SPACES FOR GROWTH

Where milieu therapy and psychotherapy meet

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INTRODUCTION

In this chapter we are going to describe the nature of psychotherapy at the Mulberry Bush School. The Mulberry Bush School was founded in 1948 by Barbara Dockar-Drysdale who had a long and close working relationship with Winnicott; they were strongly influenced by each other's ideas. Originally Dockar-Drysdale worked with evacuee children in the post World War Two period. By living alongside the children she developed a psychoanalytically informed theoretical model of residential therapeutic treatment. In the 1950's these ideas and her ways of implementing them were pioneering and radical. She developed categories of emotional disturbance which were based on the developmental stage at which traumatic interruption had taken place. Children exhibiting the most primitive level of disturbance were called 'frozen children'. Those children with some areas of healthier functioning were described as archipelago children; she also had various categories of false self. All these categories defined different levels of 'unintegration'. Her aim was that children became integrated through the treatment offered by the school. Each category had its own discrete conceptual

framework and treatment model – she had a very rigorous method of assessing children perhaps as rigorous as Anna Freud's Diagnostic profile (1965).

Today the school functions as a non-maintained therapeutic residential school for primary aged children with severe emotional disturbance. Milieu therapy and psychodynamic principles inform the day to day work and most children are here for three years. The aim of milieu therapy is to provide a 'total' social environment in a group living setting, which meets the emotional, social and physical needs of the children. The children go to school on site and the educational provision is strongly weighted towards the social and emotional aspects of learning and is definitely part of the therapeutic milieu. We can take up to 32 children and most are resident for 38 weeks a year. They live in 4 houses on site, each with its own garden. We also offer day placements and weekly boarding. There is a thriving therapy department which includes psychoanalytic child and adolescent psychotherapy, music therapy and dramatherapy.

Dockar-Drysdale's vision of the work of the Mulberry Bush involved what she called 'gap filling' using the idea of 'symbolic experiences' to plan primary provision rather than using individual psychotherapy. She says, "*We have, then, the task of providing primary experience in symbolic form; the task of 'gap filling'*" (1965 : 82). Her view was that these children were functioning at a pre-transference level where they had been '*broken off rather than separated from the mother'* (1968 : 157). She did not believe that

children could make use of traditional individual therapy but rather that all workers needed to be alert to the children's communication at all times of the day. She believed this could only be done with what she described as the 'deep involvement' of the workers in the emotional lives of the children rather than through transference interpretations in psychotherapy (1963). However her belief about psychotherapy for these children needs to be understood in its historical context. In the early days of child psychotherapy the prevailing view held that it was only effective for children living in intact families. Therefore for the staff in her day the direct work with children was exceptionally intense and more a way of life than a job. We wonder if the experience for them was a bit like Winnicott's idea of 'the ordinary devoted mother' (1986).

Dockar Drysdale's ideas were developing at the same time as those of Bowlby and the Robertsons who were the first to research that disturbance in early attachments had profound long term impact on all aspects of a child's development. Today even though the work remains intense the organisation has to balance its focus on the children's specialised needs alongside external preoccupations. The school has found itself under the same pressures as other local authority departments for example having to comply with the requirements of Ofsted and other government initiatives and this has inevitably had some impact on practice. Furthermore therapeutic childcare theory has developed and changed since Dockar Drysdale's time as we learn more about attachment, abuse, neglect and neuroscience to name but a few of many other research developments.

As child psychotherapists working in a residential setting with a long psychodynamic history, we are faced with interesting challenges in thinking about and understanding our role: for example what is a child psychotherapist's role in an environment which aims to understand a child's transference to the school as part of its daily work? Another issue that takes up much of our clinical thinking concerns the technical demands of working with children with histories of severe abuse, neglect and attachment disorders: children who have not managed to function in the community or in foster care and who, by the time they reach us, have had many permanent school exclusions and foster care breakdowns – these children are extremely hard to place. Historically children at the Mulberry Bush School would not have been seen as suitable candidates for psychotherapy because of their tendency to 'act out' rather than be able to think and feel. However developments in technique and the broadening of the profession's understanding of what constitutes psychoanalytic work now means that we find ourselves able to work in innovative ways with these children.

LINKS WITH WINNICOTT

When the school was in its infancy Dockar-Drysdale and Winnicott worked closely together and Winnicott made many referrals. Their collaboration influenced both of their ideas and together they underpin the theoretical model of the school.

So why do we feel we can offer psychotherapy when Dockar-Drysdale did not? Winnicott's 1968 paper 'The Use of an Object and Relating through Identifications'

which he wrote late in their collaboration, states that there is analytic work which can be done with people whom Dockar-Drysdale would have described as ‘unintegrated’ (1980) and therefore unable to make use of the transference. His paper introduces the difference between object relating and object usage and at first glance, this choice of terminology intuitively feels the wrong way round. Winnicott sees object relating as a precursor to object usage: he believes that it is only when someone has achieved the capacity to ‘use’ their object that they can make use of transference interpretations. Winnicott believed that in the very earliest phase of emotional development the object is simply a ‘bundle of projections’ (p103) and therefore in the ‘subject’s omnipotent control’. By this, he means that the object has no separate existence of its own but is simply experienced as within the subject’s internal world. At this stage Winnicott would say that the patient is ‘relating’ to the object. A central tenet of his argument is that for healthy emotional development to take place the real object needs to be able repeatedly to survive attack and not to retaliate in order that the baby / patient can accept that the object belongs to a world of objective reality. This is what he would call object usage. He strongly believed that there is an important role for psychoanalysts in helping the patient to move from the earlier developmental stage (object relating) to object usage, and this is what interests us.

Winnicott understood the implications for technique about these ideas. ‘*In psychoanalytic practice the positive changes that come about in this area can be profound. They do not depend on interpretative work. They depend on the analyst’s*

survival of the attacks, which involves and includes the idea of the absence of a quality change to retaliation…….The analyst feels like interpreting , but this can spoil the process, and for the patient feel like a type of self-defence, the analyst parrying the patient's attack' (p108).

The model of thinking that Winnicott lays out in this paper gives credence to our approach to psychotherapy with the very damaged population of children that come to the Mulberry Bush. The repeated failure of containment (Bion 1962) and affect regulation (Schore 1996) as well as the experience of early and long-term neglect and abuse leave our children with no experience of an object that can survive their existence, let alone their emotional attacks. For this reason, the children we see have not healthily negotiated this developmental phase and the symbolic emotional attacks which Winnicott refers to have become very concrete, for example violence and aggression are key factors for almost all of the children referred to the Mulberry Bush School. The children also attack the staff and what is provided, as well as their therapy in a range of ways and the therapist's capacity to survive without retaliation and to continue to think about and contain the child's communication is vital.

Ongoing research into neuroscience confirms that trauma affects the long term development of neuronal and hormonal networks in the brain. Using neuro-imaging techniques alongside clinical work, neuro-psychiatrist Bruce Perry (2006) confirms physiologically that using language and interpretations might be experienced by the

child as attacking and intrusive which might trigger a fight or flight response. He says (2006:34)

'During therapy or in school, if any emotionally charged content is present, the person's state will shift. If this shift is dramatic enough, the person will essentially be so anxious and regressed that his or her functioning will be 'brainstem-driven'. The individual will think and act in very primitive ways, and therefore will be less accessible to academic or therapeutic interventions using words or therapeutic relationships as the mutative agents of change.
Transference and countertransference are also related to this neurobiological principle. In order to break these inaccurate and false associations, the client must have opportunities for new experiences that will allow the brain either to break false associations or to decrease the overgeneralisation of trauma related associations.'

Perry's work helps us to confirm that we agree with Dockar-Drysdale and many contemporary child psychotherapists that interpreting in the transference is usually not helpful at the beginning of treatment with these types of children, and that comments need to be sensitively considered as well as adaptations in technique. In Dockar-Drysdale's earlier working life, in the 1950s and 60s, child analysis was 5 times a week and anything less was a compromise. The intensity of 5 times a week work would be unbearable for Mulberry Bush and similar children and our profession now understands the potency and potential of once-weekly work which is no longer seen as a poor second choice. Alvarez (1992) has similar ideas when she talks about therapeutic work with borderline children and adults with personality disorder. However, like Winnicott, we do think that individual psychotherapy has a place in facilitating the provision of primary experience – and by that we mean the fundamental work of the school as a whole. Our aim is to support the work in group living and education as it is through these day to day relationships where growth and healing needs to take place.

Like all child psychotherapists irrespective of where they work you could say that using the transference is our main therapeutic tool. The psychoanalytic method protects the boundaries of time and space which in turn facilitates the development of the ability to 'use' an object and the transference relationship – but what do you do if the setting challenges these core principles, how do you adapt your technique and how do you make sense of the adaptations you make – sometimes on the hoof?

One of the ways in which we can think about transference in the school is starting off from the premise that the children form a transference to the organisation as a whole. It is likely, but not always the case, that the child's key worker and teacher become the main transference figures – like the 'therapeutic parental couple' which for most children is the start of negotiating Oedipal issues. More distant figures like their family team member, the nurse and the house manager may also become transference objects...

The children that come to the Mulberry Bush School, and indeed to any such therapeutic children's home or school, usually have long histories of privation, deprivation, abuse and neglect. In the language of Winnicott's (1968) paper, it could be said that, at the crucial point of development upon which the successful negotiation of this phase depends, their objects did not have the capacity to 'survive' their attacks. These detrimental experiences frequently took place pre-verbally during their infancy and have led them to view the world not just with suspicion but also with a primitive

physically imbued expectation of danger, attack, and fear. Their inner worlds tend to be populated by frightening, unpredictable, shocking objects and experiences, which cannot be separated from each other as distinct entities of experience or memory. This is Winnicott's subjective world of object-relating, in which objects remain nothing but a 'bundle of projections'. The trauma inhabits the children's bodies leaving them with an internal muddle of persecution that lives inside them and follows them around throughout their day-to-day lives, interfering with ordinary interactions and distorting potentially positive experiences. Their internal world may then become a space from which they continually seek to escape and they often do so by projecting it outward: many spend their days harshly rejecting warmth and care, verbally and physically attacking others at the slightest internal activation of these persecutory feelings, and putting themselves at risk, thereby giving others the experience of being overwhelmingly confused, terrified, powerless, and yearning for escape.

Anne Horne (2001: 8) discusses the way pre-verbal defences may be formed in children with very early trauma. She suggests that they may centre "on the body itself, its traumatisation and survival". Quoting Parsons (2009:373), she goes on to say that for these children, "emotional states *are* bodily experiences" and talks about how easily they can feel abandoned and annihilated. Glasser (1998) from the Portman Clinic describes these states as arising from the Core Complex. For such traumatised individuals, intimacy is linked with the terror of abandonment leading to what he called self-preservative violence.

Milieu therapy offers children an environment that aims to understand and make sense of their inner muddle, turmoil and pain. It allows children opportunity day-in and day-out to explore their inner world and its impact on their current lives and relationships. But if this were all it did, it would be likely to overwhelm children in a swamp of transference from which they could have no respite. Milieu therapy has other jobs too: it seeks to manage children's feelings on their behalf, to set clear limits and boundaries, to leave room for cooling off times, where the focus is not on feelings, and for building up an alternative internal world based on ordinary experiences and healthier relationships. Milieu therapy, in a different way from individual therapy, tries to 'localise' the transference so that there are times in the day when children can just begin to live their lives. This is no easy task, as the coming together of a group of children with such disturbed and persecuting inner worlds can evoke equally powerful feelings in staff. This kind of milieu is an example of what Winnicott calls a 'facilitating environment', one which can belatedly encourage the maturational process (1968:105) and see children through developmental phases which were stalled or distorted.

It is exactly this 'swamp of transference' that seems to find its voice in therapy for some of these children. Psychotherapy is a potent space for these highly persecuted children; its mere existence seems to act as a concentrated focal point for this swamp-like persecutory inner world. It is as though the four walls of the therapy room concretely represent the claustrophobic space of the children's minds and the therapist becomes

the physical manifestation of the muddle of persecuting relationships – like Winnicott's '*bundle of projections'* (1968:103). This can make it difficult for children to use the space in a traditional sense, as a space to enter and feel the boundaries of its walls and of the therapist herself as a container for the transference to emerge and be explored. Instead, in therapy, children seem to embody the transference. The persecuting voices inside them are projected outwards and come alive to them. In describing adult borderline patients Fonagy (1999) suggests that the transference is experienced as real. He says, "The therapist is the abuser – no as-if about it" (1999:7), a statement that resonates with Winnicott's concept of object relating. Many children are unable to use the space to play freely, to talk, or even to think with the therapist. The therapist, in partnership with residential and school staff, may have to do all the thinking. The availability of this space with a non-retaliatory therapist as a focal point for this sense of persecution, where this feeling that lives inside them all the time can be felt, escaped from, returned to repeatedly, can sometimes free up other relationships to be experienced in a more benign way. It is the therapist's capacity repeatedly to survive the child's attempts at destruction, without retaliating, that Winnicott would suggest is essential to see them through to the more mature phase of development. What he says, in no uncertain terms, is that this destruction is measured by the object's success or failure to survive (1968:110). The therapist therefore has to help the child negotiate a stage of development which has been complicated by earlier failures. This can only be done with the support of residential and school staff, without whom this kind of work cannot be sustained. Good communication with these staff members is essential in

order that joint understanding, rather than splits and enactments, can emerge. Cant (2002) says, “For the child psychotherapist working in such a setting, the traditional model of confidentiality does not apply. Confidentiality is held by the whole staff group, not in isolated pockets within the community’ (2002:270).

NATALIE

We would like to give a clinical example but have struggled with how to preserve confidentiality while still giving necessary background information. We have decided therefore to say something about the kinds of experiences that children who come to the Mulberry Bush School and other such places have had, without giving the particular history of the child in question. Natalie, who we are going to talk about, came from an environment of the most chaotic and perverse kind, which involved much moving around and a great deal of lying to authorities. This example is not intended to give a full picture of her psychotherapy or even an important moment in it. Instead, we hope to convey through her something about how the utter chaos and confusion gets right into the work with these children. This is representative of a great many children at the school.

Natalie was 10 years old and presented classically as a child with a disorganised attachment (Main & Solomon 1986). In her sessions, she was the whirlwind that one would expect, powerfully enacting, among other things, the bewildering sense of constant change and instability that would have been so incomprehensible to her as an infant. But it was her relationship, physical and emotional, to the therapist and the

room, which, for the purposes of this paper, we want to draw attention. Here is an extract from a session that illustrates this issue. This short vignette gives the flavour of most of her twice-weekly sessions, which were interspersed with short periods of play and very occasional direct and painful communication.

> The therapist could see her approach from the school building as she arrived at the therapy room with her residential worker, Becky. She walked jerkily and jumpily and her high-pitched anxiety-filled voice could be heard from some distance. The therapist immediately felt her own anxiety levels rise. Becky held Natalie's hand firmly, and the therapist could also see anxiety in Becky's face. Becky determinedly did not engage with the rising manic quality in Natalie's voice, instead keeping the focus on her approach to the therapy room. We had spent much time as a team thinking together about what therapy meant to Natalie and how she was using it, and Becky, while remaining a containing presence, was now resisting the temptation to set down too firm limits or to shut down communication, which might have led Natalie to take flight from therapy before she and her therapist could even make contact. Natalie sneered as she came in the room and without a moment's pause said, "what are you looking at?" and then she made some high-pitched screeching noises. She went in and out of the room a few times complaining each time – "who do you think you are, sitting there like that?", for example, and then came in and shut the door. She went straight to the window and began to say that she would climb out and stuck one leg out of the window, which was as much as would fit. The therapist thought about her own sense of feeling trapped: whether she spoke or was silent it was experienced in the same persecuted way by Natalie and the therapist was left filled up with Natalie's anxiety but it felt impossible to offer her relief and left the therapist wanting to escape. The therapist suggested as lightly as possible that there might be a 'one foot in, one foot out kind of trapped feeling' that made it hard to feel anything else which, only briefly, lowered the pitch of the session.

It felt as though, by the time Natalie had crossed the threshold of the room, something powerful and internally driven had been activated inside her, which left her feeling highly anxious and intensely persecuted. From a moment long before she actually entered the therapy room, the therapist had become nothing but a projection of Natalie's internal world and nothing could be said or done to help Natalie understand this as a

transference experience rather than a real life experience. This is the 'swamp of transference' and the therapist had become Winnicott's '*bundle of projections'* (1968:103). Hannah Segal (1957) helps us to understand this when she talks about symbols and symbolic equations. About symbolic equations, she says, "the symbol-substitute is felt to *be* the original object" whereas the symbol proper is "felt to *represent* the object." (1957:395) For Natalie, her therapist did not represent her internal objects, she became them. It was as if she was bringing to the therapy room a kind of pre-verbal merged state that she needed someone else to experience with her, without retaliating or dragging her deeper into the swamp. Surviving her attacks was not always an easy task. In fact, she was extremely adept at showing how unbearable her own mind was to her. Natalie's emotionally destructive behaviour could be described in Winnicott's terms as her attempt to place the therapist outside the area of her omnipotent control 'Without *the experience of maximum destructiveness (object not protected) the subject never places the analyst outside and therefore can never do more than experience a kind of self analysis, using the analyst as a projection of a part of the self'.* (1968:107). In order not to retaliate the therapist had to actively and repeatedly take note of what could feel unbearable: her yearning to escape the therapy room, moments of relief when Natalie left the therapy room, and anxiety on her return. This was so important because it helped the therapist to understand how it felt for Natalie to live with her own mind – except Natalie had no respite from it.

Many times, when doing this kind of work, we have questioned its value and even its ethicality: why, would we continue to torment this child with such a persecuting and painful experience? Is this child, in an environment with firm rules and boundaries, simply feeling coerced to come to sessions when, in another setting, she may have voted with her feet? However, aside from the obvious counter-transference understanding of these questions, we have gradually come to another understanding of what role this kind of therapy can have for a child: for Natalie, it offered her some relief just to have the freedom to experience the therapist and relate to her through this persecuted and paranoid lens that tinted her everyday life and made ordinary interactions a Herculean task. To have someone else fully experience it alongside her, without retaliation, seemed to help her begin safely to enjoy the benign and restorative parental preoccupation and primary care that residential staff were offering.

Her attempts to escape her internal world by coming in and out of the therapy room communicated much about her inner turmoil and about the fragmented experience of her early life. It did not matter whether or not she was in the therapy room during her session time as the boundaries of the physical space had little meaning to her. The development of Natalie's ability to 'use her object' was in part dependent on the therapist's capacity to survive her attacks whether Natalie was physically present in the room or charging around the community in a chaotic state. The acute feelings of anxiety, powerlessness and other feelings raised during her flights from therapy carried as much meaning as those aroused when she remained in the room. The location of

the therapy room, central in the community but at the same time separate from its daily workings, enables the possibility of being attuned and connected to a child as well as helpfully separate.

Sometimes when Natalie and her therapist would cross paths around the community outside of her therapy time, Natalie would actively try to engage her as an advocate. This usually happened when residential staff had become so inextricably filled up with her persecutory projections that helpful communication between them had become impossible. Both Winnicott and Dockar-Drysdale talk about children deprived and traumatised at the earliest stages of life as living under threat of total annihilation and this gives a picture of how Natalie experienced every day life.

We have no doubt that Natalie will remain vulnerable and fragile but she did begin to speak, briefly and cautiously, with residential staff about fleeting memories of people and events from her past. She stopped using, for example, graphically sexual language around the school, as if saving it all up for her sessions where it flowed freely. She seemed to be beginning to separate her internal world from external reality. This move toward integration appeared to make current relationships feel that little bit safer and less threatening to her capacity to survive. Children like Natalie seem unconsciously to know that psychotherapy is the place where these powerful projections can have free reign.

OLLIE

Ollie aged 8 was a child who had moved on from the kind of state that Natalie was in. He was hovering somewhere between object relating and object using where it slowly became possible to start cautiously verbalising the transference. When Ollie first came to the Mulberry Bush, he was ‘unintegrated’ like Natalie, but after about a year by the time he started psychotherapy, it was possible to see the therapeutic effects that the milieu had had on him. There were islands of functioning and perhaps Dockar-Drysdale might have called him an archipelago child. However, there was a missing link in connecting these islands which is what this clinical example describes.

‘Being covered by the crushed bones of dead people’ was how Ollie, aged 8, first began to talk about his father’s death. In his play, the car, which represented Ollie was covered with play doh. He said the crushed bones had swamped the car so it couldn’t see where it was going and it only had a tiny hole through which it could breathe.

Ollie’s father hanged himself in the doorway to Ollie’s bedroom a few weeks before his 4th birthday. Ollie came out of the bathroom to find his father hanging, and from his twice-weekly therapy we strongly suspect that Ollie touched his father who was still warm, and that this threw him into total panic and confusion. In the assessment sessions he added hot water to an area in the sand tray and kept comparing the warm and the cold sand, wanting the therapist to touch it and to agree that it felt different whilst asking ‘but why is it like that?’

In order to set this example in context, it is necessary to explain how the therapist became acutely aware of the impact on Ollie of seeing his father's hanging body and how the sudden and brutal end of his father's life was played out repeatedly at the end of sessions. Due to the severe levels of trauma which some children at the school have experienced, it can sometimes take longer than usual to gather up and process countertransference feelings about what is happening, and Ollie's therapist felt at the start of their work that this was the case and that she lagged behind him. It was not until she caught up with him emotionally that she could put some of her countertransference into words and Ollie could start to 'use' her in the way that Winnicott described. At school children are escorted to and from therapy by an adult, even if they only have to cross a corridor they are still escorted so that they have a reliable adult's emotional support. For Ollie's first fifteen sessions an escort only collected him eight times. When the escort failed to arrive he would get himself back to class or house, usually with the therapist trailing on behind watching what was happening. En route he would often muck around, be loud, disrupt other child and generally make his feelings known. It looked as if he felt dropped, unwanted and unloved. You would think that his therapist might have noticed the absence of the escort and done something about it, and in a way she did register what was happening but because the endings of his sessions were so sudden it all got very muddled and in retrospect the therapist realised that she was not able to think at all clearly.

What often happened was that Ollie would leave the room a few minutes before the end. Sometimes he would leave almost without the therapist noticing, one second he was playing and the next he was gone. On other occasions it felt as if it his leaving was in slow motion, like they were in a film moving slowly and getting nowhere, except that when the therapist realised what had happened it was too late and Ollie was out of the room. At other times she was shocked by the violence which seemed to come out of no where and the devastation he left behind in the room. For example all of a sudden Ollie would fling a bucket of sand and water over her, kick, thump and run out, or he would tip the water tray all over the floor. In themselves these events, whilst not pleasant are not unusual at the school, but for his therapist they shocked her every time and she experienced them as coming right out of the blue with no warning. At the time the therapist was probably experienced by Ollie as part of his projected internal world and this might account for why she could not get hold of the meaning of how the sessions ended. Winnicott (1968) writes ' …..*the object, if it is to be used, must necessarily be real in the sense of being part of shared reality*……' (1968:103).

On session 16 Ollie refused to come saying it was 'no fun' and his therapist had heard from the house that he was urinating on electric sockets. The next session he sat outside the therapy area on a nearby picnic bench saying that he would only come to therapy if they could go to the garden of his house, (that was about a 30 second walk from the therapy room). We increasingly understand that psychoanalytic psychotherapy in a residential setting sometimes means having to work in odd places – unconventional

places which take us to the limit. After a while of Ollie's key worker and therapist trying to negotiate him into the room, they decided to go to his garden while his keyworker watched from the house. It is difficult to say exactly why the therapist went along with his request but Ollie did say he wanted to show her something. In the garden he demonstrated his football skills then he climbed a tree and sat there for quite a while. The therapist felt she had lost him and was beginning to regret her decision. However he did come down and started to play with the swings, twirling them around and letting them unwind. This developed into a game where he pushed the 4 swings in sequence so that they were all at different levels and the aim of the game was to walk though the swings with his eyes shut and not to get hit by them. As soon as this started his therapist felt a sinking feeling inside and realised that he was graphically showing her what it must have been like to see his father hanging directly in front of him and what an unbelievably terrifying shock it had been. In displacement she talked with him about the shock of having something heavy hit him, with a massive force right out of the blue, and the more she talked the more he elaborated the game until she was able to say that she thought he had brought her to the garden today because he needed her to know that he knew exactly what that felt like. The therapist was deeply affected and she was shaking inside. Ollie let her approach him and stop the swings. The next session was where this account started – with 'the crushed bones of dead people', and Ollie for the first time was able to bring his dead father into the room and the therapist was able to respond. Winnicott says *'The development of a capacity to use an object is another example of the maturational process as something which depends on a facilitating*

environment' (1968:105). Our understanding of Ollie's emotional development connects with this quote. At the start of therapy Ollie was 'relating' to his therapist and she was experiencing his internal world alongside him. The session in the garden 'facilitated the maturational process' allowing Ollie to place the therapist outside of his projections so that the swings took on the symbolic expression of his dead father. In this way Ollie was able to 'use' the therapist. The experience in the garden really helped us understand, that the way Ollie ended the early sessions were an unconscious re-enactment of his experience of his father's suicide.

After this session in the garden there was a treatment team meeting which includes the key worker, teacher, family team worker and therapist where his therapist shared her thoughts and from then on Ollie was routinely collected on time. His key worker said that she had also experienced something similar with Ollie in the house, but that she had not really been aware of it until this meeting – perhaps an institutional re-enactment of abandonment? It was interesting that a few days later when he next spoke to his foster carers he told his foster father for the first time that his dad had hanged himself. Ollie was consolidating the move from object relating to object usage.

This was the only session they had outside of the therapy room although like many children having therapy in the school and in plenty of other settings, they sometimes spent time in the corridor and on the threshold of the therapy room. After the experience in the garden Ollie's therapist felt she could see things much clearer and

with her improved understanding of what he was trying to say the work took off at a pace.

A couple of months later Ollie was playing at the sink with a toy skateboard and asked about his therapist's wedding ring and about other children she was seeing. He said he liked walking past her office seeing her working on her laptop and likened her to a 'penguin at the zoo', but he did not like it when he saw the light on in the therapy room as he did not know with whom she was playing and what they were doing. Very aware that this was the first time he had dipped into the murky waters of the transference she asked what he thought they might be doing, and he replied saying that the skateboard had turned into a baby and was sinking. His therapist said that perhaps when he could not see her, and he thought she was playing with someone else, it gave him a sinking feeling. This was the first time that Ollie had verbalised anything about his feelings towards her in this way, and in response the first time she had felt able to explore it further.

Adam Phillips (1988) writes '*To be used, in Winnicott's sense, the object must be real; and the capacity to use objects is not an automatic development but depends, absolutely, on a facilitating object'*. In his paper Winnicott urges therapists to *'wait and wait for the natural evolution of the transference…..'* (1968:101) and Ollie's transference was voiced when he was ready.

During the year after his father's suicide Ollie was taken into care and following a number of placement breakdowns he moved into a new foster home and started at the Mulberry Bush. So before his therapy started Ollie had experienced a year where his foster carers and school staff had repeatedly survived many verbal and physical attacks yet did not retaliate and in the early sessions his therapist had also survived his high levels of aggression and violence. In the garden session she had become a 'facilitating object' for Ollie, able to attune to his symbolic communication. In previous weeks, the way he left the therapy room unconsciously set the scene for what he was trying to show her and by trusting her countertransference she enabled him to 'tell' her the rest. Verbalising to Ollie about the 'heavy thing hitting him right out of the blue' was the beginning of things being brought together for him. Ollie needed his therapist to understand what had happened in relation to his father's suicide. He had repeatedly and unconsciously re-enacted it in the way he left the early sessions but needed her to witness something directly.

In the intervening months between the garden session and the first transference session, Ollie had made significant progress – especially in his developing ability to talk to his teacher and staff in his house, about his father's death. Making sense of what had happened in an ordinary way meant that he was developing ego strengths. He was then able to 'use' his therapist and see their relationship in a slightly different light. Gradually he was able to tolerate and make use of her transference comments as he no longer felt merged with her, but was able to see her as a separate person – someone who had

relationships inside and outside of the school*. Winnicott would say he moved from object relating to object usage.* We might take this further and suggest that the therapist as a facilitating object acts as a bridge between object relating and object usage. Looking at the therapy in the context of the whole school we could think of Ollie's therapy as a catalyst, facilitating the work to take place in the 'milieu' of house and class, with people who were safe enough to receive it. The therapist acted not just as a facilitating object enabling the transference in therapy to evolve but also as a facilitating object for his relationships across the school and beyond.

Conclusion

So what have we attempted to say about 'spaces for growth' in this chapter? Dockar-Drysdale would have said that the spaces for growth for these children can be found primarily within day-to-day relationships, which themselves have space to develop within the facilitating environment of milieu therapy. She would have said that individual psychotherapy, with its emphasis on transference interpretations, could be of little use to these children who lacked the capacity to symbolise. In fact, in 1965:82 Dockar-Drysdale wrote, "emotionally deprived people … leave out the 'as if' . Our experience echoes the idea that the children we work with seem to be missing this 'as-if' capacity. They interact with those around them in a way largely informed by their internal worlds, with little possibility of separating this view of their relationships from reality.

In this chapter we have discussed current psychoanalytic concepts which have brought Winnicott's ideas into a contemporary framework linking together trauma, violence and bodily defences. With Natalie and Ollie, we can see such defences in action: Natalie's one-leg-in-and-one-leg-out way of relating vividly embodied her emotional experience of chaos, loss, and unintegration; Ollie's physical experience of his father's death, 'being hit by something heavy', needed an equally bodily expression in order to make it heard and understood. It could be said that without using their bodies they simply could not communicate their feelings. Inevitably, this work will be a struggle for children who have become so skilled at using their bodies to escape difficult feelings.

The Mulberry Bush does its best work for children when we all work together to understand how every aspect of the milieu plays its own equally important part in making sense of a child's inner world and helping him with it. It is the milieu itself, including psychotherapy, that we believe provides the possibility of change and growth. We enter into the work we do in the spirit of respect for every component of the milieu. Together, our aim is to help the children reach a stage in which they can enter the turbulence of adolescence with a little more ego strength.

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