Potential Space: Knowing and Not Knowing in the Treatment of Traumatized Children and Young People

Yael Lesser

Dr. Yael Lesser, a psychiatric social worker, was a member of staff in the Child and Youth Psychiatric Unit at Sheba Medical Centre, Israel (1979–2001). She is a psychoanalytic psychotherapist in private practice, teaching and supervising graduate social workers in their clinical studies, in the School of Social Work, Bar Ilan University.

Correspondence to Yael Lesser, School of Social Work, Bar Ilan University, Ramat Gan 52900, Israel. E-mail: lessery@mail.biu.ac.il

Summary

This paper illustrates some contributions of psychoanalytically based thinking in social work practice with children and youth removed from their homes due to severe maltreatment or incapacity of parents. It is suggested that when working with severely deprived and traumatized children, the therapist should hold in mind the lacking of rapport with primary caretakers, and the need of the child to form meaningful and intimate relations in his or her future life. Psychoanalytically based thinking enriches the treatment process by offering new ways for understanding of the patient’s needs, aiming to reach the child’s subjective experience and re-establishing his sense of self and a meaningful rapport with an other. The concept of ‘potential space’ and the area of experience (Winnicott, 1953/1975) will be described with elaboration on its variety and use in theory and practice, focusing on two major themes: the dialectics of knowing and not knowing, and the search for selected material. A clinical illustration is presented to show these dynamics as they appear in the clinical process and the therapeutic session. The material was selected from supervision of graduate social work students involved in therapeutic work with children.

Keywords: potential space, traumatized child, knowing, subjective experience

Introduction

The ideas presented in this paper have evolved throughout a decade of teaching and supervising graduate social workers in their studies for a Masters degree in the clinical programme, in the School of Social Work of Bar Ilan University.
All students are practitioners working in treatment/therapeutic contexts, Child and Adolescent Mental Health settings and multidisciplinary teams. The ‘Child and Youth’ seminar (part of the clinical programme) offers developmental and clinical psychoanalytic theories, accompanied and supported with group supervision. The supervision sessions are purposefully designed as a space for exploring therapeutic interactions and processes. The students present cases of their choice with a description of the child’s background and a detailed verbatim account of a session. Students are encouraged to reflect on and share their feelings and understanding of the dialogue and the way they experience the child and her communications. This temporary refuge from other responsibilities facilitates the students in reaching the child’s inner world and becoming in touch with her subjective experience. Most of the students in the ‘Child and Youth’ seminar work in therapeutic or educational residential facilities for children and adolescents who are removed from their homes due to severe parental maltreatment, or the parents’ inability to care for the child. I will describe in some detail the special difficulties that arise in working with traumatized children and young people.

**Social work in statutory child-care settings and the problem of assessment**

Statutory residential facilities for children and youth differ in their structure and orientation. Some facilities have gradually evolved into a therapeutic milieu with a clear commitment to a psychodynamic orientation with ongoing psychoanalytic consultancy. In others (as in the clinical illustration below), educational and social adjustment is the main objective and social workers who offer individual treatment to some of the children are usually the sole representatives of therapeutic capacity. Assessment of the child is carried out by a multidisciplinary committee, and focuses on the context of the removal from home (i.e. the child’s safety and functioning, the family background and events that brought about the decision for displacement). Alvarez holds that the notion of trauma assumes some degree of ‘pre-trauma’ healthy development. However, abuse in its various forms does not ‘pop up’ at one point in time; rather, it is usually a continuation of inability to provide for the child over a number of years. It follows that an assessment should include considerations of damage to developmental processes, memory, cognition, learning and in fact the whole personality (Alvarez, 1992, p. 152).

It seems then that there are two ways of understanding the child’s situation. One way is based on what we know and governed by immediacy of needs. The other way would be based on thinking about early experiences of the past and possible developments in the future, of what is yet unknown. Although traumatic events are observed and reported, the subtleties and nuances of early emotional deprivation emerge gradually, and can be fully grasped only within and during a therapeutic process. These silent nuances and communications bear heavily upon the social worker who is in direct contact with the child, activating intense emotions...
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and fantasies. Aspirations for becoming a more skilled and sensitive therapist emerge from workers treating severely traumatized population with multiple environmental and developmental deficits. The following material illustrates the psychoanalytic view of the difficulties encountered in the treatment process.

**Psychotherapy in child-care settings from a psychoanalytic orientation**

Although psychoanalytic thinking has been part of traditional social work, issues of transference have been subtly and continuously bypassed, in spite of the cardinal importance placed on transference–counter transference phenomena in the process of change or cure (Brandell, 2004, p. 81). Clinical writings and psychiatric research (Marry and Andrews, 1994; Cohen, 1988; Dockar-Drysdale, 1990; Alvarez, 1992, 2000; Fonagy, 2001; Cohler and Friedman, 2004) suggest that prolonged nourishing psychotherapy, with special attention paid to understanding the child’s self-experience, is the treatment of choice for traumatized children for resuming full life in society. Hence, looking into the dynamics of the therapeutic process is essential. In writing about psychoanalytic-oriented supervision for workers who are not psychoanalytically trained, Martindale (1997) stresses the importance of understanding transference–counter transference phenomena:

> If counter transference reactions are not able to be made conscious and reflected upon, there can be many forms of harmful enactments or verbal communications to patients or avoidance of emotional contact with them and their problems. The more disturbed the patient, the more likely are disturbing counter transferences and the more vulnerable is the patient to these reactions by staff (p. xx).

Encounters with harmed and traumatized children intensify counter transference reactions, and the therapist’s capacity to be aware and work through her own feelings is a key factor in enabling such work (Chethic, 1989; Dockar-Drysdale, 1990; Hurry, 1998; Alvarez, 2000; Horne, 2001; Sprince, 2002). Children referred to welfare agencies often carry with them an aura of emergency if not drama—a result of trauma, abuse or severe neglect. Psychoanalytic conceptualization and technique may at first appear far removed from this type of urgency. While psychoanalytic evaluation and treatment require a long time span, in child welfare services, there is often pressure for immediate solutions. The psychoanalytic approach aims at reaching the inner unconscious world; yet the child’s environmental conditions supply ample testimony of concrete painful events and inadequate caretakers. This environmental burden might obscure or taint the possibility of being in touch with the child’s subjective experience. For example, many workers find it difficult to accept empathically the child’s ongoing love for an abusive parent. The traumatized child evokes strong feelings in people involved in her situation, with the natural emotional response being the need to rescue and protect the child (Cohen, 1988; Sprince, 2002). In some
cases, however, the very nature of the child’s rapport with her primary objects is already damaged. The capacity for having normal and satisfying object relations has either not developed or otherwise has been altered or malformed (Dockar-Drysdale, 1990; Alvarez, 1992, 2000). Hence, the child can not ‘use the goods’ offered by a benevolent setting and the provisions of the new environment are not sufficient. The child has to be helped through some developmental process. This may include the working through of a trauma, enduring grief and loss, containing the child’s anger and hate (Sprince, 2002) or overcoming tormenting and unthinkable anxieties (Dockar-Drysdale, 1990). No less important is the need to re-establish and internalize an object that is based on trust (Alvarez, 2000, p. 16; Daniel, 2000, p. 194), which will enable the child to develop meaningful and loving relations in the future. Furthermore, if the child does not respond to a devoted therapeutic investment, the inexperienced therapist or caretaker may become confused, flustered or even retaliating. Cohen (1988) suggests that premature termination of treatment or removal of the child to another facility (assuming treatment options have been exhausted) is, in many cases, a result of overlooking the special intricate projective identifications and counter transference responses of the staff.

When moving to a psychoanalytic orientation, the focus of attention gradually changes from ‘welfare’ to ‘well-being’, from actual events such as problematic behaviour and possible solutions, to the area of emotions and experiences not yet coherent to either patient or therapist. Being in touch with unclear material, stripped of facts that compose a tangible ‘story’, requires a transition from purposefulness to reflection. In this context, psychoanalytically based thinking and supervision offers the therapist a frame of mind to think about the child and his rapport with the world—a place to dwell and experience his own feelings and needs (Cohen, 1988; Dockar-Drysdale, 1990), to tolerate and contain projections and behaviours of the child, which are at times hateful or destructive, gradually enabling a different experience. A special ‘space’ has to be formed and allotted for the therapist to enable the process of internalization of this new orientation and for becoming tolerant, aware and reflective (Sedlak, 1997; Miehls and Moffatt, 2000). I have found Winnicott’s concept of Potential Space (or the absence of space) helpful to describe the emergence of this therapeutic presence.

**The concept of potential space**

In his paper, ‘Transitional Objects and Transitional Phenomena’, Winnicott set down his hypothesis describing how the developmental area of experience precedes and continues to exist next to emotions and cognition (Winnicott, 1953/1975, p. 230). The broader concept of potential space (Winnicott, 1967/1989) was chosen to define a ‘place’ that has no physical attributes, or a specific location. Winnicott suggests a third area of experience in addition to the inner psychic reality of the person and the actual world that is common property and objectively perceived (Winnicott, 1967/1989, p. 103). I have selected two citations to
summarize some of his ideas regarding potential space, in the hope that these will suffice for further developing my theme:

The place where cultural experience is located is in the potential space between the individual and the environment (originally the object) . . . . For every individual the use of this space is determined by life experiences that take place at the early stages of the individual’s existence (1967/1989, p. 100).

The potential space between baby and mother, between child and family, between individual and society or the world, depends on experience which leads to trust. It can be looked upon as sacred to the individual in that it is here that the individual experiences creative living (1967/1989, p. 103).

According to this concept, we do not live entirely within our inner world, nor totally in an external reality, but rather in some space between them. Once the experience of play, creation and discovery with an other (originally the mother) in trust has taken place, the potential space for the individual becomes an area that hosts the world of symbols, the thinking processes, imagery and storage of ongoing human experiences. It is where needs, aspirations and the ability to create emerge, expressed in the child’s ability to play, transforming later into creative living and reflective capacities (Winnicott, 1967/1989, p. 101). Like some other psychic developments, potential space can better be traced by its absence. When working with children, the lack of space will show in the child’s inability to play. There may be extinction of curiosity, imagination and volition, as the world of fantasy and wishes is impoverished or numb. In an adult, this absence will be reflected (among other phenomena) in difficulty in thinking or mediating, feelings of being ‘attacked’, criticized or invaded by another opinion, or being compelled to act.

Potential space in the clinical setting

Viewing the psychotherapeutic setting as an ‘Ideal Type space’ suggests a second developmental chance offering the patient an encounter with the object/environment in trust. In the process of treatment, this space can become an interpersonal field in which the individual can experience a new object that is considered safe and can gradually relinquish internalized threatening or disappointing objects. If this encounter is to turn out well, we would expect the renewal or emergence of the patient’s inner world—a wider spectrum of emotions, thoughts, desires and, ultimately, hope.

Using the paradigm of potential space in supervision and teaching offers a way to expand the therapeutic capacity of students in their first exposure to psychoanalytic thinking by initiating their sensitivity to transference–counter transference phenomena. The aim of becoming aware and developing such a space, of making room for the new, can bypass defences and ‘injuries’ (Lloyd-Owen, 1997; Sedlak, 1997) of relatively experienced social workers when discovering unknown territory.
Before introducing the clinical material, I would like to describe two main themes that reflect some of the dynamics of potential space phenomena: the dialectics of knowing and not knowing, and the search for selected material. These themes will be further elaborated in the group discussion of the session.

**Knowing, not knowing: the development of an inner dialogue**

Winnicott (1967/1989, p. 100) stressed the variability of potential space that differs from one person to another as a result of early life experiences. It would be interesting to observe fluctuations of this feeling of space and its dependence on a number of conditions. The potential space as a third area, neighbouring the inner psychic on one hand and the objective world on the other, suggests temporary wavering in the degree of freedom one feels vis-à-vis environmental situations or internal positions. The feeling of inner space may grow, for example, in treatment or other forms of emotional learning. Conversely, situations of feeling bewildered, inadequate or not knowing can augment anxiety and reduce the capacity to think or experience.

Lloyd-Owen (1997), who supervised mental health workers with forensic patients, supplies a broad view regarding the problem of knowledge and the understanding of difficult psychosocial problems. She refers to the pressure to ‘know’ as projected onto the worker from a diffuse external atmosphere. Using Melanie Klein’s terminology, she describes society as ‘splitting off’ its responsibility of caring for extremely disadvantaged or deviant populations and mandating some professional group (i.e. social workers) to shoulder the burden by producing ‘miraculous solutions’. The issue of knowing reverberated in writings within the profession as well. Wooton (1959) humorously criticized some definitions of social work practice as verging on omniscience and omnipotence (p. 187). Walker thinks this criticism is relevant to this day and is expressed by an appetite for certainty, apparent clarity and effectiveness of definitive models of practice, inherent in some areas of social work (Walker, 2001, p. 30). In my view, professing accurate evaluations and correct solutions to intractable problems is indeed a position that verges on omniscience and omnipotence. Such a position may mean the denial of helplessness, anxiety and frustration—a denial that is in fact an ‘unconscious collaboration’ with society’s quest for miraculous solutions. It is precisely the ability to allow oneself not to know, or to be at times uncertain, to maintain a tentative or explorative position (Michls and Moffatt, 2000; McBeath and Webb, 2002), that puts such omniscient aspirations in proportion, accepting the reality of deep psychic damage and the slow process that is needed for change.

Eigen (1993) elaborates on different levels of knowing and views omniscience as replacing the ability to feel or experience. Clearly, the therapist knows a great deal about the patient, but if he decides to focus on the gaps, the unclear or bizarre, if he allows himself to be without knowledge, it is this attentive suspension that makes him ready to be used by the patient by way of experience.
Winnicott sees growth or healing as a creative process where the patient is the one who arrives at understanding, and this involves the ability to use the analyst. The knowledge of the therapist is always secondary to what the patient is able to feel and discover. Winnicott (1963/1990) stressed the importance of respecting the privacy of the self (the need of the patient not to communicate) and the analyst’s waiting for the patient to arrive at an interpretation.

The search for selected material

Difficulties in child psychotherapy have been stressed by a number of psychoanalysts (Bick, 1941/1987; Coppolillo, 1987; Chethic, 1989; Hurry, 1998; Alvarez, 1992, 2000). The child does not use verbal communication as his main mode of expression. The therapist has to tolerate long hours of uncertainty, not comprehending the meaning of play or other productions in the session. The child may be chaotic or resisting for extremely long periods (Hurry, 1998). Bick (1941/1987) describes the archaic fears and fantasies of infancy and the need of therapists to rely on their own unconscious processes in enabling this material to emerge. Dockar-Drysdale (1990) writes about the slow process in which the child sheds off the armour of anger, suspicion or numbness, getting in touch with feelings of dependency and neediness. The need to wait for material to evolve and become coherent and meaningful is taxing, and can be threatening for the therapist with a planned purposeful intervention. The therapist may feel inadequate in her ‘not knowing’, or futile in ‘not doing what she should be doing’. The pressure to know, cure or bring about rapid improvements may curtail her otherwise prominent potential space.

Typical difficulties arise when a child or adolescent exhibits destructive behaviour outside the treatment, endangering self or others (Sprince, 2002). Young abused children or those who endured profound deprivation may act violently with peers or caretakers (Dockar-Drysdale, 1990). Escaping from home or from the residence, truancy, vandalism, theft or drug abuse are also common among the adolescent population. Adolescents who were sexually abused may pursue further abusive encounters. Traumatized children carry with them a painful story. This agenda is difficult to put aside and wait for the child to speak about his pain. For some therapists, such waiting equals ‘not caring’—a kind of obliviousness of the child’s problems. It is perhaps this difficulty that propels therapists to pose questions or to try and develop a purposeful conversation, in the hope of preventing future harm. The therapist faces a constant dilemma whether to address himself to the child’s inner psychic or deal with problems occurring in the real world. If, however, transference is not picked up and counter transference is not reflected upon, if deep unknown material does not surface and the therapist awaits specific material, the danger arises of remaining with concrete events without touching on deeper levels that could transcend the actual, expand the scope of communication and intimacy, and provide the child with a new experience with an other.
Alvarez (1992) relates to the necessary pace for working-through of trauma. She describes the piecemeal ‘one step at a time’ work with sexually abused children where the therapist has no way of knowing how fragmented bits of memory have been stored and how these will gradually unfold during treatment. Alvarez writes:

A thought becomes thinkable often by a very slow gradual process, a process that cannot be rushed . . . the ‘remembering’ may involve a million tiny integrations taking place, each one under conditions where other aspects of the abuse, other aspects of integration can afford to be forgotten (p. 153).

Britton (1998) described and distinguished between two interpretive terms that are difficult to identify and differentiate. He referred to a ‘selected fact’ as an intuitive decision of the analyst choosing an interpretation that evolves in the session. A selected fact can assist in defining the current situation and is therefore conducive to the treatment. The term ‘overvalued idea’, on the other hand, stems from a private unconscious belief of the analyst, and as such is likely to impede understanding (p. 97), since it has less to do with the world of the patient. The relevance of this distinction to the treatment of traumatized children is the danger of a complying child accepting the ideas selected by the therapist, without being fully aware of his own thoughts and words that have not yet emerged.

For the child, a ‘not knowing’ position of the therapist may be felt as an empty non-threatening non-assuming container, waiting to accept whatever the child feels in a given situation. For the therapist, expansion of space can mean suspension, experiencing deep emotions without verbal discharge, at times absorbing anger and hostility and thus ‘collecting’ the impact of these interactions into the treatment process.

The ability to relinquish the anticipation of specific data, to wait for material and to make use of not knowing, making room for one’s own inner space, requires that therapists place trust in their professional community (i.e. a community trained along similar therapeutic views), which will show an understanding of the case in question as well as the therapist’s endeavour. In the absence of such trust and support, a residential treatment facility will lose its therapeutic character and become a boarding home for displaced inmates, thus adding to the traumatic impact on the child (Cohen, 1988).

Clinical illustration

The clinical illustration below was selected from group supervision in the seminar. The student, Mrs A., presented a verbatim of a session from the early stages of treatment of Molly, a twelve-and-a-half-year-old girl. The session is given here in detail followed with most of the thoughts that emerged in the group’s discussion. I had the opportunity to review this case in private supervision two years later, when Mrs A. was about to terminate Molly’s treatment as her work in the residence
ended. This brief follow-up is presented with my reflections about the case. My purpose here is to highlight occurrences that limited the therapist’s space due to external pressures and internal processes, the subtle nuances of knowledge versus experience reflected in the verbatim, and the development of the session.

Molly: sexual abuse of a latency girl

When Molly was nine, her uncle raped her. Later, from the ages of nine to twelve, her brother, who was two years older, repeatedly sexually abused her. Molly never spoke about this and kept it as her private secret. At times, she would run away from home for a few days to hide. Her parents were not alarmed on such occasions. They never searched for her or called in the police. When Molly was almost twelve, she told her secret to a friend in class. Upon disclosure, both Molly and her brother were removed from their home. Molly was placed in a full-residence emergency centre for children at risk, where she had complete environmental provisions (day caretakers, instructors, teachers, special school classes) and psychotherapy with Mrs X. twice a week. After seven months she was moved to another residential facility, where she was to continue treatment with Mrs A., and resume classes in a regular school.

Although the parents were perceived by their local social worker as neglectful and oblivious of the child’s suffering and, in Molly’s view, they fully supported the offending brother, Molly continuously protested being in the new residence and repeatedly asked to be sent home. She ran away from the residence several times. When suicidal thoughts emerged in sessions, she was referred for psychiatric evaluation. This evaluation was never completed, as Molly did not communicate with the psychiatrist. She was hospitalized in a psychiatric ward for observation and was released to the residence after a few days.

Mrs A., the current therapist, knew that Molly’s mother resented having the girl back home at that point. It was obvious to all staff concerned that Molly had to stay in residency. Mrs A. found herself repeatedly immersed in arguments in which she tried to convince Molly why she should remain in residential care and treatment. At a certain point, wishing to extricate herself from the argumentative situation, she announced to Molly that she had no authority in regard to her staying or not staying in residence. This statement was not entirely true, but it was difficult at this stage to decide how to handle the issue differently.

The following session took place after Molly had spent a weekend with her parents and was asked by Mrs A to return to the residential facility. The session began with Mrs A. expressing concern for Molly’s feelings.

Verbatim:

Molly (weeping): I don’t want to be here. I want to be at home.

(1) Mrs A. (touching Molly’s hand): I know it’s difficult, I’m trying to understand better what you mean when you say you want to be home.
Molly: But what is there to understand better? I want to be home!

Mrs A.: I think there are also other feelings behind the wish to return home. I want to understand these feelings better.

Molly: I don’t know how to understand it better. I want to return home.

(2) Mrs A.: Sometimes I feel you are at war.

Molly (with a sudden change of mood): At war? You mean with myself?

Mrs A.: It is as if you have two voices inside you: One voice telling you not to become attached to this place, because you fear they might forget all about you at home. This voice urges you to return home and fight for your place. The other voice keeps reminding you that you were not really happy there. You were continuously running away.

Molly: You know by now that I do feel good in the new residence and with the girls too. It’s the school that I dread; I just sit there not understanding a thing.

Mrs A commented on Molly’s ability to differentiate the school from other issues and suggested discussing the school later and continuing now to explore feelings about home.

(3) Molly then drew a house, saying she had a wonderful time at home with her friends. She also drew a heart with arrows and on each arrow wrote the name of a friend from home.

Mrs A: You have a big heart.

In response, the girl smiled and added more arrows with names of staff members including Mrs A.’s name. The drawing seemed to be a free and pleasant experience that enabled an association.

(4) Molly remembered how a long time ago she got burnt by hot water in a domestic accident.

Molly: My father rushed me to the hospital, I remember holding Mom’s hand, I didn’t want them to leave me and they stayed. They were with me all the time, brought me candy . . .

Mrs A.: Perhaps this is what you want to feel now—that they care and love you, hold your hand.

(5) Molly: But they don’t care, they don’t even think of me. Do you really think I want to return home for my parents? I just want to be with my friends and my brother and sister. My brother is all mother cares about, she visits him, she brings him money. She doesn’t care about me at all.

Mrs A.: You are disappointed; it hurts to think about what your brother did to you and that your parents support him.

(6) Molly: People don’t understand why I still love him, but he’s my brother. I’m angry because he did not control his impulses but I still love him.
Mrs A.: Perhaps it is difficult to understand how one can love and hate simultaneously, like wanting something and being disappointed.

Molly: My uncle—I hate him. He really ruined my life. He tried to catch me once but my father came and shouted at him.

Mrs A.: How did you feel when your father appeared?

Molly: I was glad he showed up.

Mrs A: I’m glad he protected you, but this was not always the case . . . .. What do you mean about your uncle when you say he ruined your life?

(7) Molly: If in the future when I want to get married, should I tell. I think no one will want to marry me if he knows what happened.

The session ends with Mrs A.’s comment that Molly will be the one to decide about telling or not telling and they will take time to explore this further.

Group discussion of the session

The therapist, Mrs A., identified her anger about being pushed into an unfavourable position with a resisting child. Her enduring arguments with Molly and the unresolved suicidal threat limited the therapeutic space of Mrs A. I thought it necessary to outline the environmental pressures of the new residence playing a role in Molly’s resistance. There had already been some talks about separating from Molly’s previous therapist, Mrs X. One should also bear in mind Molly’s move from a fully protective warm and sheltering setting (designed to enable regression), into another facility closer to the real world and the demands of a new school. Mrs A. could then make room for her feelings of jealousy; Molly had already talked about the story of her sexual abuse during her seven months of treatment with Mrs X. and now behaved as if the trauma had been sufficiently worked through. Mrs A. felt deprived of the opportunity to be helpful, as if ‘robbed’ of doing the important stuff, and peeved with herself for not reaching the girl. Mrs A. also posed a question to the class: should she agree to an offer made by Mrs X. to send Molly a monthly allowance from her own private income? The intrusion of Mrs X. into the treatment by offering to send Molly money was another ‘external’ factor that contaminated the current rapport. It became clear that Molly’s previous treatment was gnawing on the present one, as both therapists wanted to be more meaningful for the child. The suggestion to send money was seen as a severe breach of ethical values and professional boundaries—an act that caused much distress to Mrs A., putting her into a somewhat competitive position. The wish to be loved and needed by the patient causes pressure on the therapist who is fending off the insult (Bick, 1941/1987), thus reducing his capacity to contain and experience.
When reading the session verbatim, a number of other themes appeared to be waiting for investigation or response, had the therapist felt more ‘space’ and less occupied by the search for specific material. A good example of a ‘knowing–not knowing’ dialogue can be found in the transcript concerning Molly’s home (1). Mrs A. knew that the family, especially the mother, was not prepared at this time to have Molly back. Statements about the bad home (‘you were not really happy there, you were running away’; ‘Father did not always protect you’; ‘when you think about what your brother did’) were offered in the hope that Molly would adopt what the therapist knew, as if wanting an agreement with the girl about the unfitness of her parents. Mrs A.’s knowing about the family was impeding her capacity to experience and empathize with the girl’s natural sadness and her rightful longing for home and family. At this stage, it was too complicated for Mrs A. to endure Molly’s pain of rejection by a non-responsive parent.

An interesting moment occurred when Mrs A. was able to make room for her own reflection when she thought that Molly was at war (2). This remark seemed to echo Molly’s feelings. Her mood changed and she revealed new interest. The conflict, verbalized by Mrs A. (based again on her knowledge of the facts), was avoided by the girl (‘I do feel good here’). It was only when Mrs A. allowed herself attentive suspense and suggested to ‘explore feelings about home’ that the girl could experience safety and engage in creative work (3), followed by her own associations from early childhood. Molly described her feelings when she was loved and protected (4), and later discovered for herself what Mrs A. was trying to make her see (‘She doesn’t care about me’) (5).

Once trust was established, Molly continued to explore another area: her feelings towards her brother (6). She made a distinction between the uncle who raped her and ruined her life, and the brother whom she still loved and missed. Mrs A. responded by explaining about emotional ambivalence. Here, the therapist’s understanding was settled too soon, without investigation. Molly stressed that ‘people don’t understand how I can love him’. A more open response might have been asking to hear more about her feelings, expressing a readiness to understand. It is possible that Molly’s perception of abuse was encapsulated within the rape by her uncle while her brother was not felt to be abusing at all (her statement ‘he did not control his impulses’ seems to be an adopted explanation provided by an adult). Perhaps Molly had distorted her ability for love (Alvarez, 1992, p. 152)—had become fascinated with the abusing brother and dependent on his powerful ‘proofs of love’ which she did not receive from her parents. Allowing suspense without judgement can bring one close to the child’s subjective experience. Molly’s statements at the end of the session could open a host of possible questions: perhaps she was asking about love, how does it come about, would she herself ever be loved or was she damaged? (7). These themes should be stored in the therapist’s mind for a later phase in the treatment.
Follow-up

Molly had been more than two years in the residence and in treatment with Mrs A. She never formed close relations with other girls and refused to enjoy spending afternoon hours with hosting families living close to the residence. Her escapes persisted, acquiring an habitual pattern (she was usually found walking the road towards her home town). When trying to evaluate the gains of treatment, we could say that Molly developed the capacity to ‘think thoughts’ about herself, of what had happened in her life, and to relate emotionally to a person in trust. Molly (now 15) had become verbal, reflective and less frightened. Mrs A., attuned to Molly’s subjective experience, witnessed a gradual fading of painful details of her sexual abuse, as if forgetting (Alvarez, 1992, p. 153), while feelings of rejection, enduring sadness and anger (the ‘war inside herself’) were Molly’s main suffering. In touch with her pain, she could talk about her brother. She described how both children of the mother’s previous marriage had been sacrificed and abandoned in order to maintain a troubled and shaky second marriage. It may have been this loneliness and despair that had driven them closer to each other, thus creating an incestuous situation. Molly’s escapes could be understood in the light of her continuing relations with her mother: a depressed woman who could not respond emotionally to the child’s needs. My thoughts circle around the theme of privacy of the self (Winnicott, 1963/1990)—the need to feel unique and vital, although in pain and rage. Perhaps her escapes served as a secretive place where she could feel existing and alive, fantasizing about a warm and accepting home or avenging its absence.

Summary and conclusion

The concept of potential space has been described as psychic phenomena stemming from early life experiences with an other in trust, becoming later an emotional capacity for containment, meditation and creativity. While Winnicott (1967/1989, p. 100) emphasized the variety of potential space differing from one person to another, it is suggested here that the subjective feeling of space (that has become developmentally prominent) within a person is prone to dynamic changes vis-à-vis environmental conditions and intra-psychic processes. The realm of potential space has been advocated as facilitating contact with the child’s inner world and subjective experience. This approach may be helpful, especially to children and young people whose early traumatic experience has damaged their emotional and cognitive development. In trying to summarize the effects of expanding the therapist’s feeling of freedom and space, moving from a doing to a reflective position, I have suggested the following:

1 remaining uncertain, devoid of knowledge or understanding, waiting for coherence or meaning to emerge and take form;
tolerating suspense, making use of curiosity, enjoying play;
bearing psychic pain, sadness and feelings of helplessness without the need to alleviate, reassure or undo;
feeling anger without denial or self-judgment, not retaliating;
being aware of one’s own space (like feeling alarm at not being able to think).

Long-term invested psychotherapy is considered the treatment of choice for severely traumatized children, for the sake of resuming full life in society (Alvarez, 1992, 2000; Fonagy, 2001; Cohler and Friedman, 2004). Molly’s case is an example of a prolonged psychotherapy, in which the ability of the therapist to be with the child’s pain, to relinquish the desire to ‘steer’ the treatment towards specific issues, and continue to provide emotional nourishment was the main endeavour. Naturally, this kind of space of the therapist is not always maintained, yet it should be aspired to.

It is possible that an ‘appetite’ for knowledge and effective practice (Walker, 2001), of having a dramatic story and tangible data (the sexual abuse as an overvalued idea (Britton, 1998)), and the wish to be a ‘helpful saviour’ and provide results, plays a part in assessments and decision making, leaving aside the less clear or less dramatic cases—passive or depressed people, such as Molly’s mother. Supportive and nourishing treatments are not sufficiently practised. The ability to relinquish both society’s quest for solutions and professional expectations, to make room for one’s own space and rhythm, taking the time needed to become in touch with the patient’s subjective experience, can render authentic richness and intimacy to the therapeutic encounter and better serve the treatment of emotionally deprived families who can not provide for their children.

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References


