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Providing a Containing Space for Unbearable Feelings

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When psychologists work in situations of extreme deprivation, they may feel a pressure – both internal and external – to produce solutions for their clients, and to produce them quickly. If clients are to be given the best of what psychological help has to offer, though, more space needs to be given to thinking and reflecting, and not just to action. Understanding and working with resistance is central in this process.

In this chapter, I discuss the resistance to a training intervention in a home for abandoned children. I illustrate how the resistance related to defences which were developed to protect the staff against the painful feelings they experienced while working with the abandoned children. There was no container which could facilitate the conscious processing of these feelings. As a result, practices were developed which ensured the denial of the anger, sadness and anxiety inevitably felt by both children and staff.

These defensive practices will be elucidated, and the process of creating a container for the feelings through the establishment of a staff support group will be discussed. The containment led to feelings becoming more bearable, which enabled the staff to focus more effectively on the needs of the children, and to be receptive to in-service training.

The role and importance of supervision and theory as containment for the consultation team will be emphasised.

The history of the training intervention

The university training clinic was initially contacted by a social worker who was running an in-service training course for the staff at a home for abandoned children in a historically disadvantaged community. Babies came to the home via different routes such as the police and hospitals. The request for assistance came as childcare workers had difficulty in managing children's behavioural problems. During the next two years psychologists in training at the clinic ran a number of educational workshops, disseminating information about emotional and behavioural problems among the children, discipline, stress management and ways of fostering self esteem.

The following year the clinic was again approached by the social worker for assistance to the staff at the home. Two psychologists in training (interns) and I were appointed to act as consultants to the home.

The training intervention

Initially two informal visits were conducted. We had conversations with the matron and social worker and met some staff members. Our first impression was a sense of urgent deprivation of both staff and children. Numerous comments about the lack of resources and appeals for assistance were made. The children communicated their neediness very powerfully by continuously competing for attention and physical contact. One girl, for example, repeated her name over and over – conveying her need for recognition.

The staff discussed the ways in which they were providing for the physical needs of the children (such as feeding, bathing and educational tasks), but we hypothesised that there were unconscious aims being pursued in the organisation which hampered the effective management of the children's emotional needs. Groups (organisations) may have an unconscious life in pursuit of tasks that may be different from the conscious life and tasks of such a group. A task may have a seemingly valid, overt aim, which may differ from its covert aim, derived from a hidden, unconscious meaning. The effective functioning of an organisation (i.e., a group) may be impaired by the impact of the covert aims, which are unconsciously pursued (Bolton & Zagier Roberts, 1994). Hence we hypothesised that there were unconscious aims which were impacting negatively on the effective management of the children.

A group session was set up with all the staff members in the home to explore the hypothesis further. In the group session we became aware of a strong animosity from staff members towards us. While the matron had organised for everyone to attend and was actively attempting to engage us in conversation, a palpable resistance was present in the group. While exploring the resistance, it became clear that there were very angry feelings with the clinic following from the previous two years of intervention. In particular there were strong feelings of having been abandoned by the clinic at the end of the previous year. One woman voiced it by saying: 'You come in here and you bring out all the conflict, and then you take your bags and go, and you don't care at all about those left behind.' The interruption in the

intervention at the end of the previous year had left the group with a strong defence against a repetition of the trauma – of bonding and being abandoned by the clinic. Considering the nature of the work in the organisation, the process of engagement with and disengagement from the clinic mirrored the process that repeated itself almost daily in the home – bonding with the children, and separating to give them up for foster care.

Therefore the conscious resistance towards a clinic intervention can be seen as an expression of the unconscious aim of protecting the staff against further trauma. The feelings towards the previous clinic consultation teams were transferred onto us. These feelings contained the transference of staff members' early object relations. These past internal object relationships are expressed in the present relationship with the consultation team, as they are with a therapist. 'In unravelling the details of the transference it is essential to think in terms of total situations transferred from the past into the present as well as emotions, defences and object relations' (Klein in Joseph, 1985, p.61). Later in the year the matron referred to me as the authority in the consultation team saying that I was 'like Leslie' – the psychologist who worked with two interns in the home in earlier years – and similarly held a senior position in relation to the interns. This reference confirmed the hypothesis that transference to us (a fear of connecting and being abandoned) was a transference which had been evoked in the earlier years in relation to the clinic team and re-experienced in relation to us. We worked with the anger towards the clinic and interpreted the resistance against further traumatisation. Once we had established some trust we could contract for a continued intervention.

Creating a container

Klein (1940, 1975) understood the notion of projective identification as an early primary means of communication whereby parts of the self felt to give rise to unbearable experiences are split off into an object. If the object can contain the split off parts, it can be taken back and integrated into the ego; otherwise the experiences remain unbearable and incomprehensible. This process can be facilitated in the transference and countertransference relationship in analysis. Bion (1963) formulated that the therapist acts as a container of unbearable and unthinkable feelings and in the process of digesting transforms the feelings through thoughts into bearable feelings. Klein theorised that a child internalises experiences, which give shape to the internal objects. If this takes place at a pre-verbal stage then the experience is remembered in feelings (what Klein called memories in feelings) which are then conveyed to the therapist through projective identification.

The infant establishes a primal differentiation between good and bad experiences at an early age. The infant tries to hold onto good experiences and to be the 'good', and to get rid of the bad experiences, by splitting, projection and projective identification. The undesirable feelings are split off and projected and attributed to someone else (Klein called this the paranoid-schizoid position). Anger may then be denied, split off and projected into the other person, who may then be experienced as persecutory. If good experiences dominate, there is a strengthening of the ego and an increased capacity for realistic perception, (i.e., not

projections) and the infant can be said to be functioning in the depressive position. People are then not experienced as either good or bad, but a person can have a range of feelings towards one person. Equally the child is then more able to accept their own 'bad' parts – feelings such as anger, envy and jealousy.

An individual functioning in the depressive position has developed an internal container, which allows for a full range of emotional responses to be available and to be dealt with internally. An organisation (group) functioning in the depressive position similarly will be able to contain the emotional complexity of the work in which the group members share, and members will not carry fragments of the emotional experience in isolation (Halton, 1994). Uncontained feelings are split off, denied or projected in order to relieve the group of conflicting emotions and needs. Considering the effectiveness of the interpretation of the resistance to the intervention as a resistance to further traumatisation by the clinic, it became clear that the group was functioning in the paranoid-schizoid position, with no container for the unmanageable feelings encountered in working with abandoned children. There was no conscious processing of feelings, which would lead to containment of painful experiences; hence primary defences such as splitting and denial were operative in order to manage these feelings.

When a group is not functioning in the depressive position (as with an individual patient), some provision needs to be made for the external containment of the feelings. As we felt that the unbearable feelings of loss and abandonment were not contained in the home, it was decided that the two psychologists in training and myself would continue to run a weekly staff support group to provide a container for the unmanageable feelings.

The group operated on various levels. Firstly, the group process was interpreted in a psychoanalytic framework, and related to the psychodynamic processes at work in the organisation. For example in initial discussions the staff chose to focus on the behaviour problems of one child for whom, as a result of his unruly behaviour, no foster home could be found. On reflection, it became clear that this boy was caught in the unconscious organisational defence against separation and loss. This child must have known unconsciously that by being naughty in the foster home he would be sent back to the home. The 'mothers' equally did not want to separate from him. As one group member put it: 'When he goes to foster parents, my mouth says go, but in my heart I say come'. A child needs the parents to let go first before being able to take the steps towards separation (Lubbe, 1996). Knowing that the child's stay is temporary, the anticipation of the loss probably results in an ambivalent attachment to the child. Negotiation of separation in an ambivalent attachment poses more problems than it does in an uncomplicated attachment.

While we suggested practical ways of dealing with his misbehaviour, such as time-out, we spoke about his need for attention and affirmation. We discussed the staff's sense of being reflected on as 'bad parents' when he misbehaves on visits to foster parents. Furthermore, while the substitute mothers provide for the children, there may be a phantasy of their own 'badness' as parents if they are 'abandoned' and left for foster parents. We linked his

difficulty in separating to the ambivalence of letting him go and the sense that he would not be looked after by his new parents. One group member reflected on her concern that new parents might not know that it was not the child's fault that he had been left – reflecting on the sense of a child's 'badness' when abandoned. The group was able to express their own feelings about giving up babies when they were not sure that they would be loved in new homes. A safe space for difficult feelings such as loss, abandonment and rejection was being created in the discussions. We used this group process to illustrate that it would be useful for the children to face similar feelings in the organisation, and developed a metaphor of unworked-through feelings remaining like an abscess in the psyche, which contaminates the flow of normal activity.

Secondly, the experiences and feelings of the childcare workers were discussed and contextualised within the organisational process. The resources of the matron were as depleted as those of the staff members and she was unable to be a container for the feelings of the staff or the children. Situations which evoked strong feelings – such as the loss of a child to foster care – were therefore avoided. Staff were mostly expected to part very abruptly with the children without a process of saying goodbye and working through the separation. While there were all sorts of practical reasons given by social workers for these occurrences, it seemed as if the unconscious need to protect against the pain of separation hampered the effective management of the children. It impacted on the staff's capacity to bond and separate from the children and therefore hampered their ability to facilitate a healthy separation for the children (Lubbe, 1996).

In another instance a staff member brought her distress about the sores on her body which she had contracted from working with the children. She felt that the children had contaminated her, and that the matron and social worker had ignored her pain. The issue was discussed on various levels. We spoke about the physical distress and what the practical arrangements for relief could be – the policy and compensation when staff were injured on duty. We discussed the feeling of contagion by the children and the sense of abuse that staff carried – the way in which the emotional scarring and pain was projected into them by the children (Riesenberg-Malcolm, 1999).

There was a felt shift in the openness and trust between the facilitators and the staff in the course of the year. While discussions had initially been focused on problem children, staff members started to reveal more of the painful and hurting aspects both in relation to their personal circumstances and with regard to the work. This was mirrored in the structuring of the time for the group sessions. Initially we encountered the children on arrival at the home and spent some time nurturing them. Soon the staff organised their routine so that the children would be fed and put down for the afternoon rest before we arrived, hence directing our attention to their own unmet needs.

Thirdly, particular children's behaviour and difficulties encountered with the children were discussed. For example, staff found it difficult to deal with the issue of children sleeping together and fondling each other intimately. Educational input was given about age-appropriate

sexual behaviour, and the link between sexual play and the institutionalised child's strong attachment needs were drawn. Sexual play may then be viewed as seeking closeness and emotional comfort. Discussions of material around sexual issues were contentious and staff were able to recognise how their own inhibitions related to unhelpful educational practices around these issues. Through self-reflection the staff members learned to understand the children's feelings and experiences.

The ongoing group intervention allowed us to develop the initial hypothesis that there were unconscious hidden aims being pursued in the organisation. For example, staff were treated as minors and, while acting as substitute mothers, were given no information about the histories of the children placed in their care. While a rationale was given that it was to protect the confidentiality of the information about the children, it seemed as if the covert unconscious aim was to prevent the staff from becoming too acquainted with and hence too attached to the children. This arrangement served as a defence against the pain of loss, as the denial of the personhood of the babies (histories imply continuity of identity) maintained a more superficial level of intimacy between 'substitute mothers' and babies. Babies were often referred to by the month of admission, eg., the 'March baby' – a further denial of the real identity and therefore prevention of attachment.

The provision of a container for feelings which had previously been split off altered the group task of denial and silencing of painful feelings as there was now space for reflection on and working through difficult feelings. For example, three sessions were spent on the feelings evoked when one little boy left the home.

Preventing a repetition of the trauma

Considering the initial resistance to bonding with the facilitators, we realised that the separation from the facilitators at the end of the year needed to be worked through very sensitively. We appreciated the need for some continuity in the process of the clinic intervention. It was decided that I would continue to work there on my own as a group facilitator and that two new training psychologists would join me the following year.

The issue of the child who could not find a foster home re-emerged as a symbolic expression of the regression to the feelings of abandonment, separation and neglect which the group had been struggling with before. Members fantasised that he would want to return to the home as he felt safe there, but on the other hand that institutionalisation was destructive to his individuality.

The group found it very difficult to terminate with the interns, but where there had initially been an inability to talk about the feelings which separation evoked, the separation could now be spoken about in the group. The group struggled with a sense of being left because they were not good enough for the interns. They wanted to know whether they had been telling too many sad stories, and therefore burdened them too much. They wondered whether the interns would remember them. They wanted to know where they were going and showed concern by asking directly: 'Will you be okay?'

Despite the continuity in the running of the staff support group, the sense of cohesion in the group was noticeably interrupted with the arrival of the new intern psychologists the following year. Bion (1963) formulates the idea that there can be movement between the paranoid-schizoid and depressive positions. The group moved back to paranoid feelings of suspicion in relation to the consultation team (the transference object) and reverted to the defences of the paranoid-schizoid position. The facilitators were split and the male intern was idealised and referred to as the 'daddy' and the matron's new 'haan' (a term which in English would mean the 'king of the castle') while the female intern was excluded and criticised, for example, about her inability to speak the group language – Afrikaans – fluently. (This had not been raised as an issue in the past with other training psychologists.) She battled not to withdraw from the group or to take it personally but to see it as a splitting of the container into a good and a bad part. After eight sessions in the group and hard work in finding a working relationship between the members of the consultancy team, one group member called her 'Perseverance' (in English), signifying her acceptance in the group. It was interesting, looking back, that the interns had been writing their clinical notes separately, but at this point had decided to write a combined set of notes. It may well have reflected a process of projective identification in the facilitator's group mirroring the process of splitting in the staff group.

Later in the year, when an intern missed a session due to illness, the group was concerned that they had 'made her ill'. Once again this was an expression of the sense of contagion that the staff members carried, and their fear of the destructive and damaging potential of angry feelings.

Moving towards the end of the second year there was a looming sense of threat in the group, and a group member wanted to know whether I was going to run away with the interns. The group was again able to work with the separation from the interns in a direct and open way – with words and tears. One group member linked the process of saying goodbye to the interns to that of saying goodbye to the children. An important shift in the organisational defence against separation had taken place. The group became more able to operate in the depressive position because a container for the painful feelings had been established.

Containing the container

The countertransference feelings of the therapist are taken into consideration in supervision of therapeutic work. Heimann (1950) defined countertransference as comprising all the feelings which the therapist has in relation to the patient. These emotional responses provide the therapist with a means of non-verbally discerning the experiences of the patient. Since Heimann's definition of countertransference, more attention has been paid to the psychology of the therapist and the notion that the therapist brings a relational history, a cumulative representation of lived experience of interaction, to the relationship with the patient. Thus the object relationships of the therapist play a part in the treatment process. The concept of intersubjectivity has been formulated to conceptualise the interplay of the analyst's subjective experience with the subjective experience of the analysand to form the

intersubjectively generated experience of the analytic pair (Ogden, 1994). These conceptualisations complicate the previously easy labelling of feelings experienced by the therapist as being countertransference feelings.

Furthermore, the supervisory situation can be considered from a perspective of parallel processes. The patient's relational difficulties may be enacted unconsciously towards the supervisor by the therapist. If the supervisor is aware of this process, enactments can be discussed as important information conveyed about the patient (Jarmon, 1990).

In the two years that I had been working in the organisation I acted as the container for the consultation team and the consultation team as a container for the group. The interns and myself met weekly for a supervision session among us. I had supervision from Valerie Sinason, an analyst from London who visited once a year, and occasionally at difficult moments from Kerry Gibson, the Community Psychology programme co-ordinator. It was important for me to know that I could draw on these containers.

Ideally the staff consultation team functions in the depressive position and the team has a capacity to process the projected feelings of the group members and the children (our countertransference feelings) and to distinguish between the countertransference feelings, the feelings stirred in the consultation team because of our own unresolved immature object relations, as well as the feelings aroused between the different members of the consultation team in relation to each other – which belonged solely to our own process. The extent to which the feelings could be distinguished in our weekly consultation-team supervision session, depended on the extent to which the feelings could be analysed and owned within our team. My focus was on creating a trusting environment where we could process the feelings, analyse our countertransference feelings in relation to the group material, and own the parts which belonged to our own object relations. For example, one of the interns in the staff team found it very difficult to relate to the overwhelming neediness of the children. We were able to look at his resistance in the light of his own deprivation and the concomitant pain and sense of loss re-evoked in his contact with the children, but also to look at it as a process of projective identification where the neediness and pain of the children were projected into him. Initially this intern was immobilised by the feelings and found it difficult to operate as part of the clinic team. Working through the feelings in supervision and his own analysis freed him up later in the year. As he started to find a voice in the group, some of the quieter members were able to take part in discussions. This may be seen as a parallel process between the functioning of the consultation team and the functioning of the staff support group.

Another intern spoke about his sense of incompetence. The metaphor that came to mind was a sense of having made a crap in the supervision session – as his ideas and comments were so worthless. The metaphor used by the intern was an expression of his own sense of incompetence as a developing therapist, but could also be seen as the communication of a pre-verbal experience of the child communicated through projective identification. In dealing with the staff group, the projection of the feelings into us could be seen as

unprocessed projections from the children 'passed on to us via the staff member', or a sense of each staff member's own early experiences re-evoked by contact with children. The intern gave an image (of a smelly crap) to an unprocessed feeling of helplessness and incompetence passed on to him unconsciously through projective identification.

The supervisory process acted as a container for the unbearable feelings of incompetence. We processed these feelings in our consultation team and focused on taking these understandings back to the group.

A change in the container

The function of a consultancy team includes analysis of the relationship between the staff group and the management of the wider institution, as the dynamics of the staff group may reflect the dynamics of the wider institution (Rifkind, 1995). The leadership style of the matron was authoritarian and mirrored the management of the home by the board of religious ministers. Staff were treated as minors, and while acting as substitute mothers were given no information about the histories of children placed in their care. Staff had no representation on the Management Board, no representation in decision-making processes with regards to the management and running of the home and were ill-informed of any decisions taken by the Management Board.

During the first two years the interns and I had been working in an undifferentiated unit. Although the one intern had often wanted to intervene more actively in the second year, I had not actively encouraged him to do so. Retrospectively I realise that as my own capacity to contain grew through experience, I was more able to allow and contain differentiation between me and the interns, and to encourage them to assert themselves in the group, and to challenge me directly. My management of the consultation team was a parallel process of the management of the home by the matron, and of the management of the organisation by the Management Board. The power dynamics between me and the interns were mirrored very clearly in the group during the year. There were at times power struggles in the consultation team, which facilitated a developmental process in the group. The consultation team acquired a different confronting property in conjunction with the holding, containing function. The interns took an oppositional stand in relation to the management style of the Management Board in the staff support group. The group dynamic shifted, and the themes in the group became a striving for autonomy and self-empowerment. The staff unionised themselves for the first time in the history of the home. They requested a meeting with the Management Board to air their grievances, and to ask for direct representation on the board.

As the staff members grew in their definition of an identity as a group with needs and rights, they also seemed to separate from the consultation team, which made it easier to separate from the interns at the end of that year. They expressed gratitude for the interns 'having been there for their interests' and had a strong sense of having been empowered by them. Group members also expressed feelings of sadness at the parting. There was a growing ability to deal with a range of feelings evoked by the separation.

Conclusion

I have argued that the overt aims and tasks in the home for abandoned children (for example the naming of babies) masked covert aims, such as erecting defences against the feelings of loss and abandonment which were evoked in caring for the children. Because the feelings were not contained they impacted on the effective management of the children's emotional needs. The staff resisted efforts of training and support in order to protect themselves against re-traumatisation. Through the staff support group the consultation team attempted to provide a space where these processes could be brought to consciousness and the feelings could be processed. An experience of being contained provides a model for working with and containing the feelings of the children.

The effective working of this process of containment was dependent on providing containment for the containers. It required a supervisory process where different levels of analysis could take place: an analysis of the countertransference feelings of the consultation team, the intersubjective space between the clinic team and the staff group, the parallel processes between the consultation team and the staff group, and an analysis of the parallel processes of the management of the home by the Management Board and the matron of the home. Supervision and theory provided the necessary containment to the consultation team, which enabled us to provide support to the staff group. Key to all of this was patience and an understanding of, and faith in, process from a psychodynamic perspective.

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