term.*

¹⁸¹ Differential diagnosis. Uncertainty about cause of difficulties.

¹⁸² Disclosed, suggests shame, or trust necessary before information shared.

¹⁸³ Mother's past disclosed at same time as child's soiling.

¹⁸⁴ Parental trauma, distrust of parental narrative. Possible dissociation.

¹⁸⁵ Pandora's Box develops as category related to cruelty and torture.

¹⁸⁶ Unwelcome link, possibly cruel link made by Clinician, between child difficulties and parental past.

¹⁸⁷ Parental disagreement.

¹⁸⁸ Parent ambivalent about seeking help. Homeostatic system.

¹⁸⁹ Change involves loss.

¹⁹⁰ Incongruity of functioning aspects or levels alongside difficulties and trauma.

¹⁹¹ Relationship between one parent and child excludes other parent.

FINDINGS: NARRATIVES

P3 felt that there were odd qualities to the family, with good functioning on the surface covering deep disturbance or odd social communication on closer attention. The mother had her own mental health difficulties and put a lot of effort into maintaining appearances but P3 felt this was obviously superficial to anyone who paid attention to the mother.

P3 said, *They were an interesting family because it felt like you were trying to help them... they were bringing things to you but were not taking things on board,¹⁹² or were not sort of really moving forward and I got the sense that they didn't really want things to change at one level.¹⁹³ It ended up really, things started deteriorating with the child's mental health¹⁹⁴ and we considered sending (the case) on to (another service) for additional assessment... because it was very difficult to almost believe what the family said. It was difficult to get a sense of the severity of it.¹⁹⁵*

P3 described the relationship between the family and P3 as *Odd, I think in some ways, it was quite good on the surface but I think the mum felt quite angry,¹⁹⁶ she felt that she had to come and she was doing the right thing and the family actually talked about coming along as an anxiety¹⁹⁷ and mum actually talked about coming along as opening Pandora's Box, and that's what it felt like. It felt like on the surface you had this well functioning family.... but if you scratched the surface there was just a lot of trouble.... They liked it when I saw the child individually but didn't like it when I ventured into changing anything in the family¹⁹⁸.*

¹⁹² Family presenting for help but not taking anything on board. This puts Clinician into position of witness unable to help. Link to Zero position. Link to personal and professional traps.

¹⁹³ Family not motivated to change.

¹⁹⁴ Deterioration of child's condition. Clinician success has Life or Death implications for child.

¹⁹⁵ Clinician does not trust accounts of child difficulties or own assessment.

¹⁹⁶ Difference between surface presentation and emotional state of family.

¹⁹⁷ Attending for help is anxiety provoking for parent.

¹⁹⁸ Parent wish for problems to be located in the child and for the child to receive treatment without reference to the family system.

FINDINGS: NARRATIVES

P3 had a different view of the child from the parents. The mother wanted to see the child's difficulties as OCD, the father felt the child was spoiled by the mother and it was a behavioural difficulty. When P3 tried to bring the parents' views closer together they would argue in front of P3.¹⁹⁹ At the same time the child's difficulties were escalating, involving anxieties around weight and food. P3 became seriously concerned about the child's mental and physical health.²⁰⁰ Given the level of concern and the feeling of being stuck, P3 felt the case had to be referred to another service. P3 said *that ...it felt like we were doing a bit of a dance²⁰¹ and they were avoiding something and if I would raise something with them to say I feel like this, then mum and dad would kind of turn on one another and focus on that.* P3 felt that they couldn't get to the discussion around being stuck and the family wouldn't take on what P3 was saying.

P3 noted the number of consultations and supervision sessions attended around the case which focused on whether this was the right time to help this family and questioning if P3 should let the case go, so that the family could get clear picture of the state they were in before seeking help again.²⁰²

P3 discussed the referral on to another agency, saying, *Maybe it was a relief for them²⁰³, maybe it was a bit of a tortured²⁰⁴ thing for us both, I don't know, maybe they felt that, maybe it was a relief for them to go, go away and have a fresh start or maybe it was a withdrawal from here, I don't know.* When

¹⁹⁹ Clinician witnessing parental arguments.

²⁰⁰ Life or Death anxieties in relation to the child.

²⁰¹ Family and Clinician in a dance or creative relationship to avoid parental distress and change. Parental arguments avoid change rather than promote it.

²⁰² Case stimulates professional interest and discussion.

²⁰³ End of contact as a relief.

²⁰⁴ Link with treatment and torture for both parties.

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asked to talk more about the ‘*tortured situation*’ P3 said, *Well I suppose tortured is... to fill you in, the child had been having difficulties for a number of years and the mum had resisted coming and it felt like she had come and I had ‘caught’²⁰⁵ her somehow.... Then when she was caught in the system or started to explore where things.... or lift the lid on Pandora’s Box, then there was no going back²⁰⁶. It felt like she was in conflict all the time about being here and not keeping a lid on it. She wanted to keep the lid on it but she wanted to open it a bit, but didn’t want to open it the whole way.²⁰⁷ So I suppose that’s maybe where the torture was around.... I suppose I felt that I was in the torturing²⁰⁸ position because I was the one that was trying to, it felt like I was trying to impose something on them that they didn’t want but in one way they were asking me for... I also felt a bit tortured²⁰⁹ myself as a clinician because I did feel put in the position to help and the wee child’s symptoms were very worrying and I suppose in that way I felt quite tortured because I couldn’t do what I wanted to do or what I thought would be helpful.*

P3 described vivid traumatic images from the mother’s childhood.²¹⁰ When asked if P3 felt the mother was care-seeking P3 said, *I don’t think she was care seeking. She felt quite, when she spoke about it, she felt quite distant from it and I suppose she was trying to shock²¹¹ me or traumatize me,²¹² I don’t know. I think she really struggled.... I think she wanted to come and talk, she wanted her*

²⁰⁵ Parent feels caught in Clinician’s trap.

²⁰⁶ No going back, no safe haven. Link to Pandora’s journey.

²⁰⁷ Parent ambivalent about therapeutic relationship.

²⁰⁸ Clinician feels in torturing position for doing what was asked by the family and at the same time feeling this was something that was imposed on them.

²⁰⁹ Mutual torture. Clinician feels tortured by position of being onlooker unable to reduce distress.

²¹⁰ Clinician presents visual image of a traumatic nature (not recorded due to reasons of confidentiality). Memory uses vivid senses.

²¹¹ Difficulty for Clinician to feel that the parental narrative of trauma is care seeking rather than aimed at shocking or traumatizing the Clinician. Link to perceived destructive rather than defensive functioning. Possible projection of trauma into the Clinician.

²¹² Trauma presented without any grieving or mourning, only shock. Unprocessed experience.

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own time, she wanted her own therapy.... She wasn't willing to seek that kind of help...²¹³ She couldn't have her own therapist, it had to be for the boy and this is what she wanted help with.

P3 also questioned how powerful the child was in the house and how unwilling the child was to change as it would diminish the child's control over their parents.²¹⁴ P3 thought that the mother was *overly empathic*²¹⁵ (to the child's difficulties), *and I think projected quite a lot onto the child*²¹⁶ *saying we can't upset the child, we can't make life any more difficult than it already is. That perpetuated the child's position of power*²¹⁷ *.... I suppose the experience for the child might have been quite frightening,*²¹⁸ *to have that amount of power and basically control over your dad and your mum and I think the child experienced them arguing as being actually quite ineffective at putting down boundaries for the child.*

In the discussion P3 was asked if they had thought of the torturing position, the thought that the mother came with a Pandora's Box and the therapist wanting to open it and unleash things from it, as transference. P3 said they thought they were aware of the communication but couldn't remember thinking of it as a transference or working with it as a transference.²¹⁹

Some additional thoughts about the case felt important to P3. The father was disparaging of people who were university educated, mentioning a favoured sibling but implicating

²¹³ Parent seeking treatment through child. Presenting as a traumatized parent rather than as a traumatized individual. Code as Traumatized Breast, possibly toxic breast.

²¹⁴ Disturbed power relationship in the home.

²¹⁵ Overly empathic, enmeshment.

²¹⁶ Parent projects onto child resulting in a prevention of change.

²¹⁷ One parent perpetuates the child's position of power.

²¹⁸ Clinician has an alternative empathic view of the child.

²¹⁹ Some awareness of transference but not as something worked with technically.

FINDINGS: NARRATIVES

P3.²²⁰ The father presented in ordinary clothes while the mother seemed over-dressed for the sessions. The mother's appearance and the content and style of her story about her own personal trauma made P3 feel that there was something *a bit sinister about her mind*.²²¹ There was a younger sibling in the family who was still in nappies and P3 was concerned that the mother was *grooming*²²² the younger child in case anything happened to the older child.²²³ This would be consistent with events in the parental history. P3 also hoped that the service the family was referred on to would share P3's formulation and, if so, refer the family to the Reporter²²⁴ but given the speculative nature of the concerns P3 didn't feel able to do this at the time.²²⁵

P3 reflected on the case saying that it made them question themselves and, *Now I can reflect on it and think maybe I went in too gung ho to it and maybe I should have tolerated*²²⁶ *the family not wanting to change more than I did.*²²⁷ *And maybe that is something that at that stage of my career*²²⁸ *was more difficult for me to tolerate than it is now.*

NOTES ON CODING CASE THREE

Pandora's Box emerged as a central code to understanding this case. The ambivalence around for the parents in relation to seeking help and the catastrophic nature of the change that the Clinician represented was terrifying and at the same time compelling. This is linked

²²⁰ Selectively preferred children in family system. Clinician ridiculed in sibling fashion.

²²¹ Clinician uneasy about parental state of mind. Link to Toxic Breast.

²²² Unwelcome link with child protection concerns.

²²³ Replacement child.

²²⁴ Referral to higher authority.

²²⁵ Incongruity, uncertain links, differential diagnosis and ambivalent parents leads to Clinician lacking confidence in raising Child Protection concerns and looking to another service to provide this.

²²⁶ Clinician learns from experience and views work differently after case.

²²⁷ More tolerant of small changes rather than transformation.

²²⁸ Confidence and experience helpful in managing cases, and stuck cases led to a depth of experience.

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to torture in relation to the position the Clinician is put in by the family, as someone who wants to open the box. The life or death pressures on the Clinician present an urgency to the situation while the parents fear of change demands a slow approach where trust can be developed. This puts everyone in positions where mutual torture is experienced. Coded as: Pandora's Box, The Unwelcome link leading to the Cruel Link; Traps and Torture; and Life and Death Anxieties add pressure/ act as a warning.

CASE FOUR

P4 reported working with a teenage girl and her mother. Having worked with the girl in the past P4 received a new referral requesting that P4 specifically²²⁹ meet with the girl to look at issues that had previously been felt to be important in the girl's past. When she attended sessions the girl then completely avoided²³⁰ the topic she had asked to discuss. P4 said, *...she was just talking about the weather and (when P4 started to discuss emotional issues) she would just look at me as if I was crazy.*²³¹ P4 did a re-formulation of the case and noted how isolated the girl was from a positive social, educational and work life and how over-involved the girl was with her mentally ill mother. This combination was leading to an increase in risk-taking at the same time as increasing social withdrawal. On the girl's behalf P4 negotiated with educational agencies, social work agencies and voluntary organisations²³² to put together a number of opportunities for the girl to reengage with the world. None of these opportunities were taken up and P4 felt that a great deal of effort had been invested and there was nothing in return.²³³ P4 in hindsight thought that this was repeating a pattern that the girl's aunts had been through.²³⁴ P4 said, *The aunts allegedly let them down, but they are not, they are sorting out the finances, getting mum to her appointments, and the aunts very much get rubbished, and I think that I am in with that. In a way I got in there first²³⁵ by saying there is nothing*

²²⁹ Preferred professional selected. Coded as Clinician being put in Hero position by young person.

²³⁰ Ambivalence in relation to care seeking. Requesting then avoiding.

²³¹ Help seen as crazy. Experiencing the reality of being helped results in young person putting Clinician into Zero position.

²³² Numerous agencies involved.

²³³ One-sided, non-reciprocal relationship.

²³⁴ Relationship patterns repeated.

²³⁵ Clinician anticipates humiliation in the Zero position.

FINDINGS: NARRATIVES

more I can offer, and I think I needed to do that, but I am thinking where have I left them?²³⁶ Despite the fact that I got all these services involved.²³⁷

P4 Reported making an unwelcome link to a teenager's capacity to engage with the world for social reasons that often involved risk-taking while at the same time seeking help for a separation anxiety in relation to leaving their mentally ill mother at home alone.^{238 239} This allowed the teenager to interact with a risky external world and to refuse the offer of more developmental opportunities related to education and work experience.²⁴⁰ The teenager and mother repetitively approached the clinic in a crisis but refused to work in a more planned way,²⁴¹ therefore avoiding reflection about the link the therapist had made. P4 reported feeling that, *It was as though, and I wonder how they feel about it sometimes, but it was as though I almost couldn't breathe²⁴², I couldn't get anything fresh or new in²⁴³... It was typical of more or less every encounter. Any suggestion of anything new or changing had to be sort of, I don't know what the word would be, kept like in mud really.²⁴⁴*

Interviewer: They seem to want a lot of aunt type figures to witness this and sometimes to be in a role, if I understand it, where you have let them down, even though you have set things up for them. (yes) Have you thought about that as a transference relationship?

²³⁶ Unresolved experience of providing care.

²³⁷ Reality of service provided at odds with family view leads to incongruous experience for Clinician.

²³⁸ Unwelcome link made by therapist.

²³⁹ Young person loyal to the Traumatized or toxic breast.

²⁴⁰ Young person refuses services organised by Clinician.

²⁴¹ Crisis to crisis. Functioning without thinking.

²⁴² Clinician experiences physical reaction linked to suffocation.

²⁴³ No room for manoeuvre or introduction of new ideas or thoughts. This keeps the Clinician in the Zero position of not being able to affect change while being an onlooker to the toxic situation.

²⁴⁴ Family defence against change, to keep it in mud, natural trap.

FINDINGS: NARRATIVES

P4: *No I haven't, I wouldn't say I have worked with the transference with them or with the young person.²⁴⁵ Part of the work with them was to see if she would access anything like that and I felt that she couldn't, didn't want to think just wanted to relax, didn't want to feel.²⁴⁶*

Interviewer: Almost as if having an emotional discussion was a mad discussion.

P4: *Yes, although that was what she had asked me to provide. Very confused really.²⁴⁷*

NOTES ON CODING CASE FOUR

Case Four is a situation where the young person chooses loyalty to a toxic environment with a mentally ill mother rather than take up positive opportunities that are available. Code as Loyalty in toxic environment. The Clinician falls into a pattern of relating already experienced by the young person's aunts and in this case that can be coded as Hero to Zero, with the clinician left to witness the young person reject all the carefully planned opportunities on offer. The Clinician feels suffocated by the situation and that anything new is prevented from being effective and when the Clinician makes links, these are unwelcome and the young person and family actively misunderstand them as mad links. Coded as an Unwelcome Link.

²⁴⁵ Transference not worked with.

²⁴⁶ Young person avoiding thinking about relationship with Clinician.

²⁴⁷ Confusion dominates the care-seeking care-giving relationship.

CASE FIVE

P5 described working with a child and mother when the child was referred for encopresis. P5 reported, *and we got to a stage, mum and I, in the sessions, where I was quite clearly saying to her that there is no point²⁴⁸ trying another sticker chart, we have tried all the behavioural interventions and it hasn't worked and we need to think about this in a different way²⁴⁹... and my feeling is we need to think about the whole family system.²⁵⁰ And she didn't want to do that because she was scared about thinking about her own feelings and didn't want to imagine that that could have anything to do with what was going on for this wee boy.²⁵¹ And I guess it is quite a big leap (for this mum) to say that my own feelings of sadness at my mum's dying and the way I have dealt with that have led my son to soil²⁵². But she was incredibly resistant to even thinking about that as an option, or thinking about how we might work with that in a different way.²⁵³ So, the stuck feeling came quite quickly as we were stuck on this one method of treatment that wasn't working and we kept repeating it.²⁵⁴ And there was this Groundhog Day²⁵⁵ as we were keeping on doing the things that weren't working.... I got to the point (where) I could quite clearly see where I wanted to go and she wouldn't follow me²⁵⁶. That was quite frustrating in terms of, where do I go because we are not repeating the same thing and you (mum) don't want to do this. But she was wanting to come back. Wanting something.²⁵⁷*

²⁴⁸ Pointless or meaningless work.

²⁴⁹ Clinician asking for room to manoeuvre.

²⁵⁰ Link between presenting problem and family system made by Clinician.

²⁵¹ Unwelcome link leads to scared parent

²⁵² Link made without confidence

²⁵³ Parent resistant to new thoughts.

²⁵⁴ Suck on one approach, the first approach, loyalty to first approach. Parent trying to keep Clinician in Hero position.

²⁵⁵ Endless repetition without resolution.

²⁵⁶ Clinician as leader without followers.

²⁵⁷ Parent wants something but the Clinician is not sure what. Clinician questions parent returning for appointments.

FINDINGS: NARRATIVES

Interviewer: You found yourself in a situation where you were wanting to help and offering help but you were getting frustrated, you were also left to think that you were doing a bad thing rather than a helpful thing. Did you ever think about that with the mum as a transference communication?

P5: *No, no I didn't.²⁵⁸ I was aware that the feelings I had were the same as the feelings she had about being there. I don't think I thought about it any further than that, again I was probably reacting to her signals not to go there, but I didn't talk about that with her. I suppose I talked about my sense of there is no way to go, and she was probably feeling that²⁵⁹. ... I probably did touch on that in the conversations around, I'm not sure what you want from me, we've done this bit, I've nothing else to offer you in that area and you are saying you don't want to go down the road that I feel we need to look at,²⁶⁰ I am not sure what else we need to do about that.*

NOTES ON CODING CASE FIVE

The parent in case five was the central character in the narrative and wanted the Clinician's first intervention to be successful. This was coded as Clinician put in Hero position.

When the Clinician made other links, these were unwelcome and frightening. The Clinician then repeatedly tried to pursue the link, wanting to explore the parent's experience of bereavement. This was coded as Pandora's Box, and the Lone Leader where the Clinician has an idea of where to go but has no followers.

²⁵⁸ Not working with transference.

²⁵⁹ Shared feelings identified.

²⁶⁰ Unwelcome link refused.

CASE SIX

P6 reported working with a child who was referred by Paediatrics because the child was *cheating*²⁶¹ with the diet they needed to stick to due to a medical condition.²⁶² The child denied cheating but regular blood tests meant that the truth was plain for everyone to see.²⁶³ P6 reported feeling that sometimes the child was lying to try to convince themselves and at other times it was more deliberate.²⁶⁴ Either way, there were *life and death* anxieties around the young person complying with the diet.

The father and step-mother both expected the child to change.²⁶⁵ P6 and a colleague got to know the child and discovered that the biological mother who was now estranged from the family was very ill and could die after years of chronic alcoholism.²⁶⁶ P6 noted that the child was distressed as they had no contact with the mother and P6 made a link between the mother concealing her alcoholism for years and lying about drinking, and the child cheating on the diet.²⁶⁷ P6 said the father and step-mother *didn't see that as relevant, they saw that as being in the past*²⁶⁸ and dad constantly talked about being stuck in the middle of the child²⁶⁹ and his partner and he said that he didn't know how to change that and he didn't know what to do for the child or his partner and he couldn't blame the step-mother for not coming to appointments.²⁷⁰ When the child became tearful and complained there no contact with the biological mother, not even by phone, P6 said *it got very tense and dad said that he thought that this was a difficult session for the child,*

²⁶¹ Cheating

²⁶² Life or Death anxiety.

²⁶³ Child has no room to manoeuvre and lies are found out.

²⁶⁴ Different types of lying including self-deception and manipulation of others.

²⁶⁵ Focus on child as responsible for change.

²⁶⁶ Parental addiction, Life and Death anxieties in relation to parent.

²⁶⁷ Unwelcome link made by Clinician.

²⁶⁸ Trans-generational transmission of disturbance.

²⁶⁹ Child as burden or cause of parental disharmony.

²⁷⁰ One parent withdraws from treatment.

FINDINGS: NARRATIVES

that we were making it difficult²⁷¹..... I reflected back that I thought it was very difficult for the dad.²⁷²

The father then went into a detailed complaint about being left with the child and detailed the burden,..... *and all this was said in front of the child and I reflected back to him about how this might let the child feel and he said well you wanted us to be honest, I thought you wanted us to say what we thought.²⁷³*

P6 said *To me it felt like a play out of his relationship with his first wife because she, I suppose, cheated on him with alcohol. He didn't know how bad the problem was. There was lots of themes of... people being unreliable, inconsistent, not doing what they would say they would do²⁷⁴... . He kept going on about wanting the child to commit to even small changes and he would try to break it down to, would you just do this for the next few days, then we will do more things as a family²⁷⁵. But what happened was that basically the step-mum would stop talking to the child within the home, and her logic for that was the less interaction she had with the child, the less likelihood there was the child would lie to her.²⁷⁶ So the wee child was miserable and upset at home²⁷⁷..... It just felt like we had the same conversation every time.²⁷⁸ I constantly tried to get the step-mum to come back and dad always said I will try to convince her and I know you are trying to help, you are trying to do your best.... I felt in some ways that dad was quite patronising about what we were trying to do. I am not sure what they expected us to do and I suppose it wasn't really a shared formulation.....²⁷⁹, the wee child kind of summed it up saying all they ever talked about was the medical*

²⁷¹ Discussing issues making child distressed. Code as Pandora's Box with child and Clinician wanting to open the box and parent trying to prevent this.

²⁷² Unwelcome link to father's difficulties. Dispute over hero role for the child.

²⁷³ Logical trap. Parent acts in hurtful way toward child and logically traces it back to Clinician's instructions. Possible emotional abuse.

²⁷⁴ Clinician sensitive to patterns and themes but these are unwelcome links for parent.

²⁷⁵ Parent makes developmental demands on the child.

²⁷⁶ Logic trap. Parent logically explains how maltreatment of child has purpose.

²⁷⁷ Clinician's empathic formulation of child's emotional state core to formulation.

²⁷⁸ Repetition of conversation. Groundhog Day.

²⁷⁹ Formulation not shared

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condition,²⁸⁰ they didn't really look at the wider issues so, I suppose the possibilities for change got narrowed down and narrowed down and narrowed down²⁸¹, until it became all the change hinged on one thing, and that was the wee child being different or managing things differently.²⁸² I suppose it got to the stage where we were having the same conversation every time and the child was continuing to have poor blood results, we had tried various things but I felt that unless they attended as a family that we couldn't really help them move things forward. Step-mum wouldn't come, dad didn't feel that there was any possibility of that and things were never going to be any different and he just said we are not able to do that just now and that is how it came to a sort of an end. It was a very unsatisfactory experience²⁸³ I suppose I felt a bit impotent²⁸⁴ in the situation and I felt I maybe hadn't done the best job²⁸⁵ that I could but I don't know what else I could have done, and I didn't like that I was giving up as well, I felt as if I was giving up and it made my life easier not to see them²⁸⁶, because I didn't know what else to do with them, kind of thing.

The interviewer noted the position P6 was in, of asking people to make changes that they just weren't going to make, and how similar that was to the position that the step-mum and dad were in with the boy and that the boy and dad had been in with the birth mother. The interviewer asked if P6 thought about that as a transference relationship?

P6: I think that I probably did think about that but I am not sure that I ever... discussed that... with them²⁸⁷ I suppose I was sort of doing the same as them, always hoping that things would be different or

²⁸⁰ Medical condition pre-occupying to parents to the exclusion of child's other needs.

²⁸¹ Restricting manoeuvrability.

²⁸² Pressure on child to provide solution increased.

²⁸³ Unsatisfactory end.

²⁸⁴ Clinician feels impotent. Link to Zero position.

²⁸⁵ Clinician questions professional practice.

²⁸⁶ Conflict between personal feelings and professional benevolence.

²⁸⁷ Transference considered but not worked with technically.

FINDINGS: NARRATIVES

always hoping that there would be a bit of a change and keep going and keep going²⁸⁸ I think what would have helped would have been if I had..... the time to discuss it with a colleague or something or taken time out to think it through or reflect on it properly²⁸⁹ and I don't think I took the opportunity to do that.

NOTES ON CODING CASE SIX

Case Six has Life or Death anxieties related to the child's compliance with their diet and also Life or Death anxieties in relation to the birth mother. There is a link to a Toxic Breast, an alcoholic mother who gave the child a taste for things that were harmful to them. The Clinician also has moments of vying for the Hero position and is in competition for this with the father. The Clinician and the Child want to open Pandora's Box while the father and step-mother want to keep it closed. The father and the Clinician disagree about the value of discussing difficulties as the child gets upset. The child has to navigate between being loyal to the mother, the father and the Clinician. The Clinician is seen as making Unwelcome Links. The family also use logic to explain maltreatment of the child, sometimes the Clinician's requests are at the core of the logical argument, placing the Clinician as the instigator of the maltreatment. Link to the following codes: Life and Death Anxieties, Hero to Zero, Loyalty, Toxic Traumatized Breast, Unwelcome Link, Logic Trap.

²⁸⁸ Clinician repeats family pattern, re-enactment.

²⁸⁹ Need for opportunities for reflective practice.

CASE SEVEN

P7 selected a case that was described as ‘*superstuck*’²⁹⁰ saying, *...after many years in the job, it is the one case I find myself revisiting*²⁹¹. P7 reported taking on a case from Paediatric Services and seeing a child who had difficulty managing a special diet which was required due to a medical condition.²⁹² There was a secondary reason for referral which was occasional school refusal but this was not raising too much cause for concern.²⁹³ When P7 met with the child, the child’s main concern was that their mother was a chronic alcoholic.²⁹⁴ P7 became aware of the child’s distress at seeing the mother become incapable to the point of falling over and, when drunk the mother became quite intrusive which the child found upsetting. P7 noted that the child loved the mother despite the difficulties.²⁹⁵ P7 said that the child engaged very well and P7 helped the child to find strategies for dealing with the mother’s intrusiveness and had a feeling of initial success.²⁹⁶ Individual work with the child continued with parents bringing the child along regularly but not seeking help themselves. P7 said that the child’s father was *quite happy to get a bit of feedback about what we had been doing but he did seem quite distant at one level. And on one level he could understand what I was saying about his wife’s drinking and the impact on the child but huge loyalty to his wife, as did the child.*²⁹⁷

²⁹⁰ Superstuck

²⁹¹ Preoccupying, unresolved narrative.

²⁹² Life and Death anxiety in relation to the child complying with treatment..

²⁹³ More complexity in case than initially thought.

²⁹⁴ Child’s view of problem differs from parents.

²⁹⁵ Loyalty to toxic Breast.

²⁹⁶ Initial success.

²⁹⁷ Loyalty mediates capacity to think.

FINDINGS: NARRATIVES

P7 noted that Paediatric Services had made a parallel referral to Social Work, who had not picked up the case.²⁹⁸ P7 felt that the case could have been discharged from CAMHS at this point but continued to offer support to the child.²⁹⁹

As time went on the school refusal became a more pressing concern³⁰⁰ and P7 was able to do a timeline showing a clear link between the child's attendance at school and the mother's control of her drinking. Family members found this link interesting but unconnected to the problem and solution.³⁰¹ P7 said *So that seemed like a bit of a blind alley.*³⁰² *So what was happening was the school refusing was picking up and dad was starting to get a bit, 'what are you going to do about it?' kind of thing.*³⁰³ *And I said this problem is much bigger than you and I, or me, and we need to involve other people.*³⁰⁴ *So... we got social work involved and they visited the house and they said nice to meet you, we don't need anything thanks very much.*³⁰⁵ *So social work withdrew. And I was pointing out that this is about child protection, and this child is a capable child but should not be in this situation with this woman who potentially is drunk and incapable. So they took this on board and did get re-involved.*³⁰⁶

P7 also involved other agencies, home-school liaison and educational psychology.³⁰⁷ P7 then anticipated the difficult start to the school term and organised support for the first day

²⁹⁸ Other agencies not responding to need.

²⁹⁹ Opportunity for successful end missed.

³⁰⁰ Deterioration in child's functioning.

³⁰¹ Unwelcome link.

³⁰² No room for manoeuvre with link.

³⁰³ Parent increases pressure on Clinician while refusing to work with Clinician's link.

³⁰⁴ Clinician widens the network of agencies involved.

³⁰⁵ Family does not welcome extra services organised by Clinician.

³⁰⁶ Clinician presents unwelcome link as a way of looking at the family through a Child Protection lens. Other agencies work with Clinician's lens.

³⁰⁷ Clinician widens network.

FINDINGS: NARRATIVES

of school only to find that the child had attended of their own accord,³⁰⁸ walking to school with friends. *What a celebration. Fantastic. But after a few weeks it started to slip, August, September cracks were appearing.*³⁰⁹ *And I talked to the child and dad about that and why that may be and certainly mum's drinking came into that and certainly it seemed rampant again.*³¹⁰ In response to this P7 called a multi-agency meeting to which the father of the child attended in an angry state³¹¹ and was critical and dismissive of all staff,³¹² despite a high quality of service being provided by different agencies from P7's point of view.³¹³

As part of expressing his dissatisfaction with services the father said at the meeting that the only one who understood was P7,³¹⁴ and said that P7 was the only one who could help the family.³¹⁵ P7 reported going over this moment a great deal, reflecting on how the situation was managed and feeling that the response was to father's *bad* behaviour rather than the child's needs.³¹⁶ P7 said, *Because, I am not sure ..., I think I was almost challenging him to get his wife along in a way*³¹⁷... *I felt I was kind of sticking up for the other people that were there.*³¹⁸ *And he took it,*³¹⁹ *because the other thing I said, before he stormed out,*³²⁰ *he was getting very steamed up and he was*

³⁰⁸ Child does not need Clinician's help.

³⁰⁹ Slipping. Cracks.

³¹⁰ Evidence for Unwelcome Link increases over time.

³¹¹ Parent angry at network.

³¹² Parent critical and dismissive of services.

³¹³ Clinician holds different view of services from parents.

³¹⁴ Clinician put in the Hero position.

³¹⁵ Parent isolates Clinician in Hero position next to other professionals put in Zero position.

³¹⁶ Critical moment that remains unresolved. Moment of Clinician being unwittingly caught up in action rather than responding to child's needs. Link to Britton (1981).

³¹⁷ Opportunity taken to challenge to parent to accept Unwelcome Link. Parent cornered. Logical trap, if Clinician has answer then parent must accept answer.

³¹⁸ Clinician becomes Hero for professional system rather than Hero for family.

³¹⁹ Challenge accepted. Father takes on Hero role for family in opposition to Clinician and professional network.

³²⁰ High expressed emotion of parent in relation to network.

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saying... something like 'we need radical solutions now'³²¹ and I said 'I think you are absolutely right because one of the things I have thought about is when you as parents are away on holiday, the child is symptom free, and when the child is in hospital having the medical condition stabilized the child is symptom free and this makes me think the child needs to be living somewhere else.'³²² And he took that, he said 'I completely see what you are saying', mum was pretty upset, you know³²³. And in the context of everything else that was going on it was probably the wrong setting to say it but it was absolutely okay in that moment in time to say it.³²⁴ And then the next time we met he was not apologetic for his behaviour.³²⁵ Again it was trying to get him to see what it is actually like for the child, we are trying to get the child back to school, the child knows that dad has been badly behaved at school, rubbished the people who have been trying to help the child.³²⁶ The child is very loyal to their dad...³²⁷ The child wasn't at the meeting but heard all about it and very much thought of it as dad sticking up for the child.³²⁸ And then the child got into a very negative view of the school which, up until then the child hadn't said there was a problem with school, it was okay once they got there...³²⁹ Now it was, the child didn't like what Mr A said to his dad, the child didn't like what Mrs B had said, the child didn't like, didn't like.³³⁰ So again the child lost all confidence in that support because of what dad had said in the meeting.³³¹

P7 said to the father that it was necessary for the family to attend the clinic as well as the child. P7 reported that *Mum and dad both came (to the clinic) and we opened it up³³² into dad's*

³²¹ Radical solutions sought.

³²² Battling between Clinician and Hero with a challenge to family composition.

³²³ Rules of engagement agreed. Battle over custody of child.

³²⁴ Theatre of engagement

³²⁵ Apology expected.

³²⁶ Clinician as expert on child. Attempt to get parent to take a meta-position. Battle over empathy for child.

³²⁷ Child's loyalties questioned.

³²⁸ Child puts father in Hero position.

³²⁹ Parent held responsible for child's negativity to school. Toxic influence.

³³⁰ Child empowered to have negative voice in relation to professionals.

³³¹ Clinician views child as losing confidence in support rather than finding confidence to voice negativity. Caliban.

³³² Pandora's Box.

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childhood anxiety, mum's drinking³³³ and they all very quickly formed a united front against me. So I went very quickly from Hero to Zero.³³⁴ Very, very quickly. Like all who had gone before me.³³⁵

The parents in this case then began to seek additional opinions and to find other professional who took a different view from P7.³³⁶ The parents also seemed to think that other professionals in the network were *dancing to P7's tune.*³³⁷ There was an increasing feeling from the parents that P7 was missing something, underestimating the child's difficulties and refusing to locate the problem in the child.³³⁸ After a series of consultations with colleagues and additional psychiatric assessment, P7 organised a consultation with a psychiatrist to see if anti-depressants might help the child. The parents took this as evidence that the problem was in the child and that P7 had missed the depression in the child.³³⁹

P7 reported that the father would say to P7, "*So you admit now you have got it wrong and you should have done this (sought medication) ages ago.*"³⁴⁰ P7 was concerned that the father said this in front of the child, potentially damaging the child's helpful relationship with P7.³⁴¹ P7 encouraged the father to deal with adult issues separately from appointments with the child present.³⁴²

³³³ Unwelcome links experienced as cruel or attacking links.

³³⁴ Hero to Zero, speed of change of position noted.

³³⁵ Clinician has moment of realization of being part of pattern.

³³⁶ Parents search for new Hero from within professional network.

³³⁷ Other professionals' loyalty to Clinician seen as problem for parents.

³³⁸ Attacks on Clinician's competence and suggestion of negligence.

³³⁹ Additional efforts by Clinician to find appropriate care pathways are used by parents to challenge Clinician's competence.

³⁴⁰ Legal, logic traps.

³⁴¹ Theatre of engagement now directly in front of child.

³⁴² Loyalty Trap. The theatre of engagement is anti-therapeutic from the Clinician's point of view as it involves the child seeing two Hero's battling. The Clinician is in a battle for the child's functioning while the father is in a battle for the child's loyalty.

The child was seen by a psychiatrist, anti-depressants were prescribed. The family then withdrew from any other work and allowed the child to withdraw from school using the medication as evidence that the child was ill.³⁴³ P7 felt that it had always been made clear that the child was well enough to go to school and that services like home-school support and a befriender were put in place, but the family did not want or use any of these services.³⁴⁴

Whereas the parents were increasingly dissatisfied with P7 there was still a positive relationship with the child that survived for some time.³⁴⁵

The family organised a private consultation with an independent mental health worker who was reported by the child to say that the child was not well enough to attend school. P7 said, *Dad phoned me and again it had a kind of 'gotcha' type of feel as he reported what the private consultant had said.*³⁴⁶ P7 got permission to contact this consultant who advised that they had been mis-quoted and that actually they had said it was a complex case and the child should continue with the service P7 worked for.³⁴⁷ It also turned out that the father had not spoken to the consultant but was going on information supplied by the child.³⁴⁸ P7 said, *The child, who didn't want to go to school would clutch at anything.*³⁴⁹ Also, another consultant, this time for the child's medical condition, *...came back at a time when the child was actually doing*

³⁴³ Parental view vindicated. Child officially pathologised.

³⁴⁴ Clinician persevered from Zero position but without any success. Other services are not taken up and also kept in the Zero position.

³⁴⁵ Child remains loyal to Clinician.

³⁴⁶ Institutional trap. Parent uses private resources to catch Clinician.

³⁴⁷ Clinician relentless in challenging family's view of problem and seeks and finds loyalty from other agencies and private consultants in the network.

³⁴⁸ Clinician finds alternative ways of viewing the information supplied by the family.

³⁴⁹ The child emerges as an active participant in actively misunderstanding what others say.

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a good job of getting back to school... and his advice was that maybe a day a week would be good. So the child said 'Dr X says one day a week!'³⁵⁰ So there was a wee bit of clearing up to do with them and involving the medical team in subsequent meetings.³⁵¹

When the trial of anti-depressants was up and running P7 said, *The GP phoned to say that dad and child had been in and they didn't want to come back and my colleagues were useless and, what was it (laughs) jumping to my tune.*³⁵² P7 responded by asking the GP to arrange a meeting with the family where P7 could lay out all the options for a continued service, for the family to choose, including P7 continuing to work with the child³⁵³ After the meeting the mother and child contacted the GP and asked to be seen elsewhere, in another service, by clinicians not connected to P7.³⁵⁴

The child was said to have lost 'all faith' in P7 and that P7 had let the child down by not believing the child was ill.³⁵⁵ P7 sent an additional letter to the child wishing them all the best for the future. P7 said, *End of story. And that is kind of it, and it is my own sense of that thing that happens, that for a period, it really did feel like Hero to Zero. Not even very quickly but when the turning point³⁵⁶ came it happened fantastically quickly and has left me feeling a bit, well I guess I like to be liked and I don't like hearing that person feels that I have let them down.³⁵⁷ And it doesn't happen that often because I have fallen out with people in therapy in a way that feels quite helpful because you sort it*

³⁵⁰ Child and Family find new Hero again.

³⁵¹ Clinician provides lens to new Hero, gaining loyalty from an increasing network of services.

³⁵² Family disengage in face of loyalty shown to Clinician by other professionals.

³⁵³ Clinician perseveres in maintaining helpful relationship with child.

³⁵⁴ Family end engagement and seek new service with no loyalty to Clinician.

³⁵⁵ Family disengage when child gives up on Clinician as Hero, losing all faith.

³⁵⁶ Turning point, in this case the school meeting.

³⁵⁷ Experience challenges Clinician's view of themselves as providing a benevolent influence.

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out³⁵⁸ but this just feels like, it is one of those cases I put so much into, in terms of time and energy,³⁵⁹ it felt as if, not I need to do something because I need to do something, but I felt something needed done and it seemed to me that I was doing all the running, all the pushing, and the end point just feels completely unsatisfactory. Not least for the family, because what was their experience of that feeling, let down, getting the run around, not feeling supported.³⁶⁰ When we have a different reality, they actually knocked back all the supports that were offered.³⁶¹ So maybe they were the wrong supports, or not the right supports, or maybe it wasn't done in the right way.³⁶²

P7 used the word '*dismissed*' to describe what the family had done to P7. When asked if P7 thought other professionals had the same set of feelings when the family '*dismissed*' them P7 said, *I think some of them will have felt relieved because, picking on poor dad, because it was dad who made everybody feel that way predominantly, quite a relief³⁶³..... I thought Home Support Worker felt overwhelming emotion for the child³⁶⁴..... Why is this man, it might have been the child, but why is this man mugging the child of all the relationships the child has got.³⁶⁵ It feels as if dad has mugged me, or mugged the child of the relationship... with me. On the face of it he is not a horrible man, he is a very concerned capable father, one could argue he could maybe go about his business slightly differently³⁶⁶.*

P7 then discussed the mother's poor health but said, *She would repeatedly say 'I will do anything for my child', I would say 'well you say you will do anything but you have once again not kept that appointment with your addiction worker, so on the one hand you say you will do anything but you will not*

³⁵⁸ Experience different from falling out. Something that can not be worked through.

³⁵⁹ Clinician makes high investment in case.

³⁶⁰ Sense of dissatisfaction shared by Clinician and family.

³⁶¹ Different realities. Family seen as rejecting help.

³⁶² Clinician still engaged with thinking how to provide support to the family.

³⁶³ Disengagement provides relief for professionals.

³⁶⁴ Emotional engagement with child is shared by other professionals.

³⁶⁵ Parent as emotional mugger.

³⁶⁶ Clinician maintains complex view of parent.

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*do that.*³⁶⁷ P7 organised other services for children of alcoholic parents but the father said that child did not need that as the father was there to offer support.³⁶⁸

P7 said, the child *was fantastically loyal to both parents. Now why should that be a problem? But I think it was a problem because it got in the way of the child's progress. Loyalty to both parents actually.*³⁶⁹

P7 was also involved in referring the child to the Reporter due to increasing concerns about school attendance and the parents' ability to manage the diet of the child in relation to the child's medical condition.³⁷⁰ The family saw this as being done against them, rather than for them and when P7 was invited to attend the panel the parents asked P7 whose side P7 was going to be on?³⁷¹ When P7 replied that they would be on the child's side (not the family's) then the parents said that P7 should not attend.³⁷² *The Panel's response to the whole scenario was to do what the medical team had done unwittingly and say that is a real shame, you just have to take your time... and it is okay, don't go to school till you feel ready, which I don't think was helpful, I know why they did it, for all the right reasons, they heard the story, they felt compassion, they felt pity, but...*³⁷³

When asked if P7 felt that the experience of Hero to Zero was a transference communication P7 said, *Not at the time, only after the event*³⁷⁴... *A colleague and I talked about it a number of times and that was the first time that those words were used. They weren't words I was using consciously along the way other than when I spoke about it, I spoke about the case, what is it about the dad*

³⁶⁷ Unwelcome link.

³⁶⁸ Father prefers child to look to him for support.

³⁶⁹ Loyalty as problem. Loyalty as barrier to progress. Loyalty Trap.

³⁷⁰ Clinician involved in threat to family unity. Child protection seen as threat to family.

³⁷¹ Family togetherness seen is of primary importance to the parents and Clinician offered Hero role once again.

³⁷² Clinician insistence of putting child above family moves parents to place Clinician to Zero position.

³⁷³ Clinician faces on-going dilemma that others do not use the same Lens to view the child's difficulties. The Unwelcome Link is not made by others. Clinician lens removes pity, possibly compassion.

³⁷⁴ Transference identified after the event.

FINDINGS: NARRATIVES

that makes me feel this way and what is it about me that makes him be that way, but that is as far as it went.³⁷⁵ There were no answers to that really, other than there was something unpleasant going on that didn't seem to be of anybody's particular making.³⁷⁶

When asked about how the family felt about the links P7 made between the child's problems and the parental problems, P7 said, *...when I was slipping from grace, probably some of these comments would have felt like I was just attacking them and highlighting their failings, if you like, and if I was being honest, some of them probably were.³⁷⁷ If dad had just given me a pasting then maybe some of the things that were said were to get back at him. They wouldn't have been completely off-beam, right, but the motive behind them, you know....I guess on occasions I would have felt the need to defend myself and I suppose I would have done that by trying to demonstrate some sort of superior knowledge about the situation, which is not me because I am a non-expert person, or try to be.³⁷⁸*

P7 reported pondering whether part of the difficulty was that the father felt rivalrous or resentment about the quality of relationship that P7 had with the child, *because the child would arrive looking very crushed and deflated³⁷⁹... and would become very animated... the child would light up and would leave looking as if they were pumped up³⁸⁰ and maybe dad resented that in some way.³⁸¹ He would always say, 'it won't last' and it didn't but that could be a self-fulfilling prophecy if you hear it often*

³⁷⁵ Basic manualised transference part of thinking about the case but not central to intervention.

³⁷⁶ Clinician thinks the unpleasantness is not deliberately constructed by anyone. Unconscious activity rather than planned activity.

³⁷⁷ Links as attacks.

³⁷⁸ Defensive activity by Clinician out of character, acting out in response to family functioning.

³⁷⁹ Child crushed/ deflated.

³⁸⁰ Child transformed by Clinician.

³⁸¹ Potential rivalry between parent and Clinician.

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*enough*³⁸²... *I do think that in the fullness of time the child will be okay but I would prefer it to be sooner, but I am quite confident that the child will have a life for themselves one day.*³⁸³

P7 felt regret that the work which was being done with the child on an individual basis was not continued and that wondered if getting involved in the multi-agency discussions and family work had been a mistake.³⁸⁴ P7 reported hoping the child was enjoying more freedom and independence and that P7 had confidence in the referral to a new service.³⁸⁵

NOTES ON CODING CASE SEVEN

Case Seven was coded as a Hero to Zero case, where the Clinician has a powerful experience of being raised up as a preferred care provider and then dropped by the family. There is a rivalrous relationship between the father and the Clinician and this seemed to revolve round the loyalty of the child. The case begins with the Clinician seeing things from the child's point of view and ends with the father and child claiming that the Clinician had misunderstood the child while the parents understood. Centrally this is in relation to how much pity and compassion should be shown to the child so that the child may withdraw from developmental experiences like school, or how much the child should be supported to engage with developmental activities and shielded from difficulties at home in relation to the mother's addiction. This essentially came down to an Unwelcome Link made by the Clinician and this link became disputed. The Clinician can be seen to enlist the loyalty of the professional network by sharing the Unwelcome Link and inviting the

³⁸² Parent seen as tying child to crushed/ deflated position.

³⁸³ Splitting of Hero's into Black Knight and White Knight. Negative view as defence, positive view as venturing into life and developmental opportunities.

³⁸⁴ Clinical dilemma about whether to support individual child or to engage with the network. Potential difficulty for practitioner doing both.

³⁸⁵ Clinician benevolence remains even after case closed.

FINDINGS: NARRATIVES

network to view the family through the lens the link creates. Other codes which are used in this case are: Loyalty to Toxic Breast, Attacks on Linking and Linking as Attacks, Logic and Care Traps.

CASE EIGHT

P8 reported working with a child who had encopresis. The family were described as *high functioning* but the child had a *big difficulty*³⁸⁶ and it is a *subject of secret*³⁸⁷ and *shame within the family*.³⁸⁸ *It has just become a big unmanageable problem.*³⁸⁹ Behavioural interventions had been tried but without success.³⁹⁰ P8 became increasingly aware that the mother in the family spent too little time with her child because of work commitments.³⁹¹ P8 thought that the soiling allowed a particular type of intimacy to be sustained between the mother and child, allowing the mother to feel needed and the child to be cared for in an infantile way when the mother was present.³⁹² P8 said, *I think relying on positive reinforcement and rewards and things like that aren't going to be anywhere near as powerful as having this special relationship with the mother.*³⁹³ P8 reported trying to have conversations about this with the mother and even arranging to meet with her without the child present. P8 felt that the mother was avoiding the conversation and would bring the child along so that a frank discussion between P8 and the mother was not possible.³⁹⁴ P8 said, *I am pretty sure that (the mother) wants help from this, from our sessions I would guess that she would not be happy being in a vulnerable or needy (position) I don't think that would sit comfortably with her at all.*³⁹⁵ *So I think it is help, but of a certain kind. Help that is not really that intrusive. I guess I am using the word intrusive because I've felt I might be intrusive to this family if I do sort of start to bring these things up to her.*³⁹⁶ *I think she has kind of said I don't really*

³⁸⁶ Incongruity between high functioning and difficulty at infantile level.

³⁸⁷ Family secrets.

³⁸⁸ Family shame.

³⁸⁹ Problem out of proportion.

³⁹⁰ Initial intervention fails.

³⁹¹ Unwelcome link to lack of maternal presence.

³⁹² Problem provides needed rewards. Change therefore catastrophic.

³⁹³ Clinician identifies child's needs rather than pursuing treatment for presenting problem.

³⁹⁴ Parent avoids link. Pandora's box avoided.

³⁹⁵ Parent avoids infantile position.

³⁹⁶ Clinician feels intrusive, challenging identity of benevolent practitioner.

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*want to talk about those kind of things or to go there at all.*³⁹⁷ P8 felt that both the mother and child stood to lose quite a lot if the soiling was to improve.

P8 thought the child felt responsible for the problem and the child would say *“I will fix it before my birthday next month”*.³⁹⁸ *I think part of the child was saying “please everybody go away, I will sort this out, leave me alone”*³⁹⁹.... *but in my mind... the work I need to do is with mum, preferably, dad as well... I kind of feel that I am pushing them to do something that they don't really want to do. I guess change is scary for a lot of families who come along, there is often a degree of resistance to change because things are lost and it is a frightening thing*⁴⁰⁰, *but I think there is something about this family that makes me even more cautious and wary and so I feel I am intruding and punitive.*⁴⁰¹

P8 felt uncomfortable about the idea of discharging the child *without having made any difference at all.*⁴⁰²

Interviewer: I am wondering about the relationship and the feelings that you were left with, of trying so hard and not being successful, which this family know so well, and I wonder if you had ever thought of that as a transference?

P8: *I guess it is something that I have noticed but I haven't really done anything with it*⁴⁰³....*I have noticed it, that this is what it feels like for the family,... I try to keep it in mind a little bit so that I don't become*

³⁹⁷ Parent avoids Unwelcome link.

³⁹⁸ Child wanting to take control of problem.

³⁹⁹ Child wanting Clinician to withdraw.

⁴⁰⁰ Change frightening.

⁴⁰¹ Clinician pursuing Link feels intrusive and punitive. Move from Unwelcome Link to Cruel Link.

⁴⁰² Professional need to feel effective.

⁴⁰³ Transference noticed but not worked with.

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angry or annoyed with the mum, so that I don't become frustrated, I guess it helps with my empathy for the family.⁴⁰⁴ But really that is it.

P8 reported that the experience of working with this case led P8 to additional research on the treatment for soiling and changed P8's practice so that family dynamics were considered at an early stage and included in the early formulation.⁴⁰⁵

NOTES ON CODING CASE EIGHT

Case Eight is notable because of the link the Clinician makes between the shameful problem and the hidden gains followed by the parents determined avoidance of this link. The Clinician is denied any manoeuvrability in pursuing anything other than behavioural interventions. Coded as Unwelcome link moving toward the Cruel Link as the Clinician begins to feel intrusive and punitive. Link also to Pandora's Box.

⁴⁰⁴ Awareness of transference helps Clinician manage feelings of frustration.

⁴⁰⁵ Experience of case stimulates Clinician to develop skills and thinking in relation to work.

CASE NINE

P9 reported working with a family where P9 held a very different view of a child from the one the child's mother took. *I think there is no doubt that mum would see the child, I don't think she used that word, but evil,⁴⁰⁶ that was around actually, see the child as having something innately wrong and that explained the child's behaviour. ... I saw him as a child who yes, to some extent had a biological problem that didn't help with behaviour but I saw a lot of it as an attachment and relationship issue that was just unbearable for the child at times as mum was quite emotionally rejecting... at times.⁴⁰⁷ She maybe didn't think she was being so, so yes we disagreed.⁴⁰⁸*

The child's mother had her own mental health difficulties alongside a traumatic family history and a great deal of fear and anger in relation to men in her past and present life.⁴⁰⁹

P9 referred the mother to adult psychiatry services but the mother did not attend adult appointments.⁴¹⁰ P9 said, *My first reaction to that was actually she got very stuck in just wanting this to be about her child, it was her child's difficulties and we were to fix the child.⁴¹¹ So as soon as it was thinking about her as well, because her child did have a lot of difficulties... and we recognised that, but there was no doubt in my mind that the child's relationship with... mother was part of that. I don't think she ever gave permission or wanted to understand that as being part of the formulation⁴¹²... That was a big stuckness, helping her to take that on board. I think there were times that she managed to start thinking*

⁴⁰⁶ Child viewed as evil. Link to emotional abuse.

⁴⁰⁷ Unwelcome Link. Clinician formulation includes relationship with mother. Link to toxic breast.

⁴⁰⁸ Clinician and parent hold different views of the child.

⁴⁰⁹ Parental trauma, parental mental illness.

⁴¹⁰ Parent refuses treatment in own right. Services organised by Clinician rejected. Preferred Carer chosen, Clinician in Hero position.

⁴¹¹ Parent stuck in viewing problem as located in child.

⁴¹² No permission given to explore Unwelcome Link.

FINDINGS: NARRATIVES

about that a bit but from memory that never lasted,⁴¹³ we would have discussions about that and it even remained until the next time I saw her and then something would happen and the whole thing would disappear again⁴¹⁴ as if it had never happened and you had to approach the whole area again.

P9 said *I think she could be frightening to her son.⁴¹⁵ I didn't find her frightening. She was difficult, I didn't feel particularly threatened by her, I have felt threatened by patients before but I didn't feel particularly by her. I don't know why not because she was so angry but no, although I would worry about her in relation to her child. I don't remember about her being physically threatening herself, but emotionally threatening and there was definitely an issue about her relationships with men and who she would allow into her life, given her own history, her lack of ability to protect the child.⁴¹⁶ But when she was angry I would wonder about how she would be towards the child, blaming the child sometimes... it was such a complex case, there were other stuck elements and one of them was the trying to get other services to do their bit, particularly social work as there was a lack of support at some times, too.⁴¹⁷*

Interviewer: I get the idea that she was seeking help and you were providing help that ...was making her hostile. Did you ever think about that as a transference relationship?

P9: *I certainly discussed the patterns⁴¹⁸ that we were doing but again there was a resistance⁴¹⁹ or it was just very hard for her to understand but I remember not feeling that it was very useful.....I do remember attempting to have a discussion on more than one occasion about how she was feeling and how I was feeling and patterns of behaviour we seemed to do over the years because it was a long time to see somebody.⁴²⁰*

⁴¹³ Progress short lived. Link to destructive functioning in parent's mind.

⁴¹⁴ Again destructive functioning in mother's mind.

⁴¹⁵ Parent frightening figure for child. Link to disorganized attachment.

⁴¹⁶ Parent self-destructive in relationships and not protecting child.

⁴¹⁷ Other agencies difficult to engage. Difficulty in sharing formulation and level of concern with other agencies.

⁴¹⁸ Awareness of some aspects of transference discussed but not worked with technically.

⁴¹⁹ Parent resists conversation about transference issues related to patterns.

⁴²⁰ Long time spent with parent.

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There was some acknowledgement of her being in some kind of patterns of behaviour because we probably related it to the things she would do in relation to the child's school or to social work, but again she struggled to use that or even take it on board to any great extent.⁴²¹

CODING FOR CASE NINE

Case Nine has clear elements of emotional abuse and a sense of the Clinician working with the parent for a long period of time and having a view of the parent's self-destructive functioning and lack of protection for the child. Coded as Toxic Breast, Destructive Functioning, Unwelcome Link.

⁴²¹ Parent struggling to take things on board. Developments hard to accept or maintain.

CASE TEN

P10 took on a referral for a teenage boy who had been referred to the service previously but the family had disengaged and complained about the treatment they had received.⁴²² P10 took on the case.⁴²³ The boy's behaviour was causing concern on a number of levels, he was very controlling and could be violent domestically and socially (previously having been pre-occupied with gangs, fights and being the best fighter in the gang).⁴²⁴ P10 was concerned that the boy would commit a serious offence. There were many additional mental health concerns including a long history of anxiety and in particular separation anxiety in relation to his mother.⁴²⁵ The boy's mother was convinced that he had a serious mental illness such as schizophrenia.⁴²⁶ P10 spent a year working with the boy and his mother ruling out one diagnosis after another and explaining to the mother why the boy did not fit the criteria. The mother's concerns about the boy drifted from schizophrenia to an autistic spectrum disorder to an eating disorder.⁴²⁷ While the boy did not fit the criteria for any of these there was a real concern about his functioning, his emotional development and personality development. P10 said that from the start there were concerns about how the mother was impacting on the boy as the GP had drawn attention to this in the referral.⁴²⁸

⁴²² Previous complaint about professionals puts service and previous clinicians in Zero position.

⁴²³ Clinician takes on Hero position for service.

⁴²⁴ Life and Death anxieties in relation to child's conduct.

⁴²⁵ Long standing mental health difficulties. Chronic problems.

⁴²⁶ Medical problem located in the child.

⁴²⁷ Clinician kept pre-occupied by formal assessments rather than getting to know the child and family and arriving at a formulation.

⁴²⁸ Toxic breast.

FINDINGS: NARRATIVES

After a year of working with the family P10 became aware that, *...if I was seeing the boy weekly, spending an hour, then mum needed that hour too,⁴²⁹ at least that hour, to talk about her understanding of what was going on in the house, her understanding of the boy's behaviour and just her part in it. In actual fact the relationship that has been difficult, it has been the power of mum, the relationship with mum.⁴³⁰ The prickly relationship we have had throughout the process..., what happened was when mum felt disappointed by us, rejected, felt that we weren't providing enough or responding in a way she felt met her anxiety... (then) the levels of aggression in the home were just going up and up and up.⁴³¹ He has been very close to being in secure (a secure unit) and we have been able to avoid that. But the risks at home are that we are very, very, worried about the boy ending up in secure because of mum and something fuelling this in the house.⁴³²*

It was difficult for the mother to believe her child did not have a serious mental illness.⁴³³ P10 said, *She would interpret the boy's behaviour... so that whatever he did, there was something not right about it.⁴³⁴* P10 then went on to describe the difficulties that the boy did have which were related to needing to feel in control of things and people, particularly domestic arrangements to do with routines.⁴³⁵ The boy was willing to cause domestic and social scenes to ensure he got his way and he could be violent and controlling in relation to his mother and sibling.⁴³⁶

⁴²⁹ Parent in need of service.

⁴³⁰ Stuckness in relation to parent, particularly the power held by parent.

⁴³¹ Unwelcome link between meeting parent's needs and conduct of child.

⁴³² Feeling that Clinician has avoided disaster but this hinges on moderating parent's impact on child.

⁴³³ Parent with fixed view of child with pathology. Clinician holding different views implied negligence.

⁴³⁴ Link to emotional abuse.

⁴³⁵ Child's need to control is central to formulation.

⁴³⁶ Child as frightening and violent figure.

FINDINGS: NARRATIVES

P10 said, *So there is a strong theme of things not going to plan, things feeling very anxious and not being able to predict for that anxiety.*⁴³⁷ The mother reported that she knew what would make the boy angry but not what would make him anxious. P10 pointed out that the mother found it difficult to see the anger as an expression of anxiety.⁴³⁸

P10 reported that the mother wanted a diagnosis so that she could clearly say *'that is why he does what he does'* but P10 could not provide that and indeed spent the first year ruling out diagnoses.⁴³⁹ P10 said, *So once we had eliminated that he doesn't have schizophrenia, we agree on that, he doesn't have an eating disorder, he doesn't fulfil the criteria for ASD because in his one to one work his flexibility of thought was great, he could do all of that, it was just that in context he chose not to. So...what was the way forward? And that is where I got really, really stuck.*⁴⁴⁰ *Because what you have is a mum with mental health problems and difficulties herself, from a very difficult traumatic childhood that I then found out, a year down the line she let me know.*⁴⁴¹ *So what do you do when you have got a mum who's still so fragile and you have a son who has so many mal-adaptive ways of coping with the world... Can we fix it? What can we do that is going to protect him from parts of that,*⁴⁴² *because what he is saying is, 'I am not going to go out the house, I am not going to go to school', because he hasn't been to school for years... 'I don't do school, can't be trusted to be around people', because he might lose it and can't be trusted... Wherever he goes he gets negative feedback, he doesn't come across as a personable likeable boy.*⁴⁴³

⁴³⁷ Plans not working. Random anxiety.

⁴³⁸ Parent prefers to see violence rather than need in the child. Difficult link, though perhaps not unwelcome.

⁴³⁹ Parent looking for meaning and wanting it to be related to concrete cause.

⁴⁴⁰ When pattern of ruling out diagnoses is exhausted the stuckness sets in.

⁴⁴¹ Preferred carer. Clinician put in Hero mode by parent..

⁴⁴² Child needs protection from toxic breast.

⁴⁴³ Negativity about child is network wide.

FINDINGS: NARRATIVES

P10 reported seeking consultation and supervision from colleagues and asking, *What next?*⁴⁴⁴ *Is there anything anyone can suggest as I am still seeing these two separately weekly, and I am just really struggling? Do I just continue seeing the boy, chatting about what goes on in the house and get his perception, and then speak to mum and get a different perspective and hope that they don't kill each other in between until he is eighteen and can leave the house*⁴⁴⁵. *Is that my job?*⁴⁴⁶ In response to this a colleague with an interest in forensic cases offered to joint work with the case.⁴⁴⁷ P10 felt a great relief at this offer of help and felt the colleague made a positive connection with the boy. The boy and P10's colleague have been doing anger management work but the boy has refused to opt-in to anxiety management work as *it seems to irate him*.⁴⁴⁸

When P10's colleague got involved with the boy it then freed up P10 to meet more regularly with the mother, which is what the mother wanted but it meant P10 was left to deal more directly with the mother's needs.⁴⁴⁹ P10 said that while the boy's work with P10's colleague went well, *...it is as though mum only allows him to go so far and then she doesn't want it to go any further.... That is the bit that feels really bad because you think, am I getting paranoid about mum?*⁴⁵⁰ *But it is almost as if (when) the boy begins to function then she doesn't have anywhere to come with her sense of "no one is really there for me, and no one has ever noticed my difficulties".*⁴⁵¹ *And that is really, really hard because the boy can't really get better because when he even starts to (improve) ... mum will say "oh that went well"... right on the back of that it is as though she can't let that happen*

⁴⁴⁴ Clinician seeks help.

⁴⁴⁵ Hopes at lowest level, survival. Life or Death anxieties. Separation of child and parent seen as way forward.

⁴⁴⁶ Clinician questions limits and expectations around own role and task.

⁴⁴⁷ Colleague responds.

⁴⁴⁸ Child selectively co-operates with intervention. Child becomes irate after some help.

⁴⁴⁹ While colleague responds the Clinician is still left with stuck aspect of work, parent functioning.

⁴⁵⁰ Clinician doubts own links.

⁴⁵¹ Clinician aware of intensity of parental needs.

FINDINGS: NARRATIVES

*again because the risks are too high for her if the boy gets social, or we back off, the risks are high for her if we are not there.*⁴⁵²

P10 thought that the mother disclosing her own traumatic childhood was useful for thinking about the boy but also meant that the mother should access adult services, possibly adult psychotherapy. P10 said as soon as she said this to the mother, *I think she just thought, we'll I've told you and you are just passing it somewhere else.*^{453 454} *So before I knew it I was seeing mum weekly and that has continued and I feel I am out of the realms of treating the boy and I am spending an awful lot of time with the mum, but I am hooked into doing that because if I don't, the boy suffers,*⁴⁵⁵ *things deteriorate very, very quickly and the boy is up in a cell overnight or for a couple of hours and that sets him back. For me I feel stuck and a wee bit tied.... Tied in that, I feel tied in, the knot is there and I can't really do, I am not going to untie it because I want someone to untie it who is going to be there.*⁴⁵⁶ When asked who had tied the knot P10 said, *Me and mum, mum has definitely tied it, mum has definitely tied it and she has chosen to do it with me and I want her to do it somewhere else. I don't want to be responsible for untying it.*⁴⁵⁷ When asked if the mother had tied P10 into being responsible as a care giver to the mother P10 said, *Yes, she has, but I offered that*⁴⁵⁸ *... I offered that at the time, to do that, so I can't offer that, to be there and give her time that is necessary for her, giving her time to talk about some memories she has, some feelings she has around.... It is important because it is about how she manages the boy.*⁴⁵⁹ *I can't open that and then say well we will just leave you to go and talk*

⁴⁵² Clinician aware of hidden benefits for parent of current problem with child.

⁴⁵³ Disclosure by parent followed by onward referral experience as rejection.

⁴⁵⁴ Thin skinned.

⁴⁵⁵ Deep concern for child.

⁴⁵⁶ Parent responds to forward referral by compelling Clinician to provide care through Link between child functioning and parent functioning. Link used as trap.

⁴⁵⁷ Metaphor of tied. Trap or lack of manoeuvrability set by mother. Parallel with child's relationship to the parent.

⁴⁵⁸ Clinical trap. Logic Trap. In pursuing work with the system the Clinician takes on more than anticipated from parent.

⁴⁵⁹ Clinician fluctuates on relevance of parent work to the child's treatment.

FINDINGS: NARRATIVES

about this somewhere else,⁴⁶⁰ because it relates really well to how she copes with and manages the boy's behaviour. I do agree with the focus of it and the purpose of it, but I worry about the direction of it.⁴⁶¹

P10 said, *I think she saw the boy with a nice place to come and people listening and taking things to the Reporter for him, speaking up for him, and I think that is when she started trusting us.....She was, not jealous, yes I think it is the word rivalrous,⁴⁶² she wanted that (what the boy had) at that point and she decided at that point to trust us as we had proved ourselves, because you need to prove yourself to the mum.⁴⁶³*

P10 said that, *While the boy has my colleague, mum needs to know that we have not forgotten about her and she is still very much part of the boy's treatment plan, because if you forget that, that is when things start to go wrong.⁴⁶⁴ So although I am okay with that because that is part of your job to understand where she is at and why she needs you, there is always that sense of feeling a bit blackmailed⁴⁶⁵ ... I am not, you are just part of a process and trying to remain mindful of where she is at, but I do feel stuck. When asked to talk some more about the feeling of being blackmailed, P10 reported, *Do you know that feeling that you are necessary and not just important,⁴⁶⁶ and when people want of you, and really need you and they need your time and you can really feel taken over;⁴⁶⁷ and you feel as if there is a blackmailing, and you feel that if I don't do this and don't get it right for her then the boy is going to end up in jail⁴⁶⁸ within the weekend, and that is basically what it was like.**

⁴⁶⁰ For ethical reasons. Clinician refuses to move into the Zero position.

⁴⁶¹ Focus, purpose, and direction. Clinician questions direction.

⁴⁶² Parent rivalrous with child over Clinician's time.

⁴⁶³ Parent tests professionals.

⁴⁶⁴ Parent need to be kept in mind.

⁴⁶⁵ Clinician compelled to provide service, feeling blackmailed. Child used as way to ensure care for parent.

⁴⁶⁶ Life or Death anxieties, necessary not just important.

⁴⁶⁷ Clinician feels taken over. Threat to Clinician identity.

⁴⁶⁸ Clinician freedom to think and act curtailed by threat to child.

FINDINGS: NARRATIVES

P10 reported wondering if adult services would deal with the mother very differently. P10 said, *But I must be honest, see if I was seeing mum on her own, I don't think I would have felt as tense and worried and full up, I think because I knew I wasn't seeing her in isolation, that the boy was there, was part of the picture, the sense of responsibility felt quite large.*⁴⁶⁹

P10 described the emotional impact of working with the mother saying, *She didn't trust services or people involved with her to think about her enough or to do things right, to follow up phone calls, to do the things they said they would. So there was all of that. I thought right, so I know that, so she has to be one of these people I will not forget or make a mistake in the diary with. This was one of those ones and you know when you have tried your best and made a bit of an effort and you think you get a bit of notice for it, but there was no notice*⁴⁷⁰. *For the first six months it was relentless, I couldn't make a wee error or say oh it is not next Tuesday it is next Wednesday, a wee error like that or the mother would dismiss everything of value that had previously happened.*⁴⁷¹ *....You always felt you were going to trip up.*⁴⁷² In relation to this P10 reported feeling strong emotions and physical feelings of being *Just full up. Just, oh, breathing, you need to remember to breathe.*⁴⁷³ *Because you went from being full up to feeling afterwards that there was nothing left and you can't have more than one of them a day.*⁴⁷⁴ *So when you had mum and the boy it depleted you. It affected the rest of my working week.*⁴⁷⁵ *It was hard for a while.... To be honest thinking back on it, there is probably a bit of me that is 'right, it is much better... and they need to go because I think you have had your innings out of me and that is enough.'*⁴⁷⁶ *And it is*

⁴⁶⁹ Seeing parent in child and family setting changes emotional relationship and raises anxieties. Parent presenting for help rather than as individual in own right. Link to Toxic Breast.

⁴⁷⁰ Clinician efforts not rewarded.

⁴⁷¹ Relentless dismissiveness. Clinician competence constantly monitored. Sword of Damocles.

⁴⁷² Anxiety promoted in Clinician.

⁴⁷³ Case had physical impact on Clinician. Possible experience of projective identification.

⁴⁷⁴ Physically and emotionally demanding, the case impacts on the Clinician's whole day.

⁴⁷⁵ Working week affected.

⁴⁷⁶ Clinician feels family have taken more than fair amount of service.

FINDINGS: NARRATIVES

*not fair on her because I don't think she gets out of bed in the morning and means to give me a hard day.*⁴⁷⁷

*But her behaviour was so challenging and quite needy that it was hard to sit with it, the boy is the same.*⁴⁷⁸

P10 reported that after staying with the case for a long time the feelings have changed and *it is more sadness now, I get sadness,*⁴⁷⁹ *and each time a tiny bit of hope*⁴⁸⁰ *because she is cancelling and re-arranging so she doesn't need it weekly.*⁴⁸¹

P10 thought that experience was the main thing that had helped them to manage the case alongside the opportunity to discuss the case in team case discussion, consultation and supervision, and the direct offer of help from the colleague who joined the case.⁴⁸² P10 felt the pressures of trying to balance the needs of this case alongside the rest of their caseload, and a concern that they might be asked to justify working with the case for so long.⁴⁸³ At the same time P10 felt that the boy and his mother would need help for a long time. P10 held a hope that the boy would leave home at the age of eighteen but P10 was not optimistic about that. P10 reported, *I would hate to feel that he would be there forever,*⁴⁸⁴ *if something outside the family distracts him enough, like some girl or boy or whoever, somebody distracts him enough to start to walk and once he starts to walk he will quickly run and run like the wind. That could be an option but I don't think he has the skills... so I do feel very sad for him because I think he will be a*

⁴⁷⁷ Clinician uses empathy to moderate own feelings in relation to parent.

⁴⁷⁸ Parent presentation linked to child presentation.

⁴⁷⁹ Depressive concern for child.

⁴⁸⁰ Pandora's Box.

⁴⁸¹ Reduction in need for service is done through cancellation rather than planned. Negotiation of care seeking not transparent.

⁴⁸² Clinician survives experience by drawing on own experience and using network of support available.

⁴⁸³ Case felt to unbalance caseload. Clinician balancing Life or Death anxieties in relation to this case with the needs of other cases.

⁴⁸⁴ Separation from parent seen as main hope for development. Link to Toxic Breast.

FINDINGS: NARRATIVES

*prisoner in the house.*⁴⁸⁵ *He has no need to go anywhere because mum provides for him very, very well. So he just kind of exists in the house.*

When asked if P10 had considered the feeling of being blackmailed or controlled into providing care for the mother as a transference, in other words would the mother have had to make her own carers provide for her, P10 responded, *I think she would, I have never spoken to her, or used that word,*⁴⁸⁶ *or did it like that, but I think I could have that conversation with her, and the reason I can safely say that is that she talks quite well now about how she sees the boy as a reflection of her, she talks about how her own mum was and the strong feelings that brought about and then her marriage....*

The mother was also able to discuss how the boy's father (who was no longer living with the family) was very controlling and the boy's behaviour was similar to his father's.⁴⁸⁷ P10 showed a high level of sensitivity to the mother's functioning and her ability to make links at times although when the mother was tired this would be more difficult.⁴⁸⁸

P10 detailed thinking about how to phrase things when talking to the mother because P10 didn't want the mother to feel that P10 was retaliating if the mother's behaviour was difficult.⁴⁸⁹ P10 reported, *I spoke to my supervisor a lot about it,*⁴⁹⁰ *because I don't think the mother gets up in the morning to do that to me, I thought a lot about how I could say it.*⁴⁹¹

⁴⁸⁵ Child seen as trapped, prisoner in home.

⁴⁸⁶ Transference not worked with but thought to be useful for the work.

⁴⁸⁷ Child repeating patterns from father.

⁴⁸⁸ Clinician knows parent very well and is in touch with mother's internal states.

⁴⁸⁹ Clinician diligent in containing negative feelings toward parent.

⁴⁹⁰ Supervision used, case felt to use a lot of supervision time.

⁴⁹¹ Clinician considers how to talk to the mother, paying attention to the detail of the communication.

NOTES ON CODING FOR CASE TEN

Case ten is dominated by the idea that the parent uses the child's needs to *blackmail* care for themselves. The high level of emotional need and the enmeshment with the child, alongside the conviction that there is a psychiatric disorder are all convincing descriptions of emotional abuse, this is coded as Toxic Breast. The child's level of violence and controlling behaviour adds Life or Death anxieties in relation to the case. The Clinician is the preferred carer and having picked up the case following a complaint is in Hero Position for both the service and the family. In this case the Clinician invites the parent to make a link to their own functioning. The parent welcomes this and compels the Clinician to persevere with it. This is coded as Pandora's box. The Parent uses Ethical and Logical Traps to tie the Clinician to her so that the parent does not suffer alone. Link to Unwelcome Link leading to Cruel Link.

CASE ELEVEN

P11 reported the following experience: *It was a case where there had been really horrendous sexual abuse⁴⁹², which is obviously difficult for any family to deal with, but when I saw them it was- they had been to social work, it had been unhelpful, the legal system had been unhelpful, the court system had been unhelpful, and you get into a sort of rescue mode and you are going to be different and give them a different experience.*⁴⁹³ P11 worked with the case for around a year before discharging the case having made little difference but ending on good terms with the family.⁴⁹⁴ Several years later a colleague came to talk to P11 about the case as a new referral had arrived and the family were now reporting that seeing P11 had been unhelpful.⁴⁹⁵ P11 felt angry at this and insisted on being the case manager and being responsible for the case again.⁴⁹⁶ P11's colleagues did not disagree with this.⁴⁹⁷ P11 had a break and a chance to reflect on the angry feelings that the re-referral evoked and was able to return and ask for a colleague to manage the case with P11 contributing to the work.⁴⁹⁸ P11 reported that colleagues agreed with this but it puzzled P11 that colleagues had not challenged P11's initial plan, despite what P11 felt was an obvious emotional reaction to the referral.⁴⁹⁹

When P11 met the family again and was introduced to them the mother *blanked* P11 as if they had never met before,⁵⁰⁰ despite P11's feeling that when they had worked together

⁴⁹² Child trauma.

⁴⁹³ Clinician moves into Hero position in response to child distress and reports of network failing to help.

⁴⁹⁴ Clinician repeats pattern of agencies trying to help.

⁴⁹⁵ Clinician part of pattern now witnessed by professional network. Clinician openly in Zero position.

⁴⁹⁶ Clinician attempts to regain the Hero position.

⁴⁹⁷ Professional by-standers.

⁴⁹⁸ Reflection and grading of difficulty happens in Clinician's private life, not through institutional support.

⁴⁹⁹ Experience isolates Clinician from colleagues. Colleagues seem blind to Clinician's emotional response to case.

⁵⁰⁰ Parent puts Clinician in Zero position.

FINDINGS: NARRATIVES

before there had been a good engagement, even though there had been no shift in the problem.

Interviewer: You have gone from being a rescuer or a hero in some way, to nothing. Have you thought about this as a transference relationship?

P11 made a link between a transference relationship and the mother's own mother attending a session *and she said on two occasions I don't really care about ...the mum... she is not important it is just the child.*⁵⁰¹ *Explicitly about her daughter..... she said it on two occasions and everyone who had heard it was quite struck about how hurtful that could be,*⁵⁰² *so...I think I just got caught up in just looking at this horrendous trauma that had happened*⁵⁰³ *and it was years down the line and they had been (to different services) who I know are very good and they were slagging everybody off and I should have thought, what is happening here, and I didn't include the wider system and ask them*⁵⁰⁴ *.... About transference, now that you say, yes, and those really strong reactions that I have had to think about, but I suppose initially when I saw them I thought I was doing a good job*⁵⁰⁵ *and although things hadn't changed, we didn't leave on bad terms and I kind of felt it was a journey that they were going through and they weren't angry when they left, we saw some changes but they lost them very quickly and we could link that in to things that were happening. Does that answer your question? I probably didn't think about it until it evoked really strong feelings, I felt really strongly when they came back this time.*⁵⁰⁶

⁵⁰¹ Transference question stimulates thoughts about inter-generational dynamics.

⁵⁰² Parent alienated from own parent's care.

⁵⁰³ Trauma central to difficulty in thinking. Trauma restricts manoeuvrability.

⁵⁰⁴ Clinician caught up in re-enacting pattern of services trying to help without linking intervention to other services.

⁵⁰⁵ Transference not gathered or prioritised in first episode of treatment.

⁵⁰⁶ Need for transference to be considered linked to strong feelings in relation to the case. Transference communication only gathered over time and with experience of Hero to Zero.

FINDINGS: NARRATIVES

Interviewer: There is a certain gap that they leave that people want to run in as rescuers and it sounds like a very powerful dynamic that they set up, either through what the story is or through the rubbishing of what has gone before it.

P11: Yes, because.... *although (the mother) kind of blanked me as if I was not important, as if we hadn't had this relationship, C 2.... was talking for this mother as if they had a really close relationship, and probably (some) years ago, I might have done the exact same thing.*⁵⁰⁷ *I could see myself there and really fighting her corner, so she does do that to people.*⁵⁰⁸ *But as quickly dismisses them.*⁵⁰⁹ *And it made me start thinking, does that child feel like*⁵¹⁰*that because the child goes between grandparent and mum's and mum would say things like my house is not a home, it is some place that we live.*⁵¹¹ *Which is quite a strange thing for a mother to say....C2 was saying I've got her to do all these things, I've got her to do up the child's room, well she did that four years ago and it still didn't become a home, C 2 had the child sitting on a toilet, I did that too, I felt as though you could check the notes, so I felt as if I was justifying what I was doing, but it was the exact same as Clinician 2 had done.*⁵¹² *So she was seductive, she was a person who made you think yes I am going to make a difference. And she believed in you and she was ... very confident with the relationship when she had it.... as if she was quite secure in that relationship*⁵¹³ *..... and you should always be wary when people are like that with you.*⁵¹⁴

P11 reported that the mother wanted things to change but struggled to think about her own part in the change process. P11 felt that a team approach and involving other

⁵⁰⁷ Clinician sees colleague repeating own pattern.

⁵⁰⁸ Parent evokes Heroes.

⁵⁰⁹ Parent dismisses Heroes, moving them to Zero.

⁵¹⁰ Empathy with child. Gathering transference information without conceptualizing it as such.

⁵¹¹ Empty breast.

⁵¹² Clinician justifies intervention by comparison to colleague.

⁵¹³ Parent confident in eliciting professionals loyalty.

⁵¹⁴ Clinician wary in hindsight.

FINDINGS: NARRATIVES

generations and taking a wider view of the family were important if there was to be any movement.⁵¹⁵

NOTES ON CODING FOR CASE ELEVEN

The trauma in Case Eleven plays a central role in terms of how the Clinician understands the pattern and nature of the relationship. Some transference communication was gathered but not conceptualized as such. The Clinician moves from Hero to Zero position and has professional on-lookers to witness this. From the Zero position the Clinician is left to watch a new Hero repeat the same patterns. The transference is gathered more thoroughly by following the case over time and making links to intergenerational relationships and patterns. The case was coded Hero to Zero and Traumatized Breast.

⁵¹⁵ Involving colleagues and working across generations felt to be necessary to gain manoeuvrability.

CASE TWELVE

P12 reported working with a young person who was referred by a Tier 2 service because of concerns around self-harm.⁵¹⁶ P12 said, *From the first time I met them the young person just had me so concerned because the young person was so low and sad and you were left with those feelings after the meeting for the rest of the day*⁵¹⁷. *And I had tried to do some work around self harm and it felt as though that wasn't getting anywhere and wasn't helping because we could never really get onto that work because the young person was just so distressed and sad.*⁵¹⁸ *I asked Psychiatrist 1 to see the young person and Psychiatrist 1 prescribed an anti-depressant and I thought that maybe if we boosted the young person's mood a bit we might be able to work on the self harm, and it has really been a difficult relationship since then.*⁵¹⁹ *I wanted to see the young person with the family and the young person brought mum a couple of times but... mum has not been back.*⁵²⁰ *This is despite the mother being very concerned that the child will commit suicide.*⁵²¹ *The mother has other relatives that require constant care.*⁵²² *What was interesting is that the black picture the young person described was in stark contrast to how mum described it.*⁵²³ *The social isolation the young person described... it sounded like quite a desperate situation the young person was in, it was quite different to what mum described. It was really useful to have mum on board because I felt as though I was getting more of the real story. And now mum is not attending, I don't know, there is a bit of a feeling of being taken for a bit of a mug, at times*⁵²⁴ *(laughs). When you have had a big*

⁵¹⁶ Life and Death anxieties in relation to child's functioning.

⁵¹⁷ Emotional impact of case affects Clinician personally and over time.

⁵¹⁸ Distress and sadness as obstacles to planned work.

⁵¹⁹ Clinician involves other professional. Difficulties start after network widened.

⁵²⁰ Parent disengages.

⁵²¹ Life and Death anxieties in system.

⁵²² Pre-occupied carer. Empty breast.

⁵²³ Incongruity between accounts of child's life.

⁵²⁴ Clinician ridiculed.

FINDINGS: NARRATIVES

*lengthy conversation with somebody and really going in to depths about how the young person can manage in the here and now and you find out that none of that was true, you kind of feel I have been had here.*⁵²⁵

P12 then reported a pattern of the young person not attending for regular appointments but presenting themselves in a crisis,⁵²⁶ usually when P12 was not there.⁵²⁷ As it was a crisis the young person would be seen by another member of staff and give a different account of the problems, which conflicted with the account given to P12.⁵²⁸ The young person did this repetitively so that within a short time the young person had been seen by many members of the service which was struggling with staff shortages.⁵²⁹ P12 felt that they had given the young person the key to urgent and out of hours services and that the young person used this instead of the planned appointments.⁵³⁰ There was a certain amount of professional embarrassment about this that P12 felt was shared by the Tier 2 practitioner who referred the young person to the service in the first place.⁵³¹ To avoid this P12 found that they were more pro-active about offering appointments⁵³² and said, *It is like trapping, the young person traps you.*⁵³³ *Because I know that there is not a clinical need for the young person to be seen, for me to phone and discuss it and for the young person to be seen the day after, having to really try to step away from the young person and think about it more as what is going on here and maybe the young person could get sent an appointment in a week, ten days, whatever.*⁵³⁴

⁵²⁵ Question if this is Clinician being kept in Zero position.

⁵²⁶ Crisis presentation avoids planned intervention, restricting Clinician manoeuvrability.

⁵²⁷ Network of carers widened through crisis.

⁵²⁸ Incongruent narratives increase.

⁵²⁹ Pattern of crisis repeated. Clinician concerned about impact on service.

⁵³⁰ Clinician feels responsible for child's actions.

⁵³¹ Professional embarrassment in face of professional on-lookers.

⁵³² Clinician alters usual method of care because of child acting-out.

⁵³³ Trap. Ethical trap, Distress trap.

⁵³⁴ Clinician aware of own functioning and need to move to planned appointments.

FINDINGS: NARRATIVES

P12 said *There is something about coming here that is helpful because the young person comes here when things are difficult but I am not really sure what it is that I am doing that... I am not really sure what the young person needs, you know? I am just left feeling confused.*⁵³⁵

When asked what feelings P12 had when the young person was seen, P12 said, *initially it was heart-sinking, real black mood,*⁵³⁶ *as if the young person had just taken it and 'phoot'* (makes a gesture of throwing) *just shoved it onto you and it was horrible, horrible sadness, and you really felt for the young person, very concerned.*⁵³⁷ This contrasted with a later appointment when the young person attended *really, really bright, extremely bright, as if cured and there was no problem.* This left P12 feeling equally bright.⁵³⁸

The interviewer had the impression that P12 was struggling to describe the situation by only using positive terms and asked P12 about this. P12 said, *I don't know. I have never thought of that before. I think thinking, trying to think with a positive slant on it helps me to stay engaged with the young person. Because if I start to think too suspiciously about these manipulative and attention seeking, (behaviour) all these negative words, then it makes it too difficult for me to meet with the young person.*⁵³⁹ *And it is difficult enough... Although when the young person cancels it is really frustrating and difficult and you know there is going to be another crisis, when the young person does cancel I am so happy and so relieved.*⁵⁴⁰ *Because I have to make an effort to think more positively to tolerate being with the young person.*⁵⁴¹

⁵³⁵ Intervention and child's needs confusing for Clinician.

⁵³⁶ Clinician emotionally affected by child.

⁵³⁷ Description of projection of emotions from child to Clinician.

⁵³⁸ Emotional projection not only in relation to distress.

⁵³⁹ Taking control over language used to describe child avoids Clinician becoming unable to relate positively to child.

⁵⁴⁰ Conflict between professional demands and personal emotional response to cancellation.

⁵⁴¹ Thinking positively requires effort.

FINDINGS: NARRATIVES

Interviewer: Maybe what the young person is bringing to you is an experience of being lied to and confused and being suspicious about the people a young person ought to have been able to trust. Have you thought about that as a transference?

P12: *No I haven't but it makes complete sense that the young person probably, given what the young person is telling people, that those feelings that I am having are most probably feelings the young person would have had if the young person had been through any kind of abusive experience⁵⁴².....I mean I was really aware that I was getting all the young person's sadness but I wasn't aware of all the other emotions I have been getting since then as a transference.⁵⁴³ Yeah that does, yeah.*

NOTES ON CODING CASE TWELVE

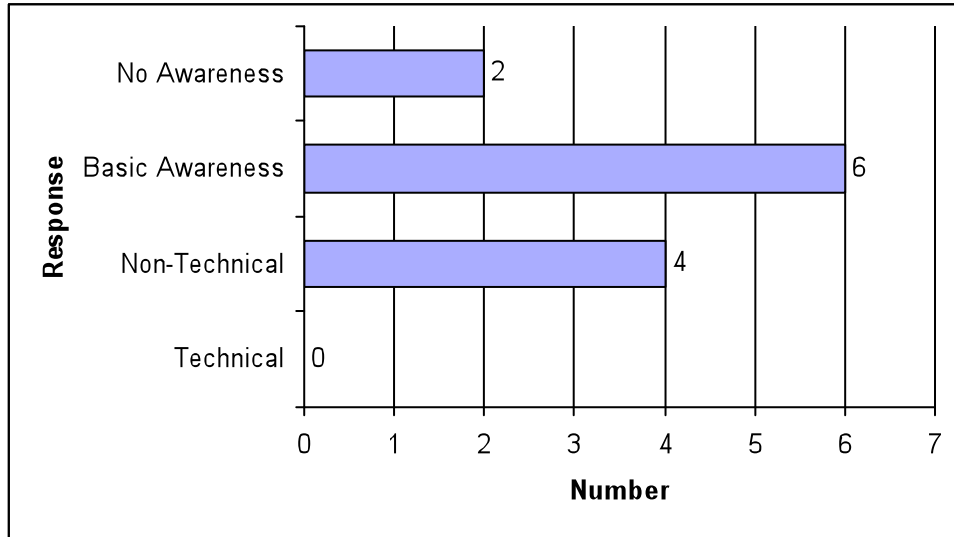
The Clinician in case twelve is torn between a high level of concern about the young person seeking help and an intense distrust of what is being said because of an increasing number of conflicting accounts. The young person communicates through emotional impact and the Clinician seems particularly sensitive to this, though has not thought about this as a transference communication. The clinician is also aware that the young person is having an impact on the wider service and that colleagues are made aware of the difficulties in helping this young person. Coded as Logic Trap, Transference Trap, Pre-occupied Breast, Crisis trap, Life and Death anxieties, Professional By-standers.

⁵⁴² Transference not considered or worked with but thought to make sense.

⁵⁴³ Complexity of transference appreciated as useful in understanding communication.

FINDINGS: CHARTS

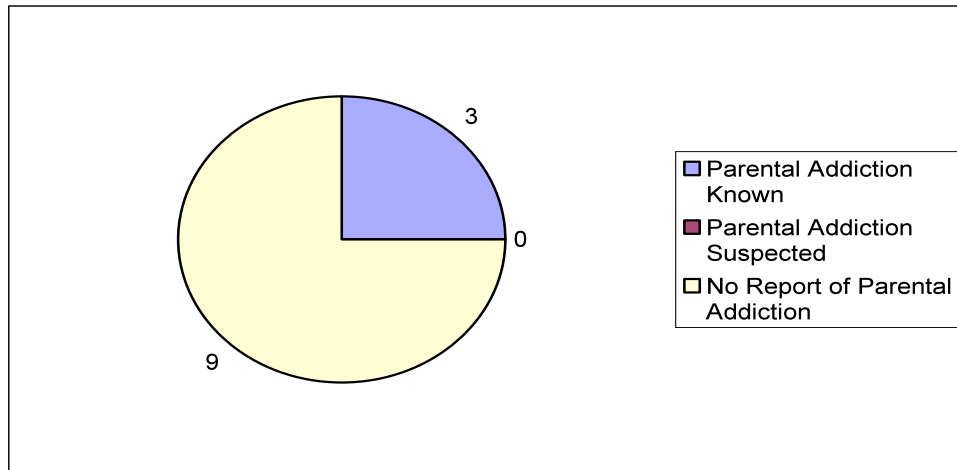
CHART 1: CLINICIAN’S RESPONSES TO TRANSFERENCE



Of the twelve clinicians interviewed two had not conceptualised any of the communication in the case as a transference. Six had a basic awareness of the transference although they were not able to put this to any use in practice. Four had an awareness of the transference and made some attempts to respond to the communication but were not working with it in any technical sense. One clinician described a basic manualized approach of thinking why the different characters impacted on each other in the way that they did. None (0) of the clinicians reported recognizing the transference communication and working with it in a technical way using careful recording, supervision and applying the theory of containment to the material.

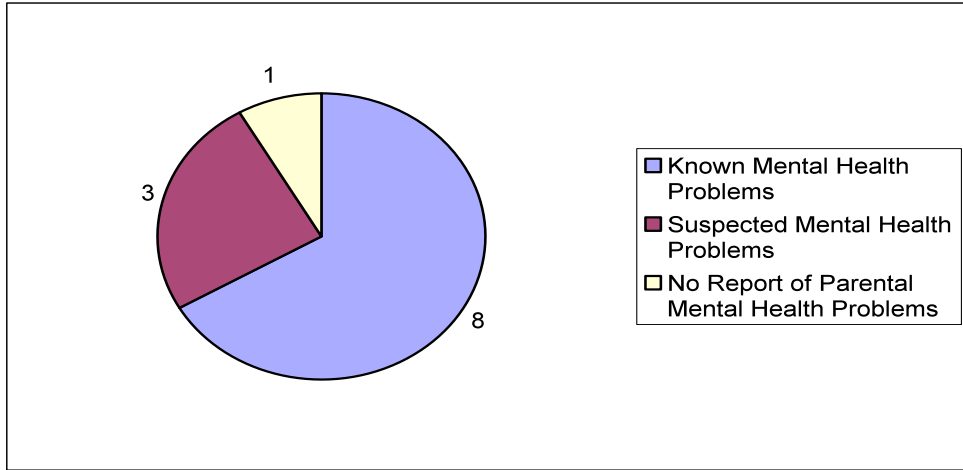
FINDINGS: CHARTS

CHART 2: REPORTS OF PARENTAL ADDICTION



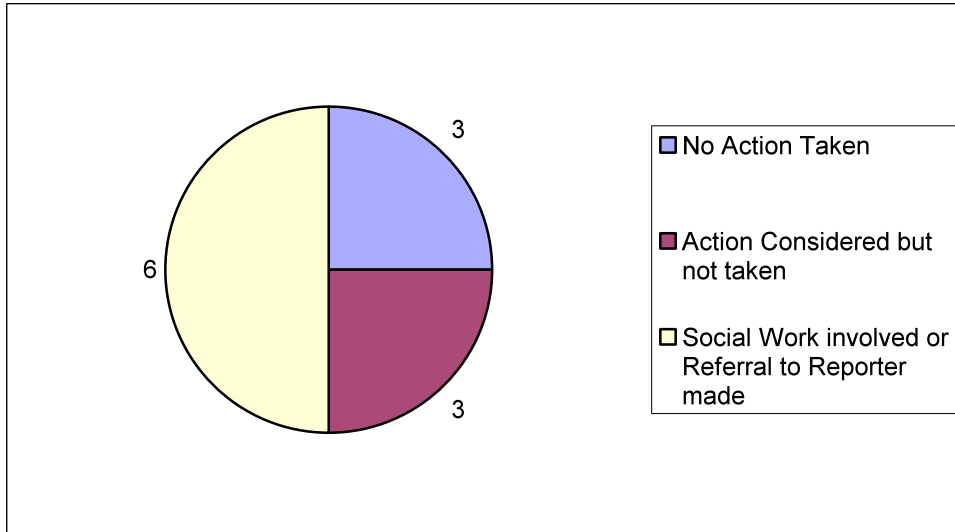
There were three reports of known parental addiction. There were no reports of suspected parental addiction. There were nine cases where no parental addiction was suspected.

CHART 3: REPORTS OF PARENTAL MENTAL HEALTH PROBLEMS



There were eight reports of known parental mental health problems. These were all long term problems. There were three reports of suspected parental mental health problems but these were unconfirmed by the parent involved. There was one case where there was no reference to parental mental health problems.

CHART 4: REPORTS OF CHILD PROTECTION CONCERNS



There were three cases where no child protection issues were mentioned. In another three cases the clinician reported considering a referral to social services because of child protection issues but no action was taken. This tended to be because of vague notions that the child was not being looked after properly but the clinician lacked a sense of confidence to make the referral a successful and useful one. There were six cases (fifty per cent) where there was an onward referral to the Social Work Department or to the Reporter to the Children’s panel because the clinician felt there were child protection concerns.

FINDINGS: CHARTS

TABLE 2. SEVERITY AND LEVEL OF CONCERN ON A CASE BY CASE BASIS

Case	Summary	Psychological Maltreatment	Life or Death Anxieties
One	Children require shielding from parental issues & neglect	Yes	Yes
Two	Fears child will be misdiagnosed under parental pressure	Yes	No
Three	Concerns around OCD soiling and parental trauma	Yes	Yes
Four	Young person choosing risk and rejecting development	No	Yes
Five	Encopresis, developmental problems and enmeshment	Yes	No
Six	Medical condition not managed	Yes	Yes
Seven	Medical condition not managed	Yes	Yes
Eight	Encopresis, developmental problems and enmeshment	Yes	No
Nine	Attachment, relationship and biological problems	Yes	No
Ten	Conduct problems and enmeshment.	Yes	Yes
Eleven	Trauma with chronic consequences related to soiling	Yes	No
Twelve	Self-harm, depression, sexual health issues.	No	Yes

Seven out of twelve of the cases involved life or death anxieties.

Ten out of twelve of the cases included clear accounts of parental psychological maltreatment that can be described as emotional abuse (Glaser, 2002). While concerns about the severity of physical abuse are clearly important, psychological maltreatment has been shown to be more strongly related to and predictive of subsequent impairments (Claussen & Crittenden, 1991).

Chart Four indicates that in nine of the twelve cases there was social work involvement or an onward referral for child protection concerns. While this is to be expected given the case content it is notable that there was a lack of confidence in the accounts of the work in relation to reporting the nature of concerns and in relation to feeling that the social work department would provide an appropriate resource or share the level of concerns that the clinician held.

The life or death anxieties ranged from fears that the child/young person would hurt or kill someone else, themselves, or that the parent would in some way harm or kill the child. At

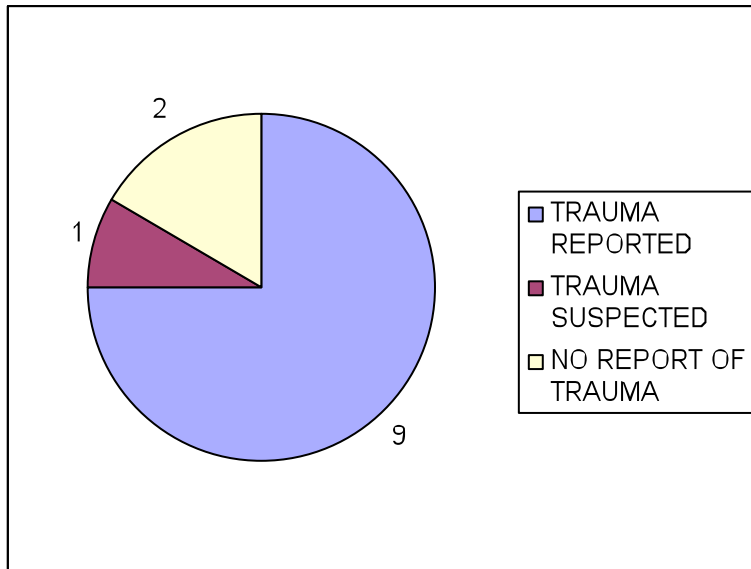
FINDINGS: CHARTS

least two of the young people had a life threatening medical condition that could be controlled but was dependent on their ability to manage effectively. While some of these concerns are real and explicit, other concerns were at a feeling level in the clinician but nonetheless evoked real anxieties for the clinician about the physical safety of the child, the parent or someone else.

There is another level of life and death anxiety that is more in relation to emotional life, personality development and the choices young people make between developmental opportunities (education, employment, peer interactions) and more risk taking behaviours and/ or withdrawal from the social world. These anxieties are therefore also in relation to the child developing a viable personality able to relate to others and engage in the social world in a meaningful way.

There is no doubt that, taken together, the concerns about psychological maltreatment and life and death anxieties combine to make these cases worthy of a high level of concern and clinical intervention.

CHART FIVE: REPORTS OF TRAUMA IN FAMILIES



In nine of the cases the clinicians reported known trauma in the family system. In one family there was suspected trauma mentioned and in two families there were no mentions of trauma.

INTRODUCTION TO ANALYSIS

It must be noted that all of the participants were extremely generous in their accounts of getting stuck. Given that the accounts were from memory, with no file, and some of the cases had been closed for a number of years, the quality of the detail and the emotional connection with the cases was striking. All of the clinicians interviewed were highly motivated to do a good job and to be successful with the children and families involved. The clinicians all questioned their own practice and the stuck cases stimulated further professional development through research or training or other forms of personal and professional development, including seeking psychoanalysis.

It is worth beginning this analysis with a recognition that the stuck cases which were reported were of great concern with immediate issues in relation to life and death anxieties and child protection. In addition to this there were high levels of concern about the emotional and personality development of the young people. There was a high level of identification with parents who bring a child for help when perhaps they know or fear that their own functioning is detrimental to their child. This may have made it difficult for the clinicians to have confidence in formulating emotional abuse in these cases even when this was implicitly recognised and described. Glaser (2002:700) says,

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Beyond the stated difficulty in operationally defining emotional abuse, there are further possible reasons for the delayed and under-reporting of emotional abuse and neglect. The terms abuse and maltreatment are considered by some to be unnecessarily pejorative and problematic when applied to emotional abuse and neglect. This is especially so in those cases where there is no clear intent to harm the child, although the interaction is clearly harmful to the child. There is a linguistic and conceptual dilemma between a wish and need to protect children from harm, and a reluctance to label or blame caregivers who hold a primary role and responsibility in the child's life. This is despite the fact that the parent is, possibly inadvertently, instrumental or causal in the harm to the child. This reluctance to use the term abuse leads to under-recognition. However, the importance of using the terms abuse-neglect or maltreatment is that, in practice, these terms embody a professional imperative to intervene to achieve protection and improve the lot of the child. There is currently no alternative and more acceptable term to encompass this notion.'

Some families have personal circumstances that are unfortunate but unavoidable. Some children grow up in poverty and with chronic family problems that include financial difficulties, educational disadvantage, social isolation, neurodevelopmental difficulties, family ill health, personality problems and a general misery. It is hard for a clinician to have some responsibility for changing this when often many agencies over many years have failed. Child and adolescent mental health clinicians (along with some other professions) may be vulnerable to personal distress in dealing with these families as it would be hoped their assessments and interventions are based on a high degree of empathy for the child and family. It may be on balance that the clinician feels that the life of the family is intolerable and has a deep seated feeling that this situation will not change and that there is a limit to the improvements that can be made during this phase of the family life cycle and possibly for another generation. This stuckness or unavailability to change characterised the functioning of the cases that were reported. The task of this analysis is to explore new ways of recognizing, understanding and intervening with a particular type of case where the parent is not deliberately abusing their child or maintaining a cycle of deprivation and instead is bringing the child and presenting themselves for help but on encountering the help offered by the clinician all parties perhaps find themselves unable to offer much to the process of change.

ANALYSIS: INTRODUCTION

Stuck cases by their very nature need additional thought, a clear formulation, plan of intervention and often require joint working with colleagues or multiple agencies. It is notable that given the high level of engagement the clinicians had with the cases and the emotional demands of working with these cases, it still remained difficult to be effective in the situation. In making sense of this it is important to highlight the emotional impact the cases had on the clinicians and the complexity of the situations the clinicians were trying to work in. As a psychoanalytic practitioner the researcher recognised some of the complex communication that was taking place and attempted to have a discussion with the clinicians by describing aspects of the complex interaction as a transference relationship. It is not entirely clear that these were transference relationships but some aspects of the relationships described certainly involved unconscious communication that psychoanalytic practitioners would refer to as transference-countertransference phenomena. The term transference usually refers to unconscious communication in a one-to one setting but how can this be made sense of when the phenomenon is experienced in a family setting or if the communication seems to originate from one of the parents and not from the referred child patient? This problem echoes some of the difficulties faced by family therapists when they first started to work using a psychoanalytic perspective and Britton (1981) focuses on the aspect of the communication that involves a re-enactment. While re-enactment is one aspect of the communication here, it may be one of a diverse range of activities that are unconsciously in motion and the psychoanalytic concept of projective identification also seems to be immediately relevant. Britton (1981) described the process of the clinicians being drawn into the material in an unconscious way and warned of professional symptoms that would be consistent with a lack of clarity and action in relation to families who present a child who is experiencing parental psychological maltreatment. I think it was a strength of Britton's work that he accepted that the phenomenon may represent interpersonal or

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intra-psychic situations and acknowledged the shared territory of systemic and psychoanalytic practice. This research has a difficulty in trying to describe the nature of the unconscious interactions without the benefit of a clear conceptualisation of the problems that would be possible if interviewing practitioners working within a psychoanalytic frame. However the term 'unconscious or unprocessed communication' gives us an umbrella term for these phenomena and using grounded theory it is possible to describe the emergence of patterns in the relationships and types of situations that are created.

EMERGING THEMES

Coding the data led to a complex array of themes and categories. There were common themes among all cases but great variations within the themes. There was a unifying theme in relation to 'unconscious/unprocessed communication', which included not working with transference communication and a range of common experiences that can be thought about under that heading such as re-enactment and projective identification, or a focus on content rather than process that resonates with systemic and psychoanalytic literature.

An important experience in all the cases is in relation to links between the child's difficulties and other aspects of the family history or functioning. The clinician feels that the links are necessary but the family find them unwelcome. There is a clear progression in many cases from an unwelcome link to a cruelly experienced link, to a persecuting link. This resonates with the ideas put forward by Bion (1959) when he wrote about attacks on linking. The repetitive nature of the links and avoidance of links leads to a deterioration in the therapeutic relationship with the clinician finding themselves unconsciously placed in the position of a torturer in relation to the family system. The difficulties with linking can

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be thought about metaphorically as a Pandora's box which must be kept closed to prevent destructive forces being unleashed.

In addition to the theme of unprocessed communication there was an array of experiences and dilemmas which were observed to make the situations more pressured and intensify the emotional experience of all concerned. A surprising example to emerge from the data is the theme of 'loyalty'. Within this theme there are issues in relation to parental trauma and parents seeking help because they recognise the damaging influence they are having on their child, while at the same time not being able to bear any separation. This theme includes parents who feel the need to compel the clinician to attend to their needs in order to improve the lot of the child.

It was also possible to review the data and to think about each stuck situation as a particular type of trap that made movement impossible. The theme of professional traps emerged with some recognisable patterns that made successful interventions impossible. Exploring the nature of these professional traps leads to patterns of relating and description of technical dilemmas that may be useful for adapting practice.

The emerging analysis leads to some important warning signs (Taboo, Blinding Trauma, Life and Death Anxieties and others) suggesting that the work is moving into a potentially stuck state and indicates that the clinician may want to proceed cautiously. Thereafter the analysis shows there is a notable difficulty in recognising and processing communication at an unconscious level or of processing particularly difficult conscious emotions and associations. The work with stuck cases can be conceptualised as a series of professional traps that reduce the clinician's sense of manoeuvrability and effectiveness in the cases. These traps are in relation to the clinician's own sense of benevolence, competence and

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professional identity or in relation to the institution or professional system. There is then a further institutional dilemma about the provision of help for families where the child's functioning and mental health is being detrimentally affected by the relationship with a parent who is also seeking help through the child. There is a debate to be had as to whether the parents' needs should be attended to elsewhere or if they should have a legitimate way of receiving an intervention within a child and family mental health setting.

WARNING SIGNS

There is a clear pattern of clinicians focusing the intervention on the content of what is presented rather than the process of what is happening between the family and the clinician. This was anticipated by the review of the systemic and psychoanalytic literature where it was suggested that the clinician gets involved in re-enactment as described by Britton (1981) or Andersen (1987) but fails to establish a meta-dialogue or take a meta position. Studying the cases in detail allowed certain patterns to emerge that could be described as warning signs that the case is becoming stuck, highlighting the need for clinicians to proceed cautiously.

WARNING SIGNS: BLINDING TRAUMA

Chart 5 (p.152) shows that out of the twelve cases studied the clinician has explicit knowledge of trauma as a factor in nine cases. Two of the nine cases involved traumatic experiences of sexual abuse. In cases of blinding trauma the clinician suspects that they are being shown an intolerable image/ situation that is beyond their control to change. In some cases they feel that the family wants the clinician to feel as disturbed and traumatized

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as they do. It is difficult for the clinician to see this as care seeking. Often this is associated with a 'trap' where the clinician feels they have been manipulated into a situation for this to happen. This leads to experiences of perceived cruelty and torture.

Two clear examples of this is can be seen in the data when in Case Three the mother disclosed a very distressing childhood with many traumas. The description of the traumas were hard to believe. Then in Case Eleven the clinician said *I think I just got caught up in just looking at this horrendous trauma that had happened... I should have thought, what is happening here, and I didn't include the wider system and ask them...*

While these two examples illustrate the pre-occupying and blinding quality of the trauma, there is no doubt that trauma influenced the functioning of many of the families and also the capacity of the clinicians to respond to it. The work of Bentovim (1992:xx-xxi) is essential in understanding this as he put forward the idea of 'trauma organised systems' saying these are,

'...essentially "action systems". The essential actors in the system are the victimizer who "traumatizes" and the victim who is "traumatized". By definition there is an absence of a protector, or the potential protectors are neutralized.

The victimizer is overwhelmed by impulses to actions of a physically, sexually, or emotionally abusive nature which emerge from his or her own experiences. These are felt to be overwhelming and beyond control. The cause is attributed to the "victim" who, in line with individual, familial, and cultural expectations, is construed as responsible for the victimizers feelings and intentions. Any action on the victim's part as a result of the abuse, or to avoid abuse, is to be interpreted as further cause for disinhibition of violent action and justification for further abuse. Any potentially protective figure is organized or neutralized by the process of deletion and by minimization of victimizing actions or traumatic effects. Deletion and minimization characterized the thinking processes of the victimizer and victim alike. The motto of those involved in the trauma-organized system is, "First- 'see no evil'; Second- 'hear no evil'; Third- 'speak no evil'; and Fourth- 'think no evil'".'

When the clinician finds themselves part of the trauma organised system it may be too late to make an adequate intervention. If unprepared then the clinician may find themselves in a

WARNING SIGNS

position of being complicit in the maltreatment of the child through a process of not noticing, being blinded by it, or not being open about it, or even not thinking clearly about it. Hopefully most clinicians will be familiar with dealing with trauma in families but a trauma organised system is quite a different matter and may not be immediately recognisable. The nature of a trauma or continued maltreatment means that the original approach which will probably have been neutral will not have provided the clinician with enough defences so that they are able to maintain a meta-perspective. The clinician needs to make a clear statement about child protection without entering into a dialogue where they implicitly justify the continued behaviour of the abusive parents. This is such a skilled task with many hazards involved that the clinician has to have access to detailed supervision and probably a colleague or team to work with.

The awareness of trauma and blinding trauma in a case should therefore be noted at an early stage and the case flagged up for more careful supervision and potential team work.

WARNING SIGNS: TABOO

The idea that a subject is sacrosanct and may not be discussed emerged as a warning sign to clinicians that they were entering stuck territory. In each of the twelve cases there were some subjects that were harder to broach than others, and some subjects seemed completely forbidden topics for discussion or change: Case One, separation of the mother and children; Case Two, any thoughts other than the dominant discourse of the mother; Case Three, any demands that may be made of the child; Case Four, any thoughts about the girl's past or independent functioning; Case Five, the maternal history; Case Six, the child's birth mother; Case Seven, the mother's alcoholism; Case Eight, the intimate

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relationship that the soiling facilitated; Case Nine; the destructive impact of the mother on the child; Case Ten, the blackmailing of the Clinician; Case Eleven, the hurt feelings of the Clinician when dropped or blanked by the parent; Case Twelve, the fact that the child is lying. In some cases the subject is clearly forbidden by the family while in others (case eight, ten, eleven, and twelve) there were professional factors involved ranging from a lack of confidence in the importance of the subject, personal embarrassment and a culture and practice of only using positive language to describe families, making some aspects of the child or family functioning out of the reach of thought.

Without stepping out of the situation the taboo can continue to be in place for a great deal of time, leading to what Clinician Five described as *Groundhog Day as we were keeping on doing things that weren't working*. If the clinician does manage to take an overview, or a meta-position but is unable to engage the family in a meta-dialogue then it is possible for them to experience being a leader without followers. This describes a situation where the clinician has an idea of how to change or improve things for the child and family and the clinician begins to make an intervention to pursue the change only to find that no one else in the system is following their lead. The clinician then feels isolated from the family and questions their view of how to improve things. This way of thinking can therefore be seen as an elaboration of the type of homeostatic system described by Britton (1981), it is not for changing.

WARNING SIGNS: LIFE OR DEATH ANXIETIES

In several of the cases there were Life or Death anxieties in relation to either the child, a parent, or a risk that the child may harm someone else (see Table 2, page 147). These

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anxieties were most obvious in cases one, three, four, six, seven, ten and twelve. These anxieties increased the pressure on the clinician to be successful and made the stuck situation more frustrating and added a sense of urgency. This can clearly be seen in cases six and seven where there were issues to do with the child sticking to a special diet because of a medical condition. At the same time, in stuck cases, the clinician feels that their efforts to help go nowhere and they have been an ineffectual helper at a time of great need.

WARNING SIGNS: CAREER SHAKING EXPERIENCES

The stuck case is one where the clinicians have had to draw on experience and on the support of colleagues to maintain a sense of professional competence. The stuck case may be one that broadcasts a sense of failure to colleagues and the professional network. The case may also have a physical impact on the clinician which not only impacts on their work life but impacts on their personal life also, shaking the boundary between one and the other. The stuck case may make clinicians question their own ability, the therapeutic qualities of their intervention and their own therapeutic capacity. It puts more pressure on the stuck case as the clinician may have a sense of having to succeed to maintain their professional standing and to give them peace of mind about their own therapeutic abilities. This can clearly be seen in Case One when the Clinician continues to *plough away* for years, in Case Two when the Clinician feels *bewildered* or in Case Ten when the Clinician draws on years of experience to make sense of what is happening. The pressure on the clinician is intensified when they are experienced as malignant rather than benevolent and where the possibility of negligence is introduced by the family or perhaps the clinician has their own anxieties about a potential accusation. Most personally damaging seems to be when a clinician is shamed in front of colleagues which happened clearly in cases two and eleven.

WARNING SIGNS: THE INSULT

Something happens between the clinician and the parents of the child where one party feels insulted to such an extent that recovery and trust is not possible. Insults range from clinicians making a link to parental alcoholism, pointing out the infantile nature of parents needs or highlighting parental helplessness, there may be a threat of a child going into care or the parents may feel blamed for the problem. Clinicians may feel insulted by not having their professional opinion respected or having second opinions sought. The insult suggests something from which there is no recovery in the way that Rosenfeld described thin-skinned patients (1987).

WARNING SIGN: CRISIS OF CONFIDENCE

Some clinicians clearly described parental psychological maltreatment and then made an intervention which they then felt had not worked. While 50% of the cases had formal reports of child protection concerns or active social work involvement, there were other cases where this was appropriate but not pursued due to a lack of confidence in the clinician's formulation and a fear that the family would disengage or that the report would cause more harm than it prevented. Some clinicians wanted another opinion or went on to refer the case on to another worker or another department with the secret hope that the next clinician would see the case from the same perspective and report the child protection concern with more confidence. These were cases that involved a high level of clinical judgement and where the clinician felt that their formulation was intuitive rather than based on a confident observation of abuse.

WARNING SIGNS: COMPELLED CARE

In some cases there was a history of complaints about the service or a threat of complaint. This is a warning sign as there is a danger that the clinician feels compelled to provide care by the institution or service that they work for. This may compromise the clinician's judgement. In Case Two the sense of complaint felt by the mother is powerfully expressed to the professional network and a series of referrals are accepted by the CAMHS service either without the Clinicians knowledge or against the clinician's advice. There seems to be a multi-agency collusion to give the child the diagnosis demanded by the mother without going through the due process of the assessment. The Clinician in Case Two makes a determined effort to maintain a professional approach and to treat the child in the same way as other children referred for a diagnosis. Despite this Case Two continues to be presented to the service and continues to be accepted in what Clinician Two feels is not normal practice.

In Case Ten there had been previous complaints about the treatment of the child and the Clinician had taken it on with a high degree of awareness that it was important not to let the parent in the family down. This played into an Evidence Based Trap (which will be described under emerging theory) where the Clinician spent a year looking to rule out one diagnosis after another. The Clinician stayed with the case, called on a wide range of supervision and other collegial support and continued to work with the case despite the feeling that the family had had their *innings*.

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Case Eleven is different again but there were powerful institutional dynamics at play even from the referral that listed previous failures to help. The Clinician in Case Eleven felt compelled to take the case on single handed yet it must have been clear to the referrer and to the receiving service that this case required a more multi-disciplinary approach from the outset.

UNCONSCIOUS/ UNPROCESSED COMMUNICATION

It is possible to look at all twelve interviews as experiences where the child and family communicated at a level that was difficult to process. Predominantly this involved communication through action and emotion rather than the spoken word. There are a range of ways of making sense of these actions and as the accounts are not drawn from one-to-one therapy there is an added complexity to noticing them and making sense of them using the language of individual therapy. Having said that, there is clear evidence of some phenomena in action that can be conceptualised psychoanalytically, particularly as they seem to have involved the processes of projection, as first described by Freud (1895).

PROJECTION

The projection of both pain and hope are clearly seen in Case One when the Clinician said, *I mean she was good at putting pain out there, and, the kids stood and waved us off and both my colleague and I felt that they had invested a lot in us to help them by helping their parents.* Despite observing this there was a trend in the data for clinicians not to conceptualise this type of communication as projection, which also meant that they were not able to apply the concept of containment (Bion, 1962b) and draw on the benefits of that way of working. Some clinicians observed projection when it was in operation within the family as is clearly described in Case Three when the Clinician said the mother was *overly empathic and I think projected quite a lot onto the child saying we can't upset the child, we can't make life any more difficult than it already was. That perpetuated the child's position of power.* Despite noticing these things the clinicians did not appear to work with the ideas of projection or begin to bring the ideas

into the discussion with the families in a way that was tolerable and made insight and change possible.

PROJECTIVE IDENTIFICATION

The intensity of the emotional communication in the stuck cases was so extreme that many of the clinicians reported a range of physical and emotional reactions to the work: Clinician One reported, *my colleague and I didn't want to feel that bad about anything*; Clinician Two reported feeling, *anxious, furious, bewildered and disorganised*; Clinician Three reported, *I felt quite tortured*; Clinician Four said, *it was as though I almost couldn't breathe*, Clinician Six felt *a bit impotent*; Clinician Seven said *it feels as if dad has mugged me*; Clinician Eight said, *there is something about this family that makes me even more cautious and wary and so I feel I am intruding and punitive*, Clinician Ten felt, *just full up. Just, oh, breathing, you need to remember to breathe. Because you went from being full up to feeling afterwards that there was nothing left and you can't have more than one of them in a day*; Clinician Eleven reported strong feelings of anger and mentioned *those really strong feelings that I have had to think about*; and Case Twelve said *initially it was heart-sinking, real black mood, as if the young person had just taken it and 'phoot' (makes a gesture of throwing) just shoved it onto you and it was horrible, horrible sadness.*

While some of these experiences are more strongly described than others it is clear that there is an emotional relationship at play that involves a high degree of unconscious communication from the family that was received but not fully processed by the clinician. The intensity of the experience and the physical and emotional nature of the experience for the clinicians suggests that these were clear examples of projective identification as described by Klein (1946) and developed by Bion (1957, 1959, 1962b) and for our

purposes most notably Rosenfeld (1983, 1987) who categorised projective functioning into three types, those used for defensive purposes, those used for communication and those used for identification and empathy. In the twelve cases the communication appeared to remain unprocessed regardless of whether the clinician reported seeking professional supervision or not. This is possibly because the concepts of projection and projective identification are not a core part of mental health practitioners training, despite common misperceptions about this. This may not be a problem for many cases but for stuck cases it means that the clinician is functioning without a technical and emotional understanding of containment as described by Bion (1962) and this means that the clinician experiences the communication as destructive and dreadful rather than a natural form of communication about experiences that are too difficult or painful to express creatively in words. This increases the likelihood that the families or members of the family will be seen as destructive influences in the child's life, and puts the clinician into a position where they see the family through a negative lens. Where there is clear evidence of emotional abuse or parental psychological maltreatment then the clinician has a technical difficulty in deciding how to acknowledge this in a way that does not blame or persecute the parent or the family, or in a way that the family do not experience it as a retaliation for the feelings the clinician has had to experience in working with the family. When this is not managed well it leads to a growing hostility between the clinician and the family who may try to dismiss or minimise the clinician's view. In response to this series of events the clinician loses a sense of themselves as a benevolent influence on the child and family and this in turn makes it more difficult to draw on feelings of compassion and to empathise with the parents in the family. It very well may be actually impossible for the clinician to raise child protection issues or issues in relation to psychological maltreatment without falling out of favour, or being treated with hostility, by the family. This puts a great deal of strain on to the clinician who may want to feel that they are helpful and a benign figure for the whole family. It is

certainly true that in cases where there are clear child protection issues there is no room for clinical neutrality (Bentovim, 1992).

TRANSFERENCE, COUNTERTRANSFERENCE, AND RE-ENACTMENT

Transference, as first described by Freud (1912), is the key concept in psychoanalytic work .

I agree with Langs (1981:3) who said,

'...the discovery of transference gave definitive meaning and function to psychoanalytic therapy, and however modified in recent years, remains at the heart of analytic work.'

Awareness of transference relationships are perhaps mistakenly thought to be a core part of all mental health professionals training. While not a projection as such, a transference relationship involves a gathering of projections, projective identifications, actions and experiences. In modern psychoanalytic practice this would also involve the study of the clinician's associations, emotional reactions and other phenomena that make up what is referred to as the counter-transference. This was described by Heimann (1960:10) who believed that a careful study of the analyst's conduct and emotional response enables him to assess if he has understood his patient.

During each of the twelve interviews the researcher attempted to describe qualities of the unconscious or unprocessed relationship and he described these as transference relationships, and asked if the practitioner had thought about this. The researcher's use of this term included a range of what psychoanalytic practitioners may describe as projection, projective identification, countertransference and re-enactment. This discussion was not intentional in the first five cases but developed spontaneously in reflexive discussion of the case once the clinicians had given their account of the work. The researcher used his psychoanalytic training to inform some of the reflections and when appropriate this naturally involved a discussion of transference. Chart 1 (page 146) shows four out of

twelve were aware of the transference and working with it in a non-technical way, six out of twelve were aware of it but not working with it, two out of twelve had not thought about the transference at all, and zero out of twelve recognised the transference and worked with it in a technical way over time. When the researcher discussed the nature of the transference relationship with the clinicians, responses showed sensitivity to the communication but either a lack of conceptualisation of the experience or a difficulty in containing (Bion, 1962b) the trauma and pain in relation to the communication.

EXAMPLES OF THE DISCUSSION ABOUT UNCONSCIOUS COMMUNICATION

The Clinician in case One said, *Well I suppose I could see that she was in a huge amount of pain and she was very keen to make my colleague and I feel some of that pain.... And my god she put her ex-partner through it as well, I mean she was good at putting pain out there and really my colleague and I didn't want to feel that bad about anything.*

This awareness of the communication balanced against the personal cost of working professionally with this family seems to have contributed to the stuckness with this case over a number of years. In this case the pain involved in containing the communication meant that it was difficult for the practitioners to conceptualize it as care seeking. The communication was therefore noticed but not processed, leaving Clinician One to feel that the mother thought the intervention offered was a *bit insubstantial*.

The Clinician in case Two highlighted a key problem for the child and family worker, asking when the source of the difficult relationship is with a parent and not the child, does the practitioner have permission to address issues such as transference, in essence does the

practitioner have permission to start to treat the parent? This will be discussed further under Professional Traps.

The Clinician in Case Seven had not conceptualized a transference communication but did, without naming it, describe a basic ‘manualized’ approach to thinking about transference. The Clinician reported asking, *what is it about the dad that makes me feel this way and what is it about me that makes him be that way, but that is as far as it went.*

The Clinician in Case Eight noticed the transference and used it to stay available to the parent, saying, *I guess I have noticed it, that this is what it feels like for the family so I guess it is, I try to keep it in mind a little bit so that I don’t become angry or annoyed with the mum, so that I don’t become frustrated, I guess it helps with my empathy for the family.* This shows that some understanding of the communication helps the clinician to maintain some tolerance for the work.

The Clinician in Case Nine reported discussing patterns with the mother but not finding it useful as the mother *struggled to use that or even take it on board.* Studying the transcript of Case Nine suggests that the mother was displaying some aspects of destructive functioning, as discussed by Rosenfeld (1987) as the progress and links that were made at times seemed to disappear as if they had never happened, suggesting that something active in the mother’s mind was attacking the links (Bion, 1959) and progress the mother made. This shows that in some cases there is a need for advanced consultation and technical development even when clinicians have a good understanding of transference communication.

The Clinician in Case Ten reported not working technically with the transference but was able to describe the struggle to provide an intervention where the mother could begin to

UNCONSCIOUS/ UNPROCESSED COMMUNICATION

reflect. The Clinician thought that the mother would and could engage with a discussion about the transference relationship.

The Clinician in Case Eleven reported not being aware of the transference type communication until the Clinician experienced strong emotions about being included in the list of people not helping. This type of communication, established over time, is difficult to gather and make sense of.

The Clinician in Case Twelve reported not thinking about the emotional reaction to the case as transference and said, *but it makes complete sense that the young person probably, given what the young person is telling people, that those feelings that I am having are most probably feelings the young person would have had if they had been through any kind of abusive experience.*

Overall there was a trend for clinicians to think that if they noticed unconscious phenomena and they then tried to have a discussion about this with the family then this was them addressing the transference. Child Psychotherapists have a great deal of work to do in enlightening other clinicians about the nature of our work, how containment is used in practice, the need for time and working through of issues and the provision of boundaries to establish a supportive therapeutic setting to address the unconscious issues. It is not the fault of the clinicians that they were not aware of these issues but it is a systemic fault, possibly to do with the secretive or mysterious perception of the nature of psychoanalytic work. This needs to be addressed so that clinicians from a range of backgrounds have increased insight into what psychotherapists can offer directly to patients and to other clinicians through consultation and supervision when appropriate.

PROFESSIONAL TRAPS

It is possible to conceptualize the stuck cases in terms of a series of traps that the family and clinician get stuck in. While the families may play the active part in creating these situations it is the responsibility of the clinician to recognise and avoid them as they will thwart therapeutic progress at the expense of the child. While it seems that very few of these traps are deliberately set, there is a difference between those that are accidental and occur because of a series of positions that are taken up and those that are more powerfully driven, if still unconsciously, by factors such as trauma and the compulsion to re-enact. These more active traps are intimately connected to unconscious /unprocessed communication. While the experience of being in a trap may powerfully influence the therapeutic relationship, this way of conceptualizing the material is designed to help the clinician recognize a situation and to consider effective ways to regain a sense of manoeuvrability.

BENEVOLENCE TRAP

Mental health professionals, along with others in the helping profession may see themselves as being helpful or benevolent figures in the lives of children and families. There is a professional trap that can occur when this sense of personal benevolence is challenged or when the intervention that is proudly offered seems to fail. All of the families in the research struggled in one way or another to accept care from the clinicians and many had an experience of the clinician being actively unhelpful, even cruel or tortuous. This may be despite heroic efforts on the clinician's part. If the clinician can continue to make sense of the difficulties the family have in receiving care, then it seems

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that some progress is possible, despite the heavy cost of that progress. For example in Case Ten where there was a gradual lessening of negativity but no sense of recognition of helpfulness by the parent. Or, in Case Two the result was quite different as the Clinician maintained a professionalism and a determination to do their best for the child but the parent's unrelenting hostility left the Clinician *bewildered*, and there was an absence of progress and continued distress for the clinician years after the case was closed. The exhaustion and distress caused to the clinicians in these two cases demonstrates the Benevolence trap where the clinician is determined to go a good job, to be professional and to help. The negativity shown by the parents in these cases is survived, more or less, but the easy confidence that it is possible to do a good job was lost. The previous experience of both clinicians was drawn on to help each of them survive and make sense of the stuck cases. Both pointed out that without years of experience the cases would have been even more destructive to their sense of themselves as capable professionals. There are many different types of benevolence trap and I will describe two of them in detail using the terms 'hero to zero' and 'Pandora's box'.

BENEVOLENCE TRAP: HERO TO ZERO

Hero to Zero describes an experience for a clinician when they begin work with a case in such a way that they imagine they will make a difference where others have failed, or they find that they have initial success in helping a child with serious problems. Additionally they may be chosen as 'the one to help' by the child or another family member. Their initial success may be relatively private and confined to the consulting room but may also involve a more public event such as a multi-agency meeting with many professionals present. At some point there is a sudden shift from success to failure and the family broadcast the

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sense that the clinician has failed to the professional network through complaints, making requests for second opinions, or through disengaging with the service and asking to be seen again, naming the previous Hero as someone who had not helped. In some cases the fall from the Hero position is more private but the clinician feels kept in a helpless state, possibly for a very long time. The position of Zero may be one where the family will have nothing to do with the clinician due to dismissing their therapeutic capacity or voicing thoughts that the clinician is not on the same side as them, in which case there may be a level of heat remaining in the relationship or it may be an actual Zero where the clinician feels they are not even recognised by the family and are *dismissed* or *blanked*.

Hero to Zero is a difficult experience for the clinician who may after the fact realize that they are not the first professional to have experienced this in trying to help the family. At multi-agency meetings they may see other members of the network around the family raised to 'Hero' status. Or, in hindsight they may recognise that the initial referral listed previous agencies who had failed to help the family and in time they may see other referrals with their name added to the list. While in the Hero mode the clinician feels satisfaction that they are helping the child with Life or Death Anxieties (see warning signs) but in Zero mode they feel that they can make no difference to the level of risk faced by the child. The clinician may also feel that they have been made to look foolish in front of other professionals and perhaps in the professional network, or that their Heroic efforts in organising a wide range of agencies to provide developmental opportunities are not taken up. While psychotherapists may recognise this as a transference relationship, Hero to Zero is difficult to detect and to work with as the communication happens over time, it comes as a surprise to the clinician and usually involves the clinician at a deep emotional level so that they are liable to act before thinking things through, or to feel that they do not have a suitable reflective forum that can help them to make sense of and work with the

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experience. The Hero to Zero cases are likely to take up a lot of the clinician's time in consultation and supervision but because of other professional traps in relation to the institution they may find that the supervision is not adequate or appropriate in tackling the unconscious nature of the difficulties. Not finding an appropriate or adequate arena to process the case leads the clinician to question their own conduct, to examine the case over and over again in a ruminative fashion, in case they have been negligent.

EXAMPLES OF HERO TO ZERO

The Clinician in Case Four reported working with a teenage girl and her mother. The girl had put Clinician Four into the hero mode by specifically asking to do this work with Clinician Four as a specified professional carer. When she attended sessions the girl then completely avoided the topic she asked to see Clinician Four to discuss. Clinician Four reported that when the topic was discussed *she would just look at me as if I was crazy*. It seemed that the reality of Clinician Four providing the help moved Clinician Four to the Zero position for this girl. Clinician Four re-formulated the case and noted how isolated the girl was from a positive social, educational and work life and how over-involved the girl was with her mentally ill mother. This combination was leading to an increase in risk-taking at the same time as increasing social withdrawal (see Loyalty to Toxic Breast). On the girl's behalf Clinician Four negotiated with educational agencies, statutory agencies and voluntary organisations to put together a number of opportunities for the girl to re-engage with the world. None of these opportunities were taken up and Clinician Four felt that a great deal of effort had been invested and there was nothing in return. Clinician Four in hindsight thought that she was repeating a pattern that the girl's aunts had been through. Clinician

Four's Heroic efforts to save the girl from risk and for improvement in the family had come to nothing.

The Clinician in Case Seven helped the child to find strategies for dealing with an intrusive alcoholic parent and had a feeling of initial success and being in the Hero position for the child. Then at a multi-agency meeting the father of the boy attended in an angry state and was critical and dismissive of all staff, despite a high quality of service being provided by different agencies from Clinician Seven's point of view. As part of expressing his dissatisfaction with services the father said at the meeting that the only one who understood was Clinician Seven who was the only one who could help the family. This public positioning of Clinician Seven as Hero created a critical moment. Clinician Seven could either side with the family in dismissing the other professionals or Clinician Seven could come to the defence of the professional group. The loyalty of the Clinician was therefore tested (see Loyalty). Either way this dilemma highlights the vulnerability of the Hero position in therapeutic work. Clinician Seven reported going over this moment a great deal, reflecting on how the situation was managed and feeling that their response was to father's behaviour rather than the child's needs. Clinician Seven actually said that it was necessary for the family to attend the clinic as well as the child. Clinician Seven reported that *Mum and dad both came and we opened it up into dad's childhood anxiety, mum's drinking and they all very quickly formed a united front against me. So I went very quickly from Hero to Zero. Very, very quickly. Like all who had gone before me.* This family in this case then began to seek additional opinions and to favour other members of the professional network as the Hero figures (for example the medical consultant, independent consultant, and children's panel). The family's requests for further assessment and second opinions from clinicians not connected to Clinician Seven increased the public nature of the Zero position.

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The Clinician in Case Eleven worked with the family for around a year before discharging the case. Several years later a colleague came to talk to Clinician Eleven about the case as a new referral had arrived and the family were now reporting that seeing Clinician Eleven had been unhelpful. When Clinician Eleven met the family again and was introduced to them the Clinician reported feeling *Dropped, yes. Because you know when you've seen people....they are actually quite pleased to see you...But (in this case) it was quite blank.* This blanking or feeling of being dropped is the Zero to the initial Hero feelings Clinician Eleven felt on receiving the first referral.

Hero to Zero does not seem to be in intentional trap or tactic used against the clinician but may indicate that one way a family can engage helpers is to appeal to their desire to make a difference. The clinicians interviewed all seemed highly motivated to help and when families in distress invest all their hope in the practitioner it is a charged situation as the sense of responsibility and duty are inflated. At times this can blind the practitioner to the fact that the pattern of relating has been repeated many times and that they have become part of the pattern.

BENEVOLENCE TRAPS: ZERO

While there was only one clear example of Zero (Case Two) it emerged as one aspect of the Hero to Zero category. In Case Two the Clinician was immediately put into the Zero position where their opinion was dismissed and the parent enlisted the network in ensuring that the Clinician was kept in the Zero position. The unrelenting nature of this was dreadful for the Clinician who has no respite or relief. Feeling increasingly isolated, the Clinician struggled to defend their own sense of themselves as benevolent and professional. While this was an instant intense negative relationship there was also evidence that the

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parent in this case became increasingly persecuted by the situation and it became a mutually distressing experience.

Also connected to Zero is an image of the ineffectual clinician. This becomes a long lasting memory held by the clinician that continues to be troubling over time, sometimes decades after seeing a family. The clinician has an image of a child in need or distress, sometimes with Life or Death anxieties, and the clinician has an image of themselves not being able to help. This is particularly disturbing as it heightens the clinician's sense of helplessness and the limits of what can be achieved in a particular professional role. It is linked to ideas of cruelty or torture where one party is made to stand witness to the suffering of another without being able to help.

BENEVOLENCE TRAPS: PANDORA'S BOX

This links clearly to the warning sign of Taboo.

The story of Pandora is one of the earliest of human myths and is an equivalent to the story of Eve who is tempted by the fruit of knowledge.

There are many versions of the story of Pandora (meaning 'all gifted'). At its heart it is a story of trickery, cruelty and punishment, all the act of revenge against someone who was protective of mankind. Prometheus (meaning 'forethought') was aware of early man's vulnerability and that man was cold and so he stole the god's fire to give to man, against Zeus' direct wishes. Prometheus was punished by Zeus by being bound eternally and having an eagle tear out his liver. As Prometheus was immortal his liver would grow back each night so that the fresh torture could begin in the morning. Prometheus had a brother,

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Epimetheus (meaning 'after thought') who Zeus also wanted to punish but he had not done anything wrong himself, indeed he had helped Zeus in the past. Zeus therefore designed a way to make the punishment seem like a gift, by sending Epimetheus a bride. Pandora was therefore created and was given gifts by each of the gods so that she was beautiful and productive. Zeus then ensured that two things happened: firstly Pandora was made to be curious; secondly, she was given a jar full of gifts for the future and told that the jar must never be opened. She was then presented in all her beauty to Epimetheus and at the same time her mind was never at peace because she was in an impossible position of having a curious nature and being unable to follow it.

Interestingly Prometheus had warned his brother not to accept gifts from Zeus as he could not be trusted but on seeing Pandora's beauty this was impossible advice to adhere to. One wonders if Epimetheus had listened to the warning and discussed it with Pandora if there may have been a different outcome to the story, but this did not happen.

Pandora fought her curiosity for some time, going to extreme lengths of hiding the jar, burying it and trying to stay away from it but she kept being drawn back and became desperate to open it a little, to see all the gifts inside. As Pandora opened the lid, just a little, a foul smell filled the air and then in a rush all the gifts escaped at speed from the jar, revealing themselves to be all the plagues and sorrows known to man. The gifts were in spirit form and included all of the illnesses and afflictions of the body and for the mind there was spite, anger, envy and more. As the spirits escaped they hid, waiting for their moment to sting. When the spirits hid they mixed themselves up with good spirits so that

no one could tell the difference between good things and bad things. In her despair at what she had done Pandora managed to close the jar with just one gift remaining, hope.⁵⁴⁴

In relation to this research, in each case there is essentially one party, usually the clinician, who makes a link between a child's presenting difficulty and something in the parental or family history. Quite separate from the accuracy of this or how welcome the link may be, this establishes an intense relationship based on the idea that the clinician wants to open up an area of the family life that is felt to be destructive and involves dread and pain. This encourages a certain type of intense acting out of behaviours where the clinician can be experienced as cruel and the clinician experiences themselves as intrusive and even at times tortuous. This emerges as a theme in several cases, most notably in relation to families who attend for help somewhat unwillingly but still attend because the parents are genuinely concerned about their child's future and fear that they are having a negative or toxic effect on the child. The parental fears are implicit. When the clinician recognizes the negative effect the parents are having or views the problem as a child protection problem then the parent feels a sense of betrayal. The parent may feel that they themselves described the problem and the clinician has acted against them rather than help them. The parent may feel that the clinician acted for reasons of cruelty or punishment or revenge, particularly if the clinician's preferred intervention had not been effective. Alternatively if the parent feels the clinician invited disclosure of parental trauma and then immediately wanted to refer the parent to another service then that parent in question can experience this as a

⁵⁴⁴ Different versions of the story have different views of hope: In one version hope was put there by Zeus as an act of kindness; in another version Pandora and Epimetheus are miserable for a long time before hope comes back to them and agrees to re-enter the jar as an act of kindness; In yet another version Zeus includes hope thinking it is a curse as it allows one to see a better future but seeing the future is a curse in itself; and finally there is a version that suggests that hope is the last and most terrible of the afflictions and is only thought about positively as it is contained and imprisoned and if it were ever to be set free then it would bring more misery than the other gifts combined. (See Bullfinch 1987).

cruel manoeuvre by the clinician. This is experienced as a severe insult to the parent who may feel that the clinician is cruel and uncaring and insensitive to the pain associated with the disclosure. This is reminiscent of the thin skinned patients referred to by Rosenfeld (1987). In worst case scenarios the clinician is seen as enjoying the pain or the distress caused by the potential for family breakdown, and even seen as torturing the family by making them face their worst fears without hope of a resolution. Some family members seem to respond to this situation by keeping the clinician in the presence of the distress but restricting their ability to influence the situation or to lessen the pain. This mutually torturous experience seems to have a particular longevity and to sustain itself over many years, to the exhaustion of the clinician and family.

To further understand the processes described under the term 'Pandora's Box' it is possible to use existing psychoanalytic theory in relation to linking. It is also important to consider the complexities of using a theory of linking when referring to a family system and the technical difficulties when the link is unwelcome. Using the concept of linking allows us to track the progressive deterioration in the therapeutic relationship with the clinician increasingly being cornered and put into a situation where the family experience the clinician as a torturer.

PANDORA'S BOX AND LINKING

Bion's work is crucial in the understanding of linking. In his papers 'Differentiation of the Psychotic from the Non-Psychotic Personalities' (1957), 'Attacks on Linking' (1959) and 'A Theory of Thinking' (1962b) he explores the nature of contact with reality, the emotional experience of linking, and the function of pain and frustration on the development of

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thinking and the mind. Bion suggests that the process of linking, or making links between objects, involves an unconscious emotional connection that is crucial for the development of the mind and the accurate perception of the world. Links are felt to give reality to experience and to give meaning. In healthy development, linking is welcomed and involves growth but it does involve tolerating the link between the parental couple and the dependent position of the child in the oedipal position. Where there is trauma or where the link may be dreaded or cause a catastrophic anxiety as it requires the person to tolerate too much frustration and pain then the frustration and the emotional growth can be avoided by attacking the links. In some cases these attacks are defensive, in order to avoid pain, and in other cases the attacks may be more destructive and motivated by an idealisation of the destructive aspects of the personality. These are unconscious processes. This was developed by Rosenfeld (1987) who suggested it was important to be able to distinguish these two types of functioning when an impasse was encountered in analytic work.

In examining the data it is clear that there were major problems for all twelve families in relation to some linking processes (these were detailed under the warning sign of 'taboo'). These links may not be of the same sort as the ones described by Bion as they are consciously made by the clinician and consciously responded to by the families but there is a clear process of linking being an area for conflict, disagreement and fear. The clinicians while wanting to offer helpful links often found that there was more than a resistance to the links but an active attack on the link through denial, dismissal or through a change in the relationship with the clinician. Relating this back to the literature review, it is important to see the different reactions to the link as having different qualities and to understand that even the most hostile response may have been defensive if the pain and frustration attached to it were overwhelming. In some other cases the functioning of one of the

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parties may have had a more destructive drive, and there was evidence of this in at least one case (Case Nine when the mother lost a sense and even a memory of the progress that had been made).

When thinking about linking in stuck cases there seems to be a progression from an intended helpful link which is at first experienced as an Unwelcome Link. If the link is pursued despite being unwelcome then the case becomes quickly and profoundly stuck. The Unwelcome Link can arise at any point in the therapeutic relationship and when the link is pursued by the clinician the family may experience it as a Cruel Link. Examining the content of the twelve narratives the Unwelcome Link is primarily about the parent of the child referred feeling that the clinician is making a link between the reason for referral and something that may involve their functioning, family relationships or even the parents own childhood history. This is not welcomed by the parent for a number of reasons: Parents may not agree with the link, feeling that it is tenuous or not worthy of exploration; Parents may feel that the clinician is trying to apportion blame for the child's problems; Parents may feel that the clinician is intrusive and prying, wanting to open a 'Pandora's Box' or a 'Can of Worms' without trusting the clinician that this will have a beneficial outcome; Parents may feel that the clinician is resorting to a link that is nothing more than a veiled attack on them as the clinician tries to hide their own failure or the lack of success of the treatment they have been offering; In the worst case scenarios the parents may feel that the link is made for reasons of cruelty.

The clinician for their part may feel that the link is obvious and when it is not validated by the parents then the clinician may become quite determined to pursue the link instead of focusing on the disagreement about the link. An unsatisfactory set of actions then take place with the clinician forcing the link and parents avoiding it and sometimes families

becoming more difficult, hostile or distressed as a result. The clinician may feel the need to explore the link and indeed to make it the central factor in their formulation.

All of this creates a technical dilemma for the clinician about what to do when a well intentioned link is attacked. Should it be pursued? In cases where there is life or death anxiety or parental psychological maltreatment then the clinician may have no choice and may feel compelled to pursue the link. There is a danger, however, that the link is not helpful and that they may feel the need to prove it or validate it for their own reasons, although this did not appear to be the true for the clinicians in this research. However, in the cases surveyed there was not a successful example of the clinicians drawing attention to the process of disagreement about the link in order to open up communication (what could be described as a meta-dialogue) and instead the disputed link became an accelerating factor in the deterioration of the relationship.

PANDORA'S BOX: PERSECUTING LINK

In addition to forming the link for themselves the clinician may try to influence a wide range of professionals and agencies to agree on the importance of the link, leading to an isolation of the family and pressure on the family to accept the validity of the link. This ultimately has the effect of splitting the network of systems around the child into those who agree with the link and those who side with the family in their avoidance of the link. This splitting can take place in different theatres with different levels of power, moving from the clinical setting to multi-agency meetings, to child protection meetings and to referrals to the Reporter to the Children's Panel (Child Protection measures). The debate around the link tends to happen alongside a deterioration in the child's presentation, sometimes with associated Life or Death anxieties. In this way the quality of the adult

interactions has failed to help the child and the therapist therefore becomes implicated in the parental maltreatment because of the inability to be effective. It is the quality of the experience for the child rather than the benign intent of the clinician that makes the stuck cases so difficult to deal with. The clinicians and supervisors who leave it too late to formulate the abusive nature of the stuck case leave themselves vulnerable to being stuck as part of a system that they can not change and they have not given themselves clear options for action from an early stage.

EXAMPLES OF PANDORA'S BOX

For Clinician Two the following example was not central but was one of a series of similar episodes with Clinician Two feeling they were constantly seen as trying to criticise the child rather than assess needs. This case never moved beyond the assessment phase. Clinician Two was undertaking an assessment of a child for ADHD when at a school meeting concerns were raised about the child perhaps having learning difficulties. This was done using professional language pointing to the fact that the child was making progress and Clinician Two noted that the progress was very limited if the child was compared to peers. Clinician Two had been concerned that a learning disability may be an important factor in understanding the child's needs alongside other neurodevelopmental difficulties. The child's parent became verbally hostile accusing Clinician Two of saying the child couldn't make progress. This was played out among the professionals present with some coming to Clinician Two's assistance and others not. Clinician Two felt that this was an example of restrictions on thinking that were being imposed on Clinician Two by the child's parent who thought she knew what the outcome of the assessment should be and resisted any links that might delay the result of the assessment or alter the course of the assessment.

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Clinician Three had been working with a family of a ten year old child for some time to help the child manage OCD symptoms when the mother ‘disclosed’ that the child was soiling. At the same time one parent disclosed their own very distressing childhood with many traumas. The parents reported that they thought they were doing the right thing by attending the clinic for help with their child but they felt the Clinician was opening Pandora’s box by making a link to the parental history and family functioning rather than just treating the child. Concrete explanations and interventions were preferable to the parents but provided no improvement, leading to long term distress about the progress of their child. Other interventions were avoided as they were too distressing. Clinician Three sought to manage this by referring for a second opinion and despite the family’s initial relief this led to them disengaging with all mental health services.

Clinician Four reported making an unwelcome link to a teenager’s capacity to engage with the world for social reasons that often involved risk-taking while at the same time seeking help for a separation anxiety in relation to leaving their mentally ill mother at home alone. This allowed the teenager to interact with a risky external world and to refuse the offer of more developmental opportunities related to education and work experience. The teenager and mother repetitively approached the clinic in a crisis but refused to work in a more planned way, therefore avoiding reflection about the link the Clinician had made. Clinician Four reported feeling that *Any suggestion of anything new or changing had to be... kept... in mud....*

Clinician Five described working with a child and mother when the child was referred for encopresis. Clinician Five reported, *And we got to a stage, mum and I, in the sessions where I was quite clearly saying to her that there is no point trying another sticker chart, we have tried all the behavioural interventions and it hasn’t worked and we need to think about this in a different way... and my feeling is*

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we need to think about the whole family system. And she didn't want to do that because she was scared about thinking about her own feelings and didn't want to imagine that that could have anything to do with what was going on for this wee boy, and I guess it is quite a big leap (for this mum) to say that my own feelings of sadness at my mum's dying and the way I have dealt with that have led my son to soil. But she was incredibly resistant to even thinking about that as an option, or thinking about how we might work with that in a different way. So, the stuck feeling came quite quickly as we were stuck on this one method of treatment that wasn't working and we kept repeating it. And there was this Groundhog Day as we're keeping on doing the things that weren't working.... I got to the point (where) I could quite clearly see where I wanted to go and she wouldn't follow me.

Clinician Six reported work with a child that involved Life and Death Anxieties in relation to the management of diet. Clinician Six said, *they didn't see the relationship or the prospect of his mum dying and (the child) not having enough contact with her in any way, they didn't see that as relevant, they saw that as being in the past....* Clinician Six's insistence on exploring the child's relationship resulted in the family withdrawing from treatment and leaving Clinician Six concerned about the life or death implications of the child's treatment not being successful.

The Clinician in Case Seven reported finding a clear (actually charted) link between a child's increasing school refusal and one parent's control of their own alcoholism. When the parent was incapacitated or the child was concerned about them then the school refusal was a far greater problem. The family found this *interesting but irrelevant* and Clinician Seven reported, *I think the problem was seen as residing in the child and it needed to be operated on somehow and the problem had to be removed, medically removed.* The family would bring the child for appointments but became hostile toward any part of the network of agencies or professionals who agreed with Clinician Seven's link. At one point the family did start to explore the link but soon formed what Clinician Seven called *a united front against me.*

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Clinician Seven then continued to persuade other agencies to accept the link that had been made and this was experienced as a Persecuting Link by the family who saw others *dancing to Clinician Seven's tune*.

The Clinician in Case Eight reported working with a child who had encopresis. Behavioural interventions had been tried but without success. Clinician Eight became increasingly aware that the mother in the family spent too little time with her child because of work commitments. Clinician Eight thought that the soiling allowed a particular type of intimacy to be sustained between the mother and child, allowing the mother to feel needed and the child to be cared for in an infantile way when the mother was present. Clinician Eight reported trying to have conversations about this with the mother and even arranging to meet with her without the child present. Clinician Eight felt that the mother was avoiding the conversation and would bring the child along so that a frank discussion between Clinician Eight and the mother was not possible. Clinician Eight felt that both the mother and child stood to lose quite a lot if the soiling was to improve, but did not feel able to explore the link with the mother.

The Clinician in Case Nine reported working with a case where more than once Clinician Nine referred the mother to adult psychiatry services but the mother did not attend adult appointments. Clinician Nine said, *My first reaction to that was actually she got very stuck in just wanting this to be about her son, it was his difficulties and we were to fix him. So as soon as it was thinking about her as well, because her son did have a lot of difficulties both of his own and to do with the situation, and we recognised that, but there was no doubt in my mind that his relationship with his mother was part of that. I don't think she ever gave permission or wanted to understand that as being part of the formulation... That was a big stuckness, helping her to take that on board. I think there were times that she managed to start thinking about that a bit but from memory that never lasted, we would have*

discussions about that and it even remained until the next time I saw her and then something would happen and the whole thing would disappear again as if it had never happened and you had to approach the whole area again. This links to Rosenfeld (1987) and his discussion of destructive narcissism attacking the parts of the patient's mind that have made progress.

Not all Unwelcome Links are made by professionals. In Case Eleven the Clinician reported working with a case of a young person referred (not for the first time) for problems with encopresis. The child's mother linked the soiling to a traumatic sexual abuse that the child suffered at an early age. There had been a series of interventions by many professionals in many agencies that had not resulted in any change of behaviour. Clinician Eleven reported noting that the same behavioural treatments and almost identical approaches had been tried by different practitioners, focusing on the soiling as a behavioural problem and thereafter avoiding the link with the intrusive sexual trauma the child had suffered. At the same time when Clinician Eleven and colleagues asked the mother to reflect on her role in creating change, the mother was unable to imagine links with her.

In many of the other cases (notably case one, case seven and case ten) there was a weariness and wish on the part of the clinicians that the links had never been made.

PANDORA'S BOX: LINKS AS ATTACKS

In the story of Pandora the so called gifts in the jar are actually given as an act of punishment of a helpful act. In relation to this study there is another very negative possibility from, the family point of view, that the Links are in fact attacks from the clinician, targeting one member of the family or shaming the whole family for seeking help

for the child. From this point of view it is possible to conceptualize the links in the following way.

It is difficult for a clinician when their offered treatment does not succeed. This may be heightened by professional beliefs in things like evidence-based interventions for treatments that 'ought' to work, despite even the best evidence base having moderate success rates, or theoretical beliefs that a certain way of thinking will improve family functioning, or experiential beliefs that this experience has helped families in the past and will help this family too. When these beliefs are challenged, perhaps repetitively by some families, the focus of the thoughts in relation to the case can change to trying to locate the pathology in a different way. There is a danger that the family may feel that this is the clinician looking to blame someone for the failure, rather than accept that the interventions have not met the needs of the child and family. This is a moment where a stigmatized area of the family life may be identified as to 'blame' or to account for the lack of success. The stigmatized area could include parental mental illness, parental addiction or alcoholism, aggressive or anti-social behaviour, a parental couple in conflict, sexual abuse of a parent in childhood, or another parental pre-occupation. This provides a technical, institutional and personal problem for the clinician. Technically there has to be a decision made about how to work with the problem in as much as it impacts on the child's presenting concern, i.e. working with a parent to think about and help minimize the impact of parental addiction. Institutionally the clinician has a dilemma as they may feel that this is someone seeking care by stealth, what is sometimes referred to as the 'unidentified patient' (Lieberman, 1996) who 'should be' seeking help from the appropriate adult services and not using up the resources of a child and adolescent service. Other institutional difficulties are created in relation to how much time and attention the case is taking up at the expense of others and also the standing of the clinician in relation to colleagues if they can not be seen to deal

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with the stuck case. It is also a personal difficulty because the clinician has to manage a range of feelings about not having been successful, feeling that they have tried to do a good job and their efforts have not been noticed or appreciated, despite their lack of success. The clinician may even feel that this family have made it impossible for them to do a good job and the experience has shaken the clinician's own view of themselves as a helpful benevolent clinician. It is a personal difficulty to continue to relate to this family in a professional way without blaming, avoiding, or losing a sense of containing the family distress.

This crucial time is noticed by families and the clinician may be seen as selecting a scapegoat or blaming the stigmatized member of the family. That person may feel unfairly treated or even that the clinician is being cruel, blaming them for having a difficulty and for maintaining the child's difficulties but not offering them help or support in managing the difficulty. For example a seriously depressed parent may feel they have been told that their depression is to blame for the lack of progress rather than feeling they are being helped to manage their depression in relation to their child. The clinician may avoid this work because of institutional or technical difficulties, may want to avoid the chronic and long-term nature of the support required, or may not feel adequately equipped to offer help that is not manualized.

At this point the helping relationship becomes 'stuck' or reaches an 'impasse' with the real needs disputed but not provided for, or through life and death anxieties the needs are provided for reluctantly with a sense of professional/ institutional and personal compromise on the part of the clinician. From the family's point of view there is a feeling that the clinician has to be made to provide care and would rather disengage than have a frank discussion about their treatment not working.

PROFESSIONAL TRAPS

In addition to the traps that involve the clinician in an intense negative relationship as detailed above, there are a range of traps that can be seen to emanate from the professional network and the structure of the services themselves. These can be thought about as professional traps.

PROFESSIONAL TRAPS: EVIDENCE BASED TRAPS

Cases Two, Five, Eight, Ten, and Eleven suggest that the family and clinician were stuck in Evidence Based Traps. By this I mean that the practitioners were responding to the content of the case in standardised ways as indicated by the National Institute for Clinical Excellence (NICE) or local guidelines and then implementing a manualized treatment plan. In relation to encopresis this meant that the first line of approach was to consider behavioural interventions. In cases Five and Eight it was soon clear that these were not appropriate and that the child needed a more emotionally focused intervention. The clinicians found themselves trapped by the parents who wanted to continue with the first approach, which was less threatening. Having made an evidence based formulation it was then difficult for the clinicians to open up a more emotional path. This is true despite the recognition by the families that the evidence based intervention was not helping them.

Case two was trapped in a different way in that the Clinician was seeking a full range of information in order to complete a comprehensive assessment for ADHD and faced frustration at every turn when the parent refused to allow differential diagnoses to be considered. Not having a definitive physical test to provide any certainty to a diagnosis the Clinician faced a battle over how to see the child's difficulties, what clinical evidence was appropriate and how to interpret it. The parent's single mindedness and determination

seemed to be as compelling to the network as the Clinician's careful gathering and analysis of the evidence in relation to the child. Without a definitive diagnostic tool the Clinician only had an opinion that was at odds with another more passionately argued view.

The Clinician in Case Ten had a different dilemma in that instead of forming a careful view of the child they were compelled by the parent to rule out one diagnosis after another. The evidence based procedures trapped the clinician for over a year as the child's presentation was matched to one diagnosis after another. It is very difficult for a CAMHS workers to form an independent view of a child when they are being asked to rule out a diagnosis following NICE or local guidelines. This is particularly difficult if a patient or family has previously complained or threatens to complain, raising difficulties for the clinicians partly because if they do not rule out a diagnosis then they may at a later date be considered to have been negligent. It was only once Clinician Ten had worked through this process that a more therapeutic approach was possible with the family.

While not completely true of the whole intervention, a large part of the work in Case Eleven was to treat the child for encopresis by using behavioural interventions and basically sitting the child on the toilet. This was done by more than one practitioner over a period of years and was completely unsuccessful, leading to frustration all round. At the same time the clinicians were aware of the trauma that the child had suffered and yet still seemed blinded to the re-enactment involved in the nature of the soiling rather than the toilet training aspect of it. The existence of an evidence based hierarchy of intervention is very important and useful but may cause clinicians to match interventions to behaviour in a way that is too rushed or does not allow for the detail and meaning of the behaviour to be considered.

PROFESSIONAL TRAP : LOGIC TRAPS

There are two types of logical trap, those that involved following the clinicians instructions to the letter and those that involved a family logic. Because they make a powerful sense to the family members it is very difficult to challenge the logic trap and a successful challenge requires the possibility of standing outside the argument and having a meta-dialogue, which was not possible in the stuck cases. Two examples of Logic traps can be seen in Case Six. The first is a Family Logic Trap that can be seen when the Clinician says, *But what happened was that basically the step-mum would stop talking to the child within the home, and her logic for that was the less interaction she had with the child, the less likelihood there was the child would lie to her. So the wee child was miserable and upset at home because she wouldn't speak.*

The danger with cases such as this is that the clinician gets caught up in trying to reason with the abusive party rather than focus on child protection. Again this relates to Bentovim's (1992) assertion that there is no room for neutrality in cases of maltreatment. At times the clinician may feel themselves to be implicitly part of the abusive system and to be the victim of inveiglement.

The second example is a Clinician Focused Logic Trap that can be seen when the Clinician says, when *I reflected back that I thought it was very difficult for the dad.* The father then went into a detailed complaint about being left with the child and detailed the burden,... *and all this was said in front of the child and I reflected back to him about how this might let the child feel and he said well you wanted us to be honest, I thought you wanted us to say what we thought.*

These traps can be seen as defensive functioning on the part of the parents who can no longer tolerate the frustrations involved in caring for a child at the expense of their own

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interests in life. The logical quality of what happens allows them to feel sensible and to have permission to pursue their line of action. If there is any negativity or destructiveness in the action then this is offset by the implied gain in the Family Logic Trap (that if the boy didn't speak then he couldn't lie) and the pursuit of therapeutic gains as implied by the Clinician's instructions in the second example. There are other examples of Logic Traps that resonate with previous categorisations such as the Evidence Based Traps in Case Ten where CAMHS are seen as diagnosing mental illness and the parent spends a year putting the child forward for one diagnosis after another. The intrusiveness and abusive nature of this are offset by the implied gain of finding the correct diagnosis. In this way the clinician's intervention becomes woven into the psychological maltreatment of the child and to disagree or object seems illogical and therefore unprofessional.

PROFESSIONAL TRAP: PROFESSIONAL ISOLATION

Many stuck cases were felt to be isolating experiences for clinicians who take on a case and soon become the focus of an intense negative transference or intense hostility or the Zero position. The hostility may be from the family but may also include members of the multi-agency network. It may also involve a simpler experience of the clinician struggling with the emotional dynamics in the case and this not being recognised by co-workers, colleagues, or supervisors who might focus on the content rather than the process of the work. Examples of this can be seen powerfully in Case Two where the Clinician was the focus of the mother's complaints toward the whole service and yet the Clinician did not feel any support from colleagues and said, *it could have been a very damaging experience without much support in the clinic, because I feel very alone and actually that became clear that you are quite alone*

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and out on a limb most of the time. It can also be seen in Case Eleven when the Clinician became so upset at being named as unhelpful that they wanted to take the case on again and colleagues who must have noticed this did not challenge this plan.

Professional isolation is a difficult experience for clinicians as it challenges their sense of belonging to a benevolent institution and a caring and nurturing team or service, provoking a feeling of isolation and vulnerability and may also lead to an experience of feeling scapegoated and left to take the hostility of others. The experience of isolation can be seen when the professional group is split in relation to the cases but it is more subtle than a straightforward splitting of a professional network and tends to be focused on the clinician as an individual who is actively and obviously stuck with a case. Professional isolation can be observed in situations where professionals function around a case or around a clinician as if the clinician is not trapped when in fact the clinician is broadcasting the difficulties they are facing in dealing with a stuck case. Colleagues act as if the clinician can work it out or the clinician getting into the trap is part of the treatment. These colleagues may offer alternative interventions or discussions with the clinician about the method of work without responding to the obvious professional pressure felt by the clinician with a stuck case. Often what the clinician really wants to do is to transfer the case or to have someone to work alongside them so that the experience is shared. This provides a particular challenge for supervision and clinical governance within the service. It is important for clinicians to make their supervisor aware that they are engaged in a stuck case but it is also crucial that the supervisor is sensitive to the complexity of the case and that supervision itself may be playing an active part in the stuckness and keeping the clinician in an isolated role.

PARENT TRAP: PARENTS NOT PROVIDED FOR SYSTEMICALLY

Chart Three shows that seven out of the twelve families had parents with explicit mental health problems and Chart Two shows that there were three known parents with severe issues in relation to addiction. It is therefore not a surprise that many of these parents seemed to want attention and help for themselves. Note that in cases one, three, nine, and ten the mother's mental health became the main focus of the clinician's concern. Note also that in cases five, six, seven and eight the parents were actively avoiding help from adult services and some even seemed *terrified* if the clinician wanted to explore adult issues.

For the parents who are seeking help there is a high level of suspicion and dissatisfaction aroused in the clinician who may question if they are working within the bounds of their service. There also seems to be a profound sense of insult to the parents in some cases when they feel they have been invited to disclose distressing personal material, only to find that the clinician wants to refer them on to adult services (cases one and ten are excellent examples of this).

Lieberman (1996) uses clinical case studies in Family Therapy to show that many adults with diagnosable psychiatric conditions will not seek help for themselves but will present with another family member as an 'identified patient'. Lieberman (1996: 173) says, '*Systematically this leads to an aggravation of the problems within the 'unidentified patient' and may reinforce those of the 'identified patient' in spite of all efforts to help.*' Lieberman (1996) gives a case example of an adolescent self-harmer who improved only after her father sought help for alcoholism and her mother for anxiety. Lieberman (1996: 175) points out the systemic importance of helping the family rather than the identified patient, drawing attention to the

dilemma where by, *'...the epistemology of our professions is such that there is no way to treat 'non-patients' ethically.'*

This resonates with the Clinician in Case Two who raised the complex boundary issues around how to respond to a child case when the intense emotional dynamic, the transference relationship, is coming from a parent. There is no easy way around these complex issues but it can also be seen that many of these parents are not using their child to get services for themselves but are presenting themselves as damaged or traumatized parents who may need to be seen as a parent seeking help rather than an adult seeking help.

For families where someone is seeking help as an 'unidentified patient' it may be appropriate to offer parental psychotherapy, where the parent is seen by a child psychotherapist or works in collaboration with staff from adult services. It is important to recognize that these people would never seek help in their own right and may only be motivated to heal the aspects of themselves that are involved in the relationship with their children.

It is an institutional trap for parents, children and clinicians that when parents do want help they may need to be seen by a service that does not recognise that their identity and motivation for change are tied to their relationship with the child. Indeed, adult mental health services may not even ask whether a patient is a parent or record that information in an easily accessed manner in the file. Loyalty can become an issue on a number of levels as the clinician is not entirely sure of the boundaries around their relationship with the parents if the whole family is the patient or just the child, what permission the clinician has to explore the thoughts and behaviours of the parent and when this stops being related to the child's needs and becomes adult work in its own right.

LOYALTY TRAP

The theme of loyalty was put specifically as a question by the Clinician in Case Seven who said the child was, *fantastically loyal to both parents. Now why should that be a problem? But I think it was a problem because it got in the way of progress. The child's loyalty to both parents actually.*

There are many possible reasons for loyalty to emerge as a theme, including experiences where the child's loyalty is tested or the clinician's loyalty is tested. The families who are involved in tensions over loyalty are constantly in fear of betrayal. There are a number of reasons why parents or a family may have concerns over loyalty or have divided loyalties in relation to seeking help:

1. The parent may not trust the clinician to provide the correct service to their child and therefore enters into a process of constant questioning and doubt about the clinician's actions and views, remaining loyal to their own family view of the problem over that of the clinician. This may be particularly difficult for families who feel that they have been let down by professional and care providers in the past.
2. Seeing the child developing a therapeutic relationship may stimulate envy in the parent who becomes rivalrous with the clinician as they find it difficult to allow the clinician to have a successful relationship with the child. The parent may fear that the therapist will usurp their place as their child's preferred carer.
3. The parent may find that as part of their child's treatment that they themselves disclose traumatic experiences from their own childhood to the clinician. This opens up a sense of neediness and dependence on the clinician who is seen to be responsible for helping the parent to deal with these difficulties as the parent may feel this is part of the treatment for the child and it was perhaps invited by the

clinician. The parent has a need for the clinician to continue to provide care to them in relation to the material that was disclosed. Any attempt to re-focus on the child's needs or to refer the parent to adult services is felt to be a betrayal of the trust that was invested in the clinician in the first instance.

4. In many cases the child is vulnerable and needs an active parental figure to make changes to their environment and to relationships in the child's life but the parent does not implement these changes for a range of reasons (mental illness, confusion in relation to boundary setting, fear of change, lack of capacity to understand the changes, feeling that the changes are being forced upon them, etc.). This can raise child protection issues. This can result in the child being put in a position where the clinician is creating a narrative where the parents are abusive and the parents are creating a narrative where the clinician is failing to help them and trying to turn the child against them. The child is caught in the middle and has to decide on who to remain loyal to, as a choice has to be made between the clinician's view and the parents' view.

There may be many other explanations for the emergence of loyalty as a theme but it certainly plays an important role in the creation and maintenance of stuck situations. Of all the traps that have been described to date this is the one that is most likely to involve the child and as such it merits further analysis. Why would a child remain loyal to a parent or family where there was psychological maltreatment, emotional abuse, or parents with a range of problems that kept them pre-occupied? I propose to use the term 'Loyalty to a Toxic Breast' to describe a situation where a parent who is damaged or who is having a negative effect on their child comes to a clinician to complain about this but is unable to change, develop, or to use the intervention on offer. The use of the term Breast in a reference to Kleinian thinking as it represents the intensity of the primitive nature of the relationship to the carer and the dependency on it. In contemplating the conceptualization

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the researcher considered the plight of a mother who wishes to breast feed but is suffering from pain due to a condition like mastitis and who is well aware that her child is not receiving enough nourishment. At the same time she may be unwilling to give up on the idea of breast feeding. The Traumatized or Toxic Breast refers to the emotional capacity of the parent to nurture and care for the child.

The parent seems to have the need to attend over a long period of time for someone to witness this, to be in the situation with them but not to change it. This can be thought about as a repetition compulsion. The clinician in these situations may feel something toxic is affecting them when they deal with the family. This could even be experienced as a physical sensation of suffocating, a lack of air or poisonous air, or a feeling that they have been affected in a way that will interfere with further work on the day the family is seen. The clinician may also feel that they are forcing a treatment on the family and that the family experience their attempts to help or their inability to help as equally toxic. When the clinician makes a move to treat the problem as a child protection issue or to put it to the parent that they are not in fact in a position to look after the child then this is experienced by the parent as a betrayal. This stuck situation is even more difficult because the child will inevitably be in a position of choosing to be loyal to their parents, regardless of the toxic impact the parent is having on them. This is, of course, normal attachment behaviour and should be expected. It can be seen clearly in cases six, seven and ten, that regardless of how damaged or damaging the parent's state of mind, the child remains loyal to them. This should not be a problem except that the clinician by this point in the treatment has been drawn in to a drama where they are seen as the agent that is trying to separate the child and parent through involving alternative carers or by referral to the Reporter to the Children's Panel. These child protection issues inevitably mean it is difficult for practitioners to maintain a shared formulation with the family. It may, however, still be

possible to take a meta-position and look at the process and recognise that the clinician is acting on the parental request to ensure their child's needs are met, while at the same time understanding the painful nature of separation. It is, of course, very likely that these parents will experience any attempt at separation as an attack rather than well intentioned.

SUMMARY OF ANALYSIS

Nature of Unconscious / Unprocessed Communication

- Projection
- Projective Identification
- Transference, countertransference and re-enactment

Warning signs:

- Taboo
- Life or Death Anxieties
- Blinding Trauma
- Career Shaking Experiences
- Compelled Care
- The Insult
- Crisis of Confidence

Emerging Theory of Traps

- Benevolence Trap:
 - Hero to Zero
 - Zero
 - Pandora's Box and Linking
- Professional Traps:
 - Evidence Based Trap
 - Logic Traps
 - Professional Isolation
 - Parent Trap
- Loyalty Trap

DISCUSSION

This research explored the nature of stuck cases where the helping relationship had reached an impasse. It asked ‘what is a stuck case?’ Are the different ways of thinking about stuckness compatible and complementary? What do professionals from different backgrounds make of the experience of becoming stuck? How do families experience becoming stuck? And can studying different ways of thinking about this material help us to understand stuckness and impasse and point to more successful ways of working?

WHAT IS A STUCK CASE?

In this research we found a common understanding of what a stuck case was as all interviewees identified cases where families and clinicians both attempted to improve the situation but they encountered mutual difficulties and disagreements that could not be overcome. While there were many reasons for this (as the literature review suggested) the research gathered information that allowed an analysis of the common factors in the experience and most notably focused on the problem of unconscious/unprocessed communication with a range of warning signs, patterns, traps and institutional factors. This goes some considerable way to addressing the question of what stuckness is and how people get into stuck situations. The literature review suggested that there would be many varied causes of stuckness and previous attempts to analyse the experience had led researchers to conclude that the reasons were too varied for there to be a single explanatory reason (Carpenter and Treacher, 1982). The literature review had suggested that there might be several types of stuckness or impasse which I will review here in relation to the emerging theory that this research has provided:

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- Impasse on the threshold of the depressive position (Meltzer 1968, Rosenfeld 1987) was not recognisable in this series of research interviews and may be a particular type of impasse which is unique to psychoanalytic work.
- Impasse related to trauma and impasse in relation to a catastrophic anxiety (Meltzer, 1968) are both clearly seen in the emerging theory of Pandora's box and processes starting with the unwelcome link. The emerging theory described here develops our understanding of the dilemma that families find themselves in when they seek help and how sensitive the clinician has to be in the timing of change and in the phrasing of interventions and how the clinician will have to abandon neutrality when child protection concerns are present.
- Sudden negative reaction after progress (Rosenfeld, 1987). This can be seen in the Hero to Zero cases. It is interesting to note that the move from hero to zero is so fast and confusing that it seems blinding. The emerging theory adds to Rosenfeld's description by detailing the nature of the therapeutic relationship and that the sudden negative reaction appears to follow a particular type of pattern.
- Negative therapeutic reaction not following progress (Rosenfeld, 1987). This can be seen clearly in the emerging theory of the Zero category. An intense negative transference is described.
- Therapist failure with context (Britton 1981, Carpenter and Treacher 1982) can be seen in the traps of professional isolation and loyalty to the toxic breast. This research adds to the understanding of this by detailing the nature of the pressure the clinician is put under and the need to work with colleagues and other agencies in an informed way. Improvement in practice in relation to this will be discussed later in relation to shared formulation and raising services awareness of the complexities of the task of helping these families.

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- Repetition compulsion (Freud 1914, Britton 1981) was clearly present in some cases crossing over many themes such as Hero to Zero and a focus on content not process and in Life or Death anxieties. It may be that there is a strong relationship between repetition compulsion and the range of traps that are described in the analysis. More detailed analysis of this would require interviews with the family members involved in the cases, to confirm the background history was indeed being re-enacted. Family interviews may also be able to address the issue of whether some families are more likely to, or more actively, elicit the professional falling into a trap more readily.

ARE DIFFERENT WAYS OF THINKING ABOUT STUCKNESS COMPATIBLE AND COMPLIMENTARY?

Study of stuckness and impasse has led practitioners from systemic and psychoanalytic backgrounds to develop both technique and theory. The themes in the research findings and analysis were consistent with the systemic and psychoanalytic literature review, particularly the emotional involvement of the clinician, the clinician being caught up in the system, the defensive nature of the functioning in most of the cases and the need for clinicians to think carefully about how they work with families where there is an experience of being stuck. Having reviewed the literature and explored the interviews in detail I am confident in asserting that developmental ways of working through the difficulties encountered with stuck cases requires both systemic and psychoanalytic ideas and practices. It is necessary to understand the difference between defensive, destructive and communicative functioning and the different quality of containment required by each. It is also necessary to pay attention to the grammar of the interpretation as well as the language of the intervention. In addition it is necessary to have an awareness of the systemic aspects of these cases, particularly where there may be a trauma organized system or child

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protection concerns in order to ensure that where possible the clinician does not become implicitly involved in sustaining the maltreatment of the child. Therefore, with a common aim of creating reflective functioning the combination of systemic and psychoanalytic ideas and techniques is essential in fully understanding and preparing effective interventions with stuck cases. Although working with these cases requires a high level of training, supervision and collaboration, this is appropriate given the level of difficulty experienced in these families and the duty of care that employers have when asking clinicians to undertake such emotionally demanding work.

DISCUSSION OF WARNING SIGNS AND WORKING WITH UNCONSCIOUS/ UNPROCESSED COMMUNICATION

Some of the warning signs outlined are more obvious than others but they are all real experiences reported in the interviews. Are they all indicative of a stuck case? It is hard to tell as many cases that do not become stuck may share some of these features. However the intensity of the clinician's experience in relation to the warnings signs should highlight the need to consider them seriously. There may be more than one warning sign in operation at once and it is fair to assume that the more warning signs there are then the more cautious the clinician should be.

How should clinicians approach a warning sign? It is clear that clinicians need to be aware of the need to keep a therapeutic distance where they are close enough to the family to empathize with them but far enough away so that they can think freely about the work. Warning signs highlight that the clinician has lost or is about to lose that essential distance and will need help to regain it. That help should be sought from professional supervisors,

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from team members, and through shared formulation, and where possible involving the family in the process of seeking extra help. The clinician has nothing to lose by being honest as he is demonstrating appropriate care-seeking to the family.

Some of the warning signs relate to child protection and in these cases good clinical practice will involve supervision and clinical governance and following the statutory procedures as necessary. There is a need for a shared multi-agency understanding about the particular difficulties that may be experienced with these cases and psychological maltreatment has to be discussed and given some shared priority among different agencies.

It may not be necessary to have a psychoanalytic and systemic view of a case when the warning signs are noticed but it is probably a good idea to have a consultation to think about the complexities of the work and to consider the range of unconscious and unprocessed communications that may be threatening a successful intervention.

It seems reasonable to suggest that professional supervisors across a range of disciplines would have access to consultations with psychoanalytic and systemic therapists so that they can have a theoretical compass dealing with the stuck cases on their supervisees caseload. However it may be that the supervision is itself implicated in the professional system and may require further intervention or discussion with a psychoanalytic or systemic practitioner to consider in detail the task that may lie ahead for the clinician.

TRAPS: IMPLICATIONS FOR PRACTICE

The traps are potentially useful ways of conceptualizing the difficulty the clinician faces in gaining a sense of manoeuvrability. The benevolence traps make it clear that clinicians are heavily invested in their work and want to make a positive difference to the families they

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meet. Institutionally this is important and valuable, indeed the positive motivation of staff is something managers often wish they could encourage. At the same time it does make people vulnerable when they are not able to see this benevolence as part of a wider picture and to see it as something that will potentially be used in a negative fashion. Child psychotherapists have a particular training involving personal analysis that should make the recognition of this easier to report in supervision and easier to monitor in practice. Indeed a large part of a child psychotherapist's work may be tolerating an intense negative transference for some time, all the time drawing the child's awareness to the fact that other more positive ways of relating are available in the room. Out of the individual setting things are more complex and there are more opportunities to be caught off guard. Good clinical governance at this time would involve adequate supervision to the needs of the case (not set or rationed supervision) and an open collegial network of consultation with other professionals in the service, including consultation with child psychotherapists and systemic therapists.

The traps also highlight the need for discussion and multi-agency co-operation in relation to training, child protection, supervision and consultation and the priorities given to the parents in these families. The parent trap demonstrates the need for the parents in these cases to be offered an appropriate intervention often alongside taking their child protection concerns seriously.

The loyalty trap highlights the need for a sensitive approach with families where there are anxious attachments. There may be a denial of the rivalry because it is so infantile and concrete but it may accurately describe the emotional poverty and insecurity in some families who are seeking help.

DISCUSSION

IMPLICATIONS OF EMERGING THEORY FOR CHILD PSYCHOTHERAPY IN SCOTLAND

This research has made an important discovery by detailing the way that unconscious/unprocessed communication of an emotional, distressing or action based nature can lead to an experience of stuckness in work with children and families. The research clearly demonstrated that this could be understood from a psychoanalytic frame as communications that were not being processed. Even the clinicians who were aware of this seemed unaware of how to work with this communication in a technical and potentially therapeutic way. This raises an important question about why these cases weren't thought about psychoanalytically, or if they were, why psychoanalytic techniques and ways of working with the communication were not used as a central way of attempting to make progress in the stuck case? The NHS in Scotland is trying to ensure that core skills are available in CAMHS and managers are beginning to think about service development needs by developing the core skills of their staff. Recognizing that unconscious communication is at play could be argued to be one of those skills but with so few Child Psychotherapists in the NHS in Scotland (18 in 2009) then who will argue for this to be a core skill? It is impossible for clinicians who do not recognize unconscious communication to ask for training and supervision in order to work with it. In this study it is clear that although some practitioners were aware of the communication and a few even tried to have a conversation about it with parents, none of them were working with the transference type communication in a thorough way through detailed observation, supervision and using the concept of containment and working through. This suggests that there needs to be a development of psychoanalytic skills in CAMHS, certainly in Scotland and perhaps throughout the UK. On another level it raises questions for the Child Psychotherapists who do work in CAMHS in relation to how they make awareness of psychoanalytic thinking and approaches more widely available and accessible to

DISCUSSION

practitioners who are not psychotherapists but who would benefit from a psychoanalytic perspective? It is a difficult balance for child psychotherapists to know whether to spend their time trying to provide treatment for children or to focus on supporting and developing the awareness and skills of other CAMHS professionals. I think that this research has drawn attention to the importance of working with colleagues and developing our services in ways that make best use of our time and skills in creating reflective spaces to consider difficult pieces of work. Child psychotherapists have to develop competences in consulting with other staff in relation to stuck cases and recognise that one possible way to provide the right level of support may be to make consultations available to supervisors in other disciplines who may want to use a psychoanalytic understanding to help their own staff recognise warning signs, understand the nature of the traps they are in and to bring about a sense of manoeuvrability to their work.

From the interviews it seems that many clinicians have struggled with cases where intense negative emotions are experienced. It is of course very difficult to survive an intense negative transference that is sustained for a long period of time. It must be much more difficult when the professional background of the clinician does not prepare them to conceptualize their own experiences as a counter-transference and encourage them to work with this in an active way to make sense of the experience and to contain it in a way that allows them to regulate it emotionally and professionally. Working with the concept of transference allows this to be a difficult piece of work that is being managed rather than a case of stress and distress experienced as a threat to a benevolent professional identity. For all of these reasons it is important that all CAMHS services have access to thinking about these issues otherwise the services are putting both their staff and vulnerable families at risk of repeated negative experiences with no progress for the child, despite extreme concerns about their health.

DISCUSSION

While the unconscious/ unprocessed communications could be conceptualized as a transference relationship, it was clear that the systemic viewpoint was as useful in conceptualizing the patterns of what was happening, particularly the idea of a need to create a meta-dialogue and to consider the experience from different points of view. There was of course a limit to the researcher's ability to apply theoretical constructs from the systemic literature and working alongside another researcher with a systemic training may have increased sensitivity in coding material and allowed further categories to emerge. While the psychoanalytic view may give ways to understand the situation and may point to ways of working with the material, the freedom of technical development in the systemic approach offers many different interventions that aim to facilitate reflection and improved communication. It seems to me that these two approaches are drawn together in relation to stuck cases as the stresses and fears and difficult communication that are shared by these families requires a complex combination of flexibility in technique, clear aims, and the ability to observe, receive and understand the communication taking place without being overwhelmed by it. To me this suggests that there needs to be a continued partnership between the different schools of thought for the benefit of clinicians and families. The systemic therapist who does not conceptualize transference relationships, projective identification, re-enactment and containment will struggle to receive the full range of emotional communication and the psychoanalytic therapist who does not use a range of systemic techniques to enable the families to communicate will struggle with getting their message across to the family and struggle to create the best arena to facilitate thought in these cases. Together it is possible to facilitate reflective processes and to begin to contain the complex emotional communications that are taking place.

PSYCHOANALYTIC DEVELOPMENTS

The research has also made an interesting development by describing several patterns in the therapeutic relationships that may be encountered in stuck situations. This points to the possibility of further research into patterns of transference relationship in purely psychoanalytic work. The idea of a Hero may be familiar to most mental health professionals who will be wary of trying to rescue a patient. This research has shown that this can be understood as a pattern in the therapeutic relationship that may precipitate the therapeutic trap. The role of hero may be projected onto the clinician in a such powerful way by a family that it may difficult not to fall into that role. Understanding the patterns to the trap makes a major difference in terms of how to think about what is happening and the need for systemic support for the clinician who may be vulnerable to institutional dynamics as a result of the projections they are attempting to contain. Pandora's box gives us a useful way of thinking about how terrifying the unconscious lives of families may be. The research has uncovered the possibility that that making links may not be experienced as helpful and can lead to experiences of mutual torture in the therapeutic relationship. This draws particular attention to the pattern of relationships that may develop when the clinician wants to open up a reflective space to include material that is terrifying for the system or one person in the system. The concepts of traps and institutional factors are useful as they provide clinicians ways of thinking about the experience, creating a fuller formulation and action plan. Creating room to manoeuvre for the clinician is central but it is also crucial that the clinician is willing to aim for small achievable changes rather than transformations.⁵⁴⁵

⁵⁴⁵ For example this would avoid organizing a series of services for a young person but rather organizing one service and assessing if the young person accesses this before organizing the next intervention.

DISCUSSION

The research also highlights the complexities around the neutral stance in work and how this may not be appropriate as the clinician may have to take action in relation to child protection issues and may also have to take action that is not neutral in order to remove themselves and the family from the stuck situation. This resonates with technical discussions in the work of Alvarez (1985) and Bentovim (1992). The clinician may also have to consider that stopping work with the family or moving toward shared-care/responsibility may be appropriate.

IMPLICATIONS FOR CHILD PROTECTION

A theme that runs throughout the cases is related to child protection and the complex nature of the clinician being unsure of the timing of a referral to child protection services or even the applicability of this. The research has shown a clear link between stuck cases and instances of psychological maltreatment of the child. The professional traps serve to make the clinician less effective in describing and reporting emotional abuse with confidence and provokes professionals' anxiety that they may be implicated in the psychological maltreatment. The toxic breast is a concept that will perhaps be more recognisable to practitioners with cases that do not become involved with services or disengage. The stuck cases are interesting because the parents in these cases do attend for help and are in obvious need of kindness and compassion but may not be able to respond to any intervention in a timely sense in relation to the child's emotional development. In these cases I would suggest that there needs to be a very clear collaborative formulation detailing that concern that the parent has that they are having a detrimental impact on their child and the aim of the intervention is to help to improve this by identifying the child's needs and systematically addressing these. The clinician, supervisor, department and the

DISCUSSION

multiple agencies involved all need to share a competence in recognising, reporting and trialling interventions in cases of psychological maltreatment or emotional abuse. If it is not possible to do this when there is clear evidence of negative parental impact then the practitioner is leaving themselves vulnerable to endless provision of services that will not be utilized, accusations of divided loyalties, and of turning on the family when child protection concerns are finally raised. I am not suggesting that all of these cases have to be referred for child protection proceedings but rather that if the parent identifies a child's needs and then displays an inability to meet the needs, then involving social work services can be seen as necessary to help provide for the children rather than invoking a persecutory agency. Of course many of these families will be hostile and reject the intervention and may turn on the practitioner, but the practitioner will be on firm ground in relation to the initial formulation and will be able to avoid accusations of turning on the family when their intervention didn't work as a way to avoid professional failure.

IMPLICATIONS FOR SERVICES

By describing the warning signs, traps and the professional isolation that can be involved with stuck cases, the research highlights the importance of sharing the formulation and working progress with colleagues who can join in conceptualizing the case as one that generates emotional demands on the practitioners, and then provide appropriate support. In some cases it may be necessary to negotiate the transfer of a case when there is an unremitting negative transference (as in case two) or to be aware of the intense pressure some families bring to clinicians. It is crucial that the professional system recognises that the clinician who tries to help a stuck family does become part of that system and needs to

DISCUSSION

have a professional network that recognises the personal and professional dangers associated with this.

How does a professional system prepare for stuck cases and anticipate that these are a type of cases that will be encountered in a Child and Adolescent Mental Health Service? The research certainly suggests that the multiple agencies involved have to work together to recognise the psychological maltreatment that may be operational in these cases and to recognise the traps that individual clinicians and professional systems can become involved with. These cases require forethought and flexibility and no one clinician should be isolated by the pressure of the case.

Many of these issues can be dealt with by good team functioning at the CAMHS level but there are aspects of the interventions that have to be supported by senior management and in multi-agency forums. It is essential that staff feel they have the appropriate forum to discuss these cases and when necessary to involve others or even have the case re-allocated so that a new clinician can begin with a more robust approach that anticipates the traps that may lie ahead. For good clinical governance managers have to ensure that staff have access to consultations with psychoanalytic psychotherapists and systemic family therapists. At a service level it is important for specialists in different approaches to make their expertise available and accessible in relation to cases. It is possible for psychoanalytic and systemic consultations to improve the effectiveness of other interventions, especially when there is an unconscious or systemic barrier to progress.

The research has identified a range of experiences that can be avoided and worked with if identified. For example, noting the importance of loyalty for children and the need to make a strong relationship without stimulating rivalry with a parent. Child

DISCUSSION

psychotherapists developed some technical ways of doing this where the child worker does not become the case manager but works alongside another professional who works with the parents and attends network meetings. This is not necessary in every case but seems very appropriate in Hero to Zero cases where the child's therapeutic relationship is protected from disputes in the wider system.

Other interventions that combine systemic and psychoanalytic approaches, such as those outlined in the introduction, also seem to be supported by this research. For example, the Screened Child Interview where the family view the psychotherapist interviewing the child, offers a chance to establish the child's perspective, opening up a meta-dialogue about the experience of being in a stuck system, while at the same time stimulating empathy and flexibility of thought. Likewise, the Screened Clinician Interview draws attention specifically and directly to the problem of stuckness itself so that a meta-position can be gained by the family and the clinician together, moving toward more of a shared formulation. While this research was not an investigation into the effectiveness of these techniques, the aims and ideas behind them have been validated as reasonable responses to the nature of stuckness.

REFLECTIONS ON THE RESEARCH PROCESS

The process of researching has been a stimulating and enlightening one. In exploring the range of approaches to grounded theory, the use of 'Constructivist Grounded Theory' felt particularly compatible in relation to psychoanalytic thinking and to the research question in particular. I do think that aspects of grounded theory are routinely part of psychoanalytic practice through process recording and detailed examination of the material.

DISCUSSION

The process of constant comparison and coding has been intensive and rewarding and I feel that it has allowed some very interesting and useful ideas to emerge from the data, many of which were unexpected.

I have had some concerns in presenting the analysis that the interpretation would be too complex and I have worked with many different ways of ordering and sorting the ideas. At one point I had included a section on 'pressurizing factors' which I thought were very useful. After further thought and feedback from supervisors I decided that these were best included in the section on 'warning signs' and on reflection this is more directly useful to clinical practice.

I also had some concerns about how to present the data and tried many different ways of thinking about this. While I could have shortened some of the narratives I felt that each had rich qualities that I did want to report. While they are very detailed, including them in the present form means that every example or development of theory can be traced back to the material in clear detail. I thought this was most appropriate to the method used. Including the narratives along with sample codes in the footnotes also showed the complexity and richness of the material and the vast array of ideas, codes and categories that emerged and of course I have only been able to focus on some of these in detail.

My biggest disappointment in the process has been the failure to include interviews with families as I think this would have been incredibly interesting and useful. Ethically the problems involved with this were too difficult to surmount in this study but I do think it would be worth pursuing this possibility in the future.

DISCUSSION

I have been surprised at the range of suggestions that have emerged for improving clinical practice in relation to stuck cases but I am also aware that the recommendations that are made here are at an early stage. I have already found myself in practice recognising the warning signs and the traps and I think that as these become more familiar in practice it will be possible to make more recommendations with confidence.

DIFFERENT WAYS TO VIEW THE DATA

I think this research project benefited from including both systemic and psychoanalytic literature and ideas. I was aware that I could have gathered the information from the clinicians in a very different format, asking about their formulation and interventions and gathering a range of other details. I feel confident that using intensive interviewing and focusing on the clinician's narratives was the best course for the research and that much of the other information is included in the data in an implicit way in relation to trauma, addiction, and child protection issues. I do think the research would have benefited enormously from the inclusion of families and this would be an area for future research if an ethically suitable way to include them could be found.

It may be that some aspects of stuckness may originate from the clinicians although this was not the case in the cohort of clinicians interviewed for this research. It is possible that less motivated clinicians may have other examples of becoming stuck where they are the active party in creating the stuck dynamic.

Other ways to view the material would be to focus on the attachment styles of the families and the clinicians using the Adult Attachment Interview (George, Kaplan and Main, 1985) and perhaps to include a measure of the child's attachment profile. This approach would

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also require family involvement and the clinicians being interviewed with a particular focus on attachment issues. McCluskey (2005) explores some of these research issues although not explicitly exploring stuckness or impasse. It would be fascinating to explore the real-time therapeutic relationship with these families and clinician and hopefully more research will be possible in the future.

This research did restrict its literature review to systemic and psychoanalytic work in English. It may be that there are other approaches and ways of thinking about stuckness in relation to specific approaches and in treatments of a manualized nature. This may be worthy of further study.

It is also important to note that the researcher is trained in psychoanalytic practice and while he has experience of systemic interventions and practice, he is not a trained systemic therapist. A researcher who came from a purely systemic background may have brought a different sensitivity to the interviews and coding and this may have led to additional ways of conceptualizing the material and to the possibility of different theory emerging.

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

Stuck cases promote thought and innovation, possibly after the fact, with practitioners being somewhat haunted by them even after many years. This research has clearly demonstrated the emotional involvement clinicians from a wide range of backgrounds have with their stuck cases and their willingness to talk and think about them. The cases described were not necessarily more complex clinically than a typical CAMHS case but the experience of being in a care giving situation was confusing/ upsetting/ puzzling or emotionally painful for the clinicians. Analysis of the cases showed that there were good reasons for the stuckness developing. In each case there was at least two levels of functioning and while the first was often straightforward, there was a second level full of unconscious communication or, if it was conscious, the communication was at a level that the clinician could not process. The analysis was able to explore the nature of the complexity by identifying warning signs that can be used by clinicians, teams, managers and supervisors so that clinicians can be well prepared for managing these cases appropriately. Further analysis of the cases showed that the nature of the stuckness had several identifiable patterns that can be conceptualized as traps. Those stuck in the traps lose all ability to act helpfully, in fact the opposite occurs and the clinicians and parents alike may both complain that the child is suffering.

Understanding the range of traps provides clinicians, teams, supervisors and managers an opportunity to protect staff, ensure quality child protection procedures are in place, and ultimately to provide some honest and direct help to children and families in distress by paying attention to the process of the work in addition to the content of the work. It is not suggested that the children and families will always appreciate this way of working but

CONCLUSION AND RECOMMENDATIONS

if the interventions are thoughtful, not blaming and include direct offers of treatment of parental mental health issues then it may be possible to navigate a slow but safe course for the benefit of the child. Preparing for stuck cases and offering families a reflective intervention gives the family freedom to move too by accepting, rejecting or taking time to consider the intervention. The clinician is also given space to be direct in a supportive environment, confident in relation to child protection issues and in the knowledge that they are able to offer meaningful help to families.

RECOMMENDATIONS

FOR CHILD PSYCHOTHERAPISTS:

- Child psychotherapist should re-considering the balance of their work between treating children and families and making their skills and way of thinking available to the wider professional group.
- Child Psychotherapists should reflect on their own training and practice when working with families and to question whether developments in technique originating from systemic practice may be of benefit to children and families, particularly in stuck situations.
- Child Psychotherapists may need to re-visit the neutral stance and how it may complicate or thwart good practice in cases where there is psychological maltreatment. This is not only about the practice of psychotherapy but with the understanding that other professionals may seek consultations for stuck cases and that neutral stance may be implicitly influencing their work.

CONCLUSION AND RECOMMENDATIONS

FOR SERVICE MANAGERS:

- Discussion is necessary about the treatment of adults with mental health problems/trauma who seek help through child services. The research points to the importance of viewing the adult as part of a system and the need to develop appropriate services, such as parent psychotherapy within CAMHS.

FOR CLINICAL GOVERNANCE:

- Senior supervisors in all professions need to have awareness of unconscious communications and to be able to help identify cases where this is leading to stuck treatments.
- Supervisors from all disciplines need to have knowledge of resources available to help think about stuck cases from within their own field and also with systemic and psychoanalytic consultants.
- Clinicians need avenues for supervision and discussion about the impact cases make on them in addition to supervision on the implementation of a treatment package. This needs to be more than routine service supervision and should include whole team and specialist consultations.
- CAMHS staff and managers need to be confident in recognising the limits of the evidence base, ensure that families are listened to, and have alternative strategies for working with children and families when the initial approach is not compatible with the family or the emerging problem.

CONCLUSION AND RECOMMENDATIONS

FOR PRACTICING CLINICIANS:

- When a clinician feels that a case is becoming stuck then at an early stage the case should be reformulated and should include concerns about unconscious processes, systemic factors, parental factors and the family history of seeking care from services. This formulation should be shared with and agreed by the parents. It should detail any areas of disagreement and different points of view so that these are explicit. It would be useful if the clinician could formulate the case following consultation or in collaboration with a child psychotherapist and systemic family therapist.

FOR CAMHS TEAMS:

- Teams should ensure that they provide thorough training for CAMHS staff in recognising unconscious communication and in ways to manage this. Teams should ensure that there are regular opportunities within the service to share dilemmas and concerns about stuck cases and there is an appropriate skill mix so that this can be done in a way that is informed by psychoanalytic and systemic perspectives.
- Need for clinical teams to be aware of the particular demands stuck cases make on the practitioner and to endeavour to prevent experiences of professional isolation.
- CAMHS clinicians should be encouraged to joint work and find time for joint reflection and supervision with colleagues when complex cases of this kind are encountered. A culture within CAMHS that supports this will improve communication and avoid excesses of isolation and anxiety often experienced by practitioners with a stuck case.

CONCLUSION AND RECOMMENDATIONS

- Each profession has to ensure that practitioners recognise that their approach will not suit all families and sticking with it may actually be harmful. Sticking to theories or techniques or professional beliefs in an intervention despite an increase in the child's distress or symptoms is to be avoided.

FOR CHILD PROTECTION PROCEDURES:

- Sharing information among agencies is important but difficult and sensitive. Practitioners need to be careful that they are sharing a formulation with other agencies in order to come to a mutual understanding, rather than have a dominant formulation that the family does not agree with. If the dominant formulation involves child protection concerns then involving child protection professionals at an early stage is important, so that the dominant formulation can be balanced by other views before going further with it.
- Share multi-agency training and practice in recognising, prioritising and trialling interventions in response to psychological maltreatment and emotional abuse of children. There needs to be a multi-agency recognition that stuck cases may make the process of challenging psychological maltreatment more difficult and confusing in practice, and appropriate support for staff needs to be provided accordingly.

PHASE TWO: CLINICAL EXAMPLES FROM MULTIPLE PERSPECTIVES

PHASE TWO, SECTION A: PARTICIPANTS

Phase two participants were identified from families who were referred by CAMHS staff to a joint child psychotherapy and systemic family sub-clinic for a stated reason of being stuck or having reached an impasse. It was important to look at the research question from different angles, including those of parents and children and not only from the perspective of practitioners.

NUMBER

Over the course of three years 18 families were referred to this clinic. Initially the researcher had aimed to interview six families but this was too ambitious. Four families expressed an interest in the research however only one family opted in with no ethical or clinical complications.

CHARACTERISTICS

The potential families had been referred to a joint Child Psychotherapy and Systemic Family Therapy Sub-Clinic for the specific reason of being stuck and the referring clinician had sought additional help from colleagues in a CAMHS setting. In particular they were

APPENDIX 1: METHOD FOR INVOLVING FAMILIES

seeking both a systemic and psychoanalytic view of the case management and of the child's problems.

All of the parties involved were familiar with the researcher and were familiar with the story of their own case history, including the need for referral for additional help.

MEANS OF HANDLING REFUSALS/ NON RETURNS

Families were sent an opt-in letter. If they did not return the opt-in then one additional approach was made by opt-in letter. Thereafter no further approach was made.

PHASE TWO, SECTION B: APPARATUS/ MATERIALS

The researcher examined the case file for a detailed history to get a sense of the clinical construction of events. Thereafter the researcher created three versions of the narrative (Anderson (2006) describes this as using different lenses) : a long version, a short version, and a children's version. The interview of the family was an intensive interview following the telling of the story using the short version, which took no longer than five minutes. There were a number of reasons for doing this. Firstly it addressed the power balance between professionals who have access to the file and therefore a 'good memory' compared to the family, secondly, it allowed the dominant discourse of the researcher's account to be voiced and therefore challenged or accepted by people who have a direct experience of the situation being researched; and lastly for ethical reasons it located the research in a past history, a story that has already been told, so that it could be reflected on, rather than bringing it into the moment which may be experienced as an opportunity to

APPENDIX 1: METHOD FOR INVOLVING FAMILIES

become stuck again, possibly compromising the therapeutic relationship. This type of interview using stories is discussed by McCormack (2004) in an article entitled ‘Storying stories: a narrative approach to in-depth interview conversations. This research differs from her approach as she returned stories to participants by post and asked them to comment on them. In this research the stories were presented live and acted as a stimulus for further intensive interviewing.

In addition to the story for the families there was a shorter, child friendly version. This was told to the child as part of the wider family interview and allowed the child to put their point of view. The child had the choice to draw, talk or play about the material and this was recorded by the researcher using a combination of process recording and video.

The interview was then analysed using constructivist grounded theory as described by Charmaz (2007).

PHASE TWO, SECTION C: PROCEDURE

INTERVIEWER

The researcher conducted all the interviews. The researcher is a qualified Child and Adolescent Psychotherapist with twenty years of experience working in a child and adolescent mental health setting. He is experienced in clinical interviewing and has extensive training in observation skills and reflexive practice.

Reliability and validity of instruments/ procedures.

APPENDIX 1: METHOD FOR INVOLVING FAMILIES

The use of the constructed stories as a stimulus for the intensive interview allowed for the inclusion of the clinician's viewpoint, the family members' views and the child's view. In addition to this the researcher was reflexive throughout the interview.

DESCRIPTION OF SETTING.

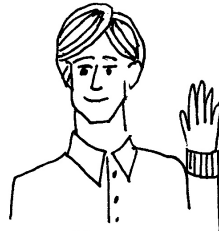
The research was set in a Child and Adolescent Mental Health Clinic in the West of Glasgow. The interview took place in a private clinical room with no telephone and an engaged sign on the door.

DURATION, NUMBER AND TIMING OF SESSION:

The family was seen once only for a session lasting seventy five minutes.

Consent Form

Andrew would like to know what you think about coming to the clinic to seek help.



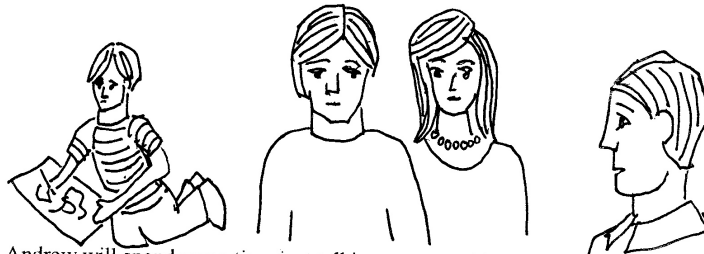
He would like to meet with you and your family to ask what you all think.



He will start by telling you his version of you seeking help. This will be like a short story and you might remember it because it happened to you.



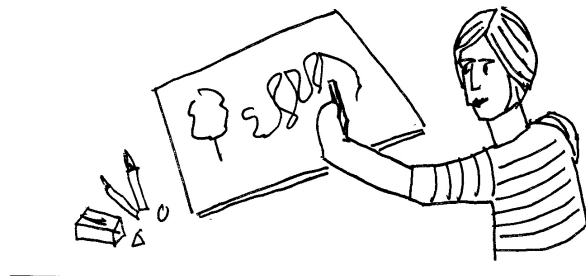
He will mostly be talking to the adults but you can listen, draw or play.



Andrew will spend some time just talking to you, asking you what you think.



You can let him know what you think by talking to him, drawing things, or by playing about it.

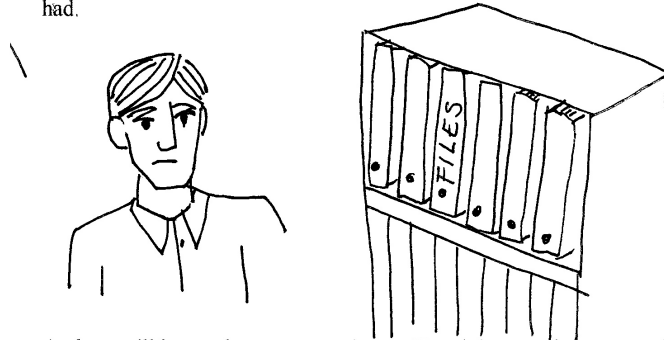


APPENDIX 2: CHILD INFORMATION AND CONSENT FORM

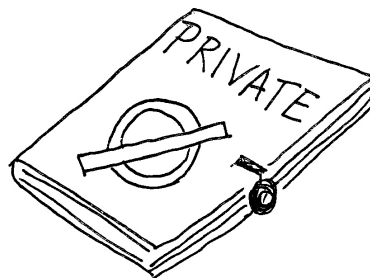
Andrew will videotape the session and will be able to think about it later.



Andrew will use your story along with others to think about how to help other children who have the same difficulties that you and your family had.

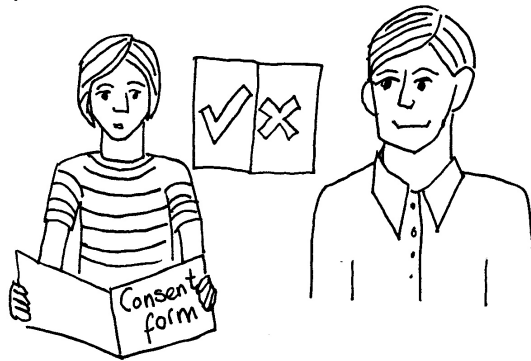


Andrew will keep what you say private. He might use what you say but he will change your name to keep it private.

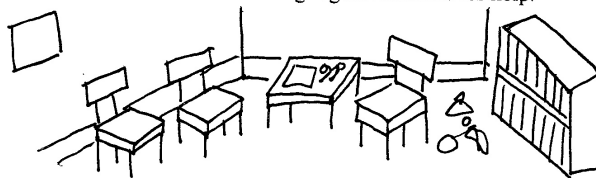


APPENDIX 2: CHILD INFORMATION AND CONSENT FORM

If you do not agree then Andrew will not use your story for his study. That is okay.



This is different from attending regular sessions for help.



Please sign here if you want to take part.

I agree to take part in Andrew's research project.

Signed.....

Date.....

APPENDIX 3: NOTES AND REFLECTIONS ON THE PROCESS OF CODING

NOTES AND REFLECTIONS ON THE PROCESS OF CODING

I coded the data gathered in the study by closely following the methodology outlined by Charmaz (2006). I was also helped to understand the process of coding by a very useful workshop with Janet Anderson when she visited the Scottish Institute.

Coding took place by making notes in a wide margin of a transcript.

These codes were created by studying the material word by word, line by line, episode by episode and study by study. I also paid particular attention to 'in vivo codes' which means that at times I felt the participants were already coding the material and using coded terms in their account. Two examples of this stood out in 'Hero to Zero' and 'Pandora's Box'. Only a small selection of codes is included in the footnotes of the narratives in the findings section. These are intended to be an indication of the range of codes gathered rather than a final coding.

Once the codes were gathered they were transferred onto post-it paper and then, using the walls and floor space of a large room, they were arranged and grouped into focused codes. This means that they were gathered into themes. This was a long process as there turned out to be a vast array of focused codes that seemed useful. Focused coding was a process that allowed me to select a number of codes that made most sense and allowed me to categorise the data. In this way some codes were elevated to categories for further exploration.

APPENDIX 3: NOTES AND REFLECTIONS ON THE PROCESS OF CODING

At this early stage of the coding there was one overarching theme that emerged and this was that there was unconscious or unprocessed communication, with particular reference to the difficulties practitioners had in conceptualizing and working with transference communication and re-enactment. While this did explain the material it was also somewhat pre-mature and led to a one line analysis: all mental health practitioners require training in psychoanalytic and systemic practice. This required me to reflect on my own impact on the material and the coding and this led to further scrutiny of the data. This involved a discussion with my supervisor about reflexive practice, noting the sensitivity that I brought to the data in this area but also allowing other ideas to emerge so that the experience I brought complimented the data rather than dominated it. This process of reflexive review thereafter incorporated into the process by including notes on reflexivity in the memos that were generated.

I then began a process of Axial coding which made it clear that the initial overarching idea of unprocessed communication needed to be re-worked to include sub-categories and allow a fuller description of the properties of the cases to emerge in order to deepen the understanding of the study. Theoretical coding was then used to try to specify the possible relationships between the categories that had developed during the focused coding.

Throughout this process, whenever a substantial organising category emerged as a possibility I would write a memo which detailed my ideas about the category and how it might be used to organise the codes. Early examples of memos were 'Transference not recognised', 'Hero to Zero', 'Pandora's Box', 'Professional By-Standers', 'Pressurising Factors', 'Maps and Environments'.

APPENDIX 3: NOTES AND REFLECTIONS ON THE PROCESS OF CODING

Constant comparison was then used to examine each of the cases in detail in relation to the ideas that were recorded in the memos. This allowed for a process where some ideas were elevated as core categories that held explanatory power, and other ideas that were less useful in relation to their applicability across cases were downgraded. I then completed a range of 'mind maps' in an attempt to display the conceptualisation in a visual form. I have included an example of an early mind map at the end of this section to demonstrate the complexity of the process of organising and re-organising the material as some categories became stronger and others were relegated back to codes (see Illustration 1).

In part, I was guided by my correspondence with supervisors in coming to a final overview. I had wanted to include a category of 'pressurising factors' but after much thought I included the material under 'warning signs'. Likewise, the traps were originally a range of 'traps, ties and toxic environments'. Eventually I simplified this to just 'Traps'. I did this by collecting all the memos in relation to traps, ties and toxic environments, comparing the memos, returning to the cases and then re-writing the 'traps memo' to be sensitive to the codes in the other memos.

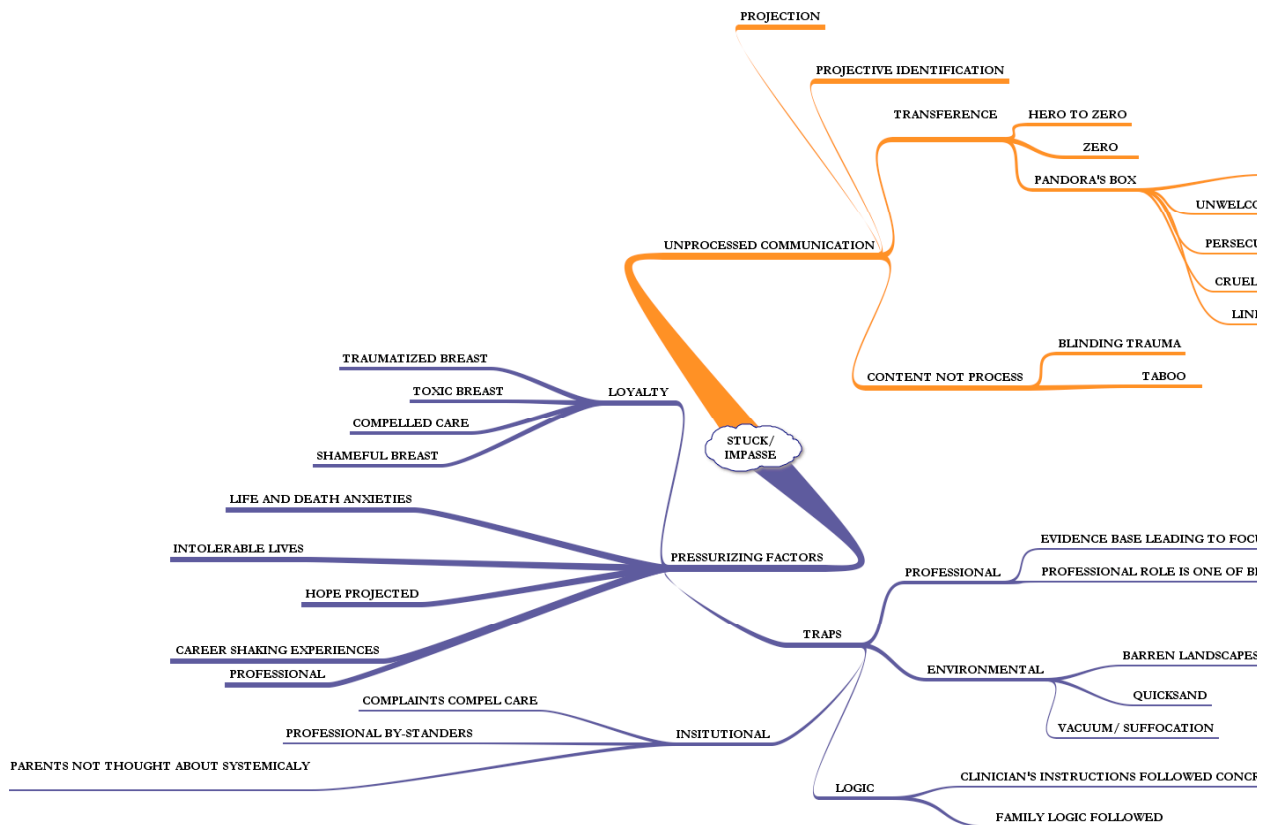
In the end I came to a theoretical view that could be described quite simply as:

- Unconscious/ unprocessed communication
 - Warning Signs
 - Traps

Stuck cases involve unprocessed or unreceived communication. There are a series of warning sign that a case is becoming stuck and a series of experiential traps that professionals, parents and children may find themselves in if the warning signs are not heeded. Each trap may require a different type of response to generate manoeuvrability and freedom.

**APPENDIX 3:
NOTES AND REFLECTIONS ON THE PROCESS OF CODING**

**ILLUSTRATION 1: EARLY MIND MAP INCLUDING INITIAL ATTEMPTS
TO CATEGORISE CODES**



STUCK/ IMPASSE

I. UNPROCESSED COMMUNICATION

A. PROJECTION

B. PROJECTIVE IDENTIFICATION

C. TRANSFERENCE

1. HERO TO ZERO

2. ZERO

**APPENDIX 3:
NOTES AND REFLECTIONS ON THE PROCESS OF CODING**

3. PANDORA'S BOX

- a. **CRUEL TORTURER**
- b. **UNWELCOME LINK**
- c. **LINKING**
- d. **PERSECUTING LINK**
- e. **LINKS AS ATTACKS**

D. CONTENT NOT PROCESS

- 1. **BLINDING TRAUMA**
- 2. **TABOO**

II. PRESSURIZING FACTORS

A. LOYALTY

- 1. **TRAUMATIZED BREAST**
- 2. **TOXIC BREAST**
- 3. **COMPELLED CARE**
- 4. **SHAMEFUL BREAST**

B. TRAPS

- 1. **ENVIRONMENTAL**
 - a. **BARREN LANDSCAPES**
 - b. **QUICKSAND**
 - c. **VACUUM/ SUFFOCATION**
- 2. **LOGIC**
 - a. **CLINICIAN'S INSTRUCTIONS FOLLOWED
CONCRETELY**
 - b. **FAMILY LOGIC FOLLOWED**
- 3. **INSTITUTIONAL**
 - a. **COMPLAINTS COMPEL CARE**

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