Psychotherapy with the Abused Child

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‘Personal psychotherapy is directed towards enabling the child to complete his or her emotional development. This means many things including a good capacity for feeling the reality of real things both internal and external, and establishing the integration of the individual personality.’ (WINNICOTT, 1946, p. 118)

Therapeutic Context
This is the story of David, a twelve-year-old boy, and my journey with him in psychotherapy. He presented with a history of disrupted care, abuse, and abandonment. I saw David for weekly individual psychotherapy in a public mental health outpatient clinic in Melbourne for the first two years of this therapy. I treated him in private practice for a further twelve months of fortnightly sessions. This paper attempts to examine the therapeutic aspects of the clinical work that appear to be the most beneficial to the patient—interpretations, words, gestures, glances, gazes, breathing, silence, play, games, laughter, tears, bodily movements, rhythms, processes, repetitions of being with the other. The paper explores modalities of
communication between the therapist and client and the use of the play in the potential transitional space. It examines the aspects of the therapeutic cultural frame which seems essential in the maintenance of such a therapy.

David’s history

David was referred to me whilst I was working in the role of Senior Child Psychotherapist at a Child and Adolescent Mental health facility in Melbourne. He was nine years of age at the time. He was referred by the case manager, an experienced family therapist. She wondered if child psychotherapy might have a contribution to make in enhancing David’s social/emotional functioning and in improving the quality of his relationships with significant others in his life.

David’s Family

David’s father was reported to be a very violent man who drank excessive amounts of alcohol when David was a baby. David is named after his paternal grandfather who was also reported to be a very violent man. His paternal grandmother was reported to suffer from anxiety and depression. David’s mother has a mild intellectual disability and early photos of her convey a woman whose face appeared to be dark in mood and preoccupied.

David’s infancy and early childhood

David was removed from the care of his birth parents at six months of age due to substantiated physical abuse. At that time he had been hospitalised for a subdural haemorrhage resulting from severe shaking by his mother. One foster family described David, at twelve months, was a baby who was very demanding and ‘screamed all the time.’ Between the ages of six months of age and three years, he had been placed nineteen times. Some of these placements were with kith and kin, some with his parents and some with foster carers. David was moved during the night a number of times in early childhood. Violence would break out between his parents, the Department of Human Services would be notified and he would be taken from his bedroom, often in his sleep, by the child protection worker, accompanied by the police, to a foster carer who was often a stranger to David. David has talked to his foster mother Dorothy about his memories of fights. He recalled a time when his father threatened his brother with a knife during an argument at Christmas. David was reported to be terrified. His father had also broken every window in the house on Christmas Eve.
**Foster Care**

At three years of age David went to live with a foster family who initially planned to have him permanently. He was said to have two words only—‘No’ and ‘Dadda’. The foster family was large and their way of managing David’s hyperactivity was to sit him in the high chair where he wasn’t allowed to touch anything. He was reported to be a very distressed little boy. Dorothy stated that he hurt himself by banging his head against walls and scratching himself. The family tried very hard with David, but ultimately the placement couldn’t be sustained. David came to live with Dorothy when he was four years of age. Dorothy is a single woman with a supportive extended family. David attends respite on a monthly basis with another family. When he was nine years of age, he was placed in a community residential unit for three weeks while his foster mother contemplated whether she could continue to look after him, as she was emotionally and physically exhausted by his relentless demands. She then decided she wanted him to return to her care. He has remained with her ever since.

**School**

At the time of referral David was in grade five. Throughout his time as a student in primary school, he had full-time integration funding to assist in dealing with his unpredictable outbursts of verbal and physical aggression to peers and adults. His aides had been taught how to use physical restraint to ‘contain’ him at times when he posed a significant physical danger to himself and others. His aide was with him for all the classroom time, play lunch and lunch time from the first year of primary school through to grade five. Funding was supplemented by the Department of Human Services to enable this to happen.

When David was seven years of age, he was prescribed psycho-stimulant medication for the treatment of Attention Deficit Hyperactivity Disorder by a consultant paediatrician with long-term involvement in his care. In addition to an earlier trial on an antidepressant to diminish his anxiety (which was discontinued), David also had an hospital admission to the state-wide child psychiatry inpatient facility in early primary school for a period of five weeks when he was nine years of age.

**Therapeutic Approach**

ANNE ALVAREZ stated said: ‘The popular image of the zipper mother, detached and frosty analyst-scientist no longer applies. The comparison instead should perhaps be with a trained and skilled but constantly improvising musician, who like the
patient, has to live and learn from felt experience and from practice’ (1992, p. 3). She states that ‘much of the time our task is to help our child patients to learn such things as restraint, self control and thoughtfulness; not to remember the past in order to be freed from it but to forget it in order to be freed from it’ (1992, p. 8). For much of the initial phase of psychotherapy with David, I was very much an enlivened, responsive, non-retaliating recipient of his words, his smells, and his actions.

David the Skunkboy

During the first sessions with David he spent much of the time emitting malodorous ‘farts’ in my face. Sometimes he would turn around, face his bottom towards me, bend forward and expel his flatulence at me with a triumphant grin on his face. At the time I dealt with this via humorous action, turning myself away from his noxious missile-like emissions. I suggested to him that his farts were trying to kill me off and that he wanted to see if I could withstand them and still stay with him. The words were uttered in the service of the whole communication. The words came after I made the room bearable, opening a window, letting out the toxic odour of his flatulence, breathing freely. When I spoke with him his eyes darted and fleetingly looked at me, engaged in a glimpse, saw me, like a trapped and terrified gazelle. It wasn’t a gaze, just a darting glance. All he seemed to be able to bear was to note that I was still there, wasn’t about to hurt him, and did not appear frightened of him hurting me. When he dared to look, he could see my face did not hold disgust, instead a wondering about, a compassion for, his need to portray himself as such a noxious beast-like person.

In those early sessions we were immediately confronted with David’s need to push his self-loathing into me. He wanted urgently, I think, to make me feel the absolute repugnance for his being that he constantly harboured for himself. It was as if he was thinking ‘well I might as well get this over and done with, completely drive this strange person away from me before I have the chance to even momentarily want her to like me and like being with me.’ This was a period which required endurance and fortitude.

Cross Modal Matching

Beebe and his colleagues (2005) state that, ‘through cross modal matching, the infant translates between environmental information and inner proprioceptive information from the beginning of life’ (p. 61). Trevarthen (1998, cited in Beebe et al, 2005) thought that the newborn functioned within a reciprocally communicative dyad. The dialogic capacities of the newborn and the carers enable both
infants and carers to be in immediate sympathetic contact, aware of the other’s purposes without words and language, by matching communicative expressions through time, form and intensity. This matching regulates both interpersonal contact and inner state. This is vitally important in understanding the impact of trauma on David’s mind when he was besieged by physical abuse, disrupted care, domestic violence and abandonment. It is also helpful in explaining how the use of humour, judiciously applied with David, allowed me to regulate his hateful thrust of fumes by playfully moving my body to dodge the direction of his ‘poison’. Ultimately the permeable boundary of the open window was necessary, preventing the game becoming really harmful spoiling the possibility of a helpful relationship between us.

Certain rituals became important. My meeting him in the clinic waiting room with his integration aide intuitively became much the same each week. I would greet him with a smile and say, in a soft but animated voice, ‘Hi David, nice to see you!’ It seemed important that my greeting was unambiguously friendly, showing that I was pleased to see him, and accompanied by a sustained deep look into his eyes. His eyes would usually dart across my face, scanning for displeasure, for imminent rejection. I walked beside him to and from the room, functioning as a shadowing other, helping him make the transition from outside the clinic, to the corridor, to the room, noting the transit markers along the route—the clown print on the wall, our secretary in her office, some of the staff that he had come to know, the turtle enclosure. My saying goodbye in the waiting room was also important. David could not often leave without an object to help manage the absence. He began to take home the crocodile puppet, which he called ‘Croc’. ‘Croc’ seemed to represent the devouring, ripping tearing, parts of him, as well as the soft cloth puppet part that was ‘bitey and needy’, rejecting but yearning for attention. He was not able to symbolically hold me inside his mind during intervals between sessions. He brought ‘Croc’ back each week, like Winnicott’s transitional object that can be messed up, thrown, scolded, but endures. At one time, when I went overseas for three weeks, we negotiated that I would send postcards, from two cities which he chose from my destinations, to assist him with the substantial break in the therapy. His foster mother reported to me that he was very pleased to receive the postcards. Perhaps they served as a concrete representation of a caring therapist that could somehow be held in mind together the rejecting, abandoning parental representation.

Implicit Memory Systems

Schore (1994), Seigel (1999), Perry et al (1995) and Beebe et al (2005) all refer to concepts of differentiated, developmentally determined, memory systems that exist within the human mind. Implicit memory processing refers to things that we know or do automatically without the conscious experience of doing them. Explicit
memory processing refers to things that we do or remember that can be brought into consciousness as symbolically organised recall for information and events—such as facts and concepts (semantic memory) and personal history (episodic/autobiographical memory). Explicit memory processing underpins the capacity for reflection or mindfulness.

Pally (2000) outlines three distinctions that can be made within implicit processing: cued/associative, procedural, and emotional. Implicit processing that is cued/associative involves associations among words and verbalized images that are entirely out of consciousness. Free association and play sequences can utilise this form of processing in psychotherapy. Beebe et al (2005) use the term implicit procedural knowledge to include both conscious and non-conscious processing, implying a view of the infant, and not only of the adult, as an active agent in the construction of procedural knowledge. Implicit emotional processing refers to primitive emotional perceptions and memories that utilise the amygdala and the limbic system. Beebe et al suggest that words can have discrete meanings but also encompass a process dimension—rhythm, volume, stress and intonation (i.e. prosody), which is implicit or affective. Bollas (1987) suggested that the ecology of the analytic space, including the analyst, analyst’s interpretations, couch and so forth become a kind of asylum for the patient. He suggested that the analyst creates an undeniably unique atmosphere for relating between the analyst and the patient:

In the transference—which is linked as much to the analytic space and process as it is to the person of the analyst, the patient is experiencing the therapist as the environment—mother, a preverbal memory that cannot be cognized into speech that recalls the experience, but only into speech that demands its terms be met: unintrusiveness, provision, holding insistence on a kind of telepathic knowing and facilitation from thought to thought and from affect to thought. (p. 24–25)

**Auxiliary Ego**

For some time after the period of fartfulness, we entered a stage of exploring the environs of the room. My office/therapy space was located within our team’s corridor, and adjacent to our secretary. We had the luxury of a contained outdoor space which had a basketball ring and fields and, within the office precinct, there was a turtle enclosure. For a number of weeks David would enter the room, commence playing with the objects of choice—the puppets—and then leave the room to see the turtles, play basketball, teach his uncoordinated therapist how to play football, chat with our secretary, or go to the toilet. David seemed to need these breaks from the room when his levels of anxiety became difficult for him to bear. The conversation with the turtles, the physical activity of basketball, the social chatter with our
secretary, soothed him and regulated his affect. With some coaxing on my part, he returned to the room on each occasion and finished the session in the room. Each time he left the room I was near him, like a therapeutic shadow. When we met with the secretary, initially he did not know how to initiate social contact, so I would instigate the interaction and he then continued with the rhythm of the conversation. When we met the turtles, we began with me demonstrating to him how to treat them so as not to frighten or hurt them. When we played basketball and football we had to negotiate proximity and distance, the maintenance of body boundaries in space. I allowed this to continue for a period of time, then gently, slowly suggested we might stay in the room to play. This timing was intuitive, perhaps somewhat delayed. Another therapist may well have placed limits on the acting out/playing out of the room well before I did.

Entering Darkness

The next phase of therapy, beginning about four months into the work, took me somewhat by surprise. David began enacting traumatic scenes in

the therapy, with me as the victim and him playing the role of the stage director. This was an unforgettable, surreal experience. Green (2005) said of Winnicott: ‘he introduces a very important idea … however bad or negative are the experiences, the presence of someone just watching, acting as a mirror, gives to the scattered part a unity that is reflected to the patient and becomes part of him’ (p. 23). Green suggested that Winnicott is the mirror who reflects something other than the negative hallucinations that the patient has of his own image. Winnicott (1971) stated that play is immensely exciting because of the interplay of personal psychic reality and the experience of control of actual objects. This is the precariousness of magic itself, magic that arises in intimacy, in a relationship that is found to be reliable. The creative phenomenon of play takes space and time, feels intensely real for the patient, and also for the therapist.

This phase of therapy involved very little interpretation. David orchestrated the play and I was the manipulated, vulnerable object in the play. This involved enormous trust for both of us, for me as much as for him. During this phase of the therapy David set the scene. He created darkness by pulling the blind, turning the light off, sometimes blindfolding me. The terror then occurred at night, in the dark. At times I had to lie down on my back in the middle of the darkened room with a blanket on me as ‘the baby’ while objects threatened to drop onto my face — puppets, symbolic heavy objects. ‘Ghosts of death’ crept up on me, menaced around me, circled and pounced unexpectedly, filled me with dread and just as ‘I baby David I’ was about to die, to exist no more, the attack stopped, the threat disappeared. It was very strange, surreal, as if I hallucinated the experience. I felt terror as it may have been
projected into me from his implicit-memory affective schema—of the infant who was ‘done to’ in a terrifying preverbal world of monsters, ghosts, murderers in the night. But it also had the quality of a surreal timelessness. The session went on forever, indeterminate, yet momentary, with the ‘neverendingness of terror’. A state of heightened, tentatively trusting, alertness prevailed. David was in absolute control. He could have hurt me, really hurt me, yet I knew that he wouldn’t. The sense of the infantile absolute dependence and vulnerability filled my bones at the same time, although I knew this was in the potential space of play.

Winnicott thought that playing was not inner psychic reality, that it is outside the individual, but is also not the external world. The ‘baby’ Toni talked to the experience of feeling so frightened, of thinking I was going to die, that there was no one to help me, of being terrified of being killed, of what would happen to me if I died. A rhythm was established whereby the ‘baby’ would be lulled into a false sense of safety by the director David, then suddenly threat would loom large, quickly and potentially devastatingly again, and again. ‘Baby Toni’ was in constant fear, frightened of ominous quiet, the eye before the storm of annihilation. Just as suddenly as the play developed to a crescendo, it would subside. David would turn on the light, lift the blind. It was now morning. The baby was alive. He would feed me with a bottle, wrap me in a blanket, whisk the baby’s bonnet off my hair—the bonnet that he had placed on my head at the commencement of the play sequence. We would emerge from the room.

David would leave the room, quiet, calm, intact. I would emerge from the room with my hair tussled from the baby bonnet. The room would be in complete disarray. My colleagues in the corridor knew this was David’s time in the week.

Clearly this segment of the therapy reinforces the importance of the setting. The clinic space, surrounded by attuned colleagues, made this work bearable and possible for therapist and client alike. The cultural frame provided by the multidisciplinary clinic setting enabled the safety of the therapeutic space to be maintained. It freed me to experience the terrifying inner world of David projected into the therapeutic arena without fear of real damage.

The interpretative work for the most part was in what Anne Alvarez (1992) might call the displaced position, within the transitional space of the metaphor of play. Lanyardo and Horne (1999) describe the different juxtaposed part object representations assumed by the therapist with the patient—the position as transference object—that of the present object and that of the organising object. During this sequence of sessions my interpretations were formulated in accordance with Daniel Stern’s (2004) realm of the present object, that which I was for David. I put into words how I, as the ‘baby part of David’ felt in the position of terror, that which he had experienced as an infant with his birth parents. Towards the end of
this period, which lasted for eight sessions, I was able to say only one sentence that linked to the transference: ‘I think you, David, are letting me know something of what happened to you as a baby.’ He gazed at me, grunted ‘Hmmph!’ and moved on. David knew, I think, that what he did to me in play was bearable because I could keep us both safe. There was part of me that was immersed in the play with him, but there was also a part of me that was monitoring and watching the drama as it unfolded. This is, as WINNICOTT (1971) described so eloquently and cryptically, the paradox of the transitional space known as the arena of play.

**Process of Changing with Daniel Stern**

Stern states that rhythmic matching or ‘changing with’ as ‘dynamic, micro-momentary shifts in intensity over time that are perceived as patterned changes within ourselves and others, that allow us rather automatically and without awareness to change with-the-other, to feel what-has-been-perceived-in-the-other’ (1985, p. 263). The focus on slight shifts in intensity in both partners is a fine-grained way of being in the fluctuations of the moment where subtle gradient changes within an affect category are more likely than a change of affect category. An affective intensity can be expressed cross modally—via facial expression, gesture, vocalisation, nonverbal analogy and metaphor. Cross modal matching then recasts the experience of emotional resonance into a quality of feeling or inner state, what Stern terms ‘forms of feeling’ Stern suggests that affect attunement provides a bridge from the pre-symbolic to the symbolic mind. Affect attunement defines a critical reorganisation of intersubjectivity towards the end of the first year of life. Stern suggests that attuned experiences define what is shareable, and what is validated. Misattuned experiences are those that cannot be validated about the self, akin to Winnicott’s notion of potential not-me experiences.

**The Matched/Imitative therapist**

The beginning of David’s therapy involved me becoming the imitative, holding environment therapist. The therapy sessions had a defined beginning and end. Initially David needed to evacuate into me his reviled, repulsive, smelly bits. I had to hold them inside me without becoming contaminated, while also noticing nanomoments of success, integration, development—‘the small faint signs in the patient’s behaviour’ that GALLO (2001) describes in her work with children who are so lost they don’t even know they exist. These children require a process of that Anne Alvarez would call ‘reclamation into livingness.’
At the beginning of my time with David, we established the rhythm of the therapy. I had biscuits in my room which my child clients are welcome to have at some stage in the session. David would eagerly open the container, take one or two but no more than that. The puppets became very important to him quite quickly. For the most part I moulded the environment to his developmental needs, matching, ensuring safety, noting success and holding joy in his achievements when he couldn’t. In the play sequences described previously David was always the narrator/director whilst I was the vulnerable victim baby. Then imperceptibly he introduced another character. The person/boy/David who was participating in the play, who was separate but watching—the participant-observer in the play sequence who would comment on Toni/baby’s suffering, and would warn me when the persecutors were coming. In the play, we would go to bed side by side. I would be set up on the floor in the middle of the room while he made his bed out of two chairs placed together, from which he controlled the environment of the room—the light through the blind, the light switch being turned off/on, the movement towards constructional activity towards the end of the session.

Developmentally Informed Psychotherapy

Klauber (2001) describes Anne Alvarez’es focus on developmentally informed psychotherapy with children who present with primary relational deficits. She states her adherence to the qualities that Alvarez writes about, the qualities of the therapeutic object required in step by step building for internalization—a sense of liveliness and interest in the other. She also suggests that the ‘good enough caregiver’ offers a complex, varied and constantly changing presence, full of dynamic flows and temporal shapes. According to Alvarez the first forms of thinking and linking occur in the presence of the object. Alvarez suggested that the present object in its aliveness and mobility may be as thought provoking and demanding of interest and attention as the absent object.

At the beginning of my time with David, it was imperative that I saw beyond his repulsive behaviours and continued to find ways of enjoying being with him. His omnipotent, ruthless control of me as his possession was tolerated as his need to insert himself into me, to trap me and prevent me from deserting or abandoning him. He needed to have complete control over his therapeutic space, while I simultaneously ensured the integrity of the space. I was absolutely involved in his play. It was intolerable for him for me to be the audience. I had to participate with him always, to be the facilitating other, aligned and moulded to his need for attentiveness, responsiveness, delight, and recognition of liveliness and worth.
Anne Alvarez points to the need to recognise that integration between the bright and dark sides of one’s nature and of one’s object is only possible when there is adequate development of both the idealising and persecutory strands. When tiny increments in idealisation occur, in patients whose capacity for hope is severely underdeveloped, it is unhelpful to expose them to constant reminders of the despair and anxiety they are finally managing, not to defend against, but to overcome. David was adept in his visuospatial skills and made exquisite constructions from his mind’s designs. I would say to him ‘Look what you can do! That is absolutely beautiful!’ I encouraged him to display his work of art to the carer/aide who brought him to therapy. He needed his capacities to be witnessed, celebrated and shared with significant others.

**Secondary School—From Abused to Abuser**

By the end of his therapy, David was a thirteen year old adolescent in his second year at high school. With adolescence, there was the appearance in the sessions of abusive sexualised heterosexual relationships. The dinosaur puppets were used by David to enact scenes of anal intercourse, and anal insertion of objects. This coincided with the care team’s awareness that David had gained access to pornographic material at school and at home on the internet. In the sequences of sadistic/exploitative sexual play scenes, I assumed the voice of the victimized other, speaking ‘about what it must feel like to be hurt by things coming into my insides. That is not love. It is abuse.’ At other times I talked from the position of the aggressive male dinosaur, saying that his forcefulness was a way of keeping the female dinosaur in the relationship and that he didn’t know how to relate in a loving way. I spoke to him about the victim’s need to be taken care of, and that the abuse must stop because they needed to be kind and caring to each other.

David was at times malevolent and cruel in his treatment of the large soft toys and I asked him to stop, as there has seemed to be an emergence of sadistic satisfaction in his treatment of the toys, which I did not want to countenance by allowing perseveration on the theme. I introduced a psychoeducational component to the sessions, which I considered a mistake, as I was not the one he needed to hear talk about masturbation and other sexual matters! His foster mother worried at times that he was becoming a very strong lithe young man. When he grabbed her in a rough embrace, she felt frightened of him. Dorothy was tearful, when she talked about his chronic state of friendlessness and when spoke of her repugnance at the times when his embraces became somewhat sexualised.
Anne Alvarez (1992) has talked about the starting point for the deprived child being that of a vision of empty desolation and nothingness—ash. His first steps towards a phantasy of possession, of winning a longed for object, pleasing it, attracting it, getting together with it need to be greeted with interpretations which acknowledge not omnipotence but powers and potency, not reassurance but the rightful need for assurance. He will hopefully learn not about the properties of absent objects, but about the properties of objects which return and about his own capacity to make them return. We need symbols for sunsets but also for new mornings. The deprived child may be moving from symbolic emptiness through a transitional stage to true symbol formation. In the latter case and on the latter flight path a different emphasis in the therapists interpretations may be required. (p. 168)

See the Moon

During the last twelve months of the therapy I moved to a different public sector workplace. I was able to see David privately, but only on a fortnightly basis, as that was within Dorothy’s budgetary constraints. The therapeutic setting changed and the cultural frame of the community team was no longer available (Bollas, 1987). The organisational structure of a Child and Adolescent Mental health Service provided a facilitating holding environment within which I, as therapist, and David, as patient, felt safe to do the work. David commenced sessions quickly and finished them slowly, eking out every single moment there was to be had in the fifty minute session. During the last few months of therapy, David invited his foster mother into the sessions in a rather impetuous way. I decided that I would follow his lead with some trepidation. Dorothy was not able to use her sessions with the family therapist to explore David’s emerging sexuality and sexualised aggression. On reflection it is possible that David was inviting his foster mother into the room as a way of foreclosing on the emerging sexualised transference within the therapeutic relationship. On reflection, it is apparent to me that I colluded with that foreclosure. I set limits on David’s behaviour including limits on his disrespectful and contumacious behaviour towards his foster mother in the sessions.

David grumbled at me for admonishing him, glaring deeply into my eyes, punishing me for daring to defy him. On one occasion the foster mother brought photographs of David’s birth family to the session. They had attended David’s biological mother’s birthday party. This was difficult for David to bear, but Dorothy and I helped him to tolerate looking at the photos. This really was an achievement for him, as it must have been bittersweet to view these images of a birth family that he can’t live with. I found his sadness palpable during that session.
The following week’s was a very difficult session. David played the role of a magician. He had me lie on the floor, tied a blanket around my head and knotted the blanket cord around my neck. I started to panic. This was not like the traumatic reenactment play we had experienced in the past. This felt potentially deadly. His foster mother was in the room watching this macabre scene. I was immobilized, aware of being shrouded in darkness and feeling a constriction around my neck. I said: ‘This game needs to stop, David! It is dangerous and no longer a game!’ I was relieved when it was time to finish.

After David left, I felt almost shattered by his sadism, his hatred, his desire to destroy. His foster mother walked out with him quietly, looking shocked. I heard ‘Toni, Toni!’ from outside the building. Slowly I prepared myself to walk out to David. I went outside to find mother and son gazing at the full moon suspended in the sky just over one of the Tullamarine freeway yellow upright constructions. He said ‘Look at the moon!’ We all gazed at the magic of the full moon. I melted inside. Despair was gone, washed away by the moment of David’s desire to repair the mayhem and destruction, the ruthless control of us, from the ashes of the session. Perhaps the new moon symbolically heralds the beginning of new potentials for David, of what he is yet to become.

Discussion

This paper ends on a sombrely contemplative note. The session above was the beginning of the end of the therapy sessions with David. The therapy could not continue. I talked with the case manager about my concerns. I told her that, with the onset of adolescence and the upsurge of sexual impulses, David had become focused on sadomasochistic themes. I sometimes felt actually frightened working after hours in the setting of my private consulting room. I no longer experienced the safety of the communal frame, of being surrounded by my mental health colleagues in the corridor. I was no longer able to think creatively. I was feeling frightened of speaking in case there was a violent reaction from David. I sensed his foster mother’s desperation, her rage at his contemptuous sexualised verbal attacks on her. ‘Fucking bitch!’ he would yell at her, into her, when she refused to give him his mobile phone to play with in the session. The sinister nature of the psychic darkness in the earlier sessions was being acted out in potential reality.

I conferred with the case manager. We decided on a case conference with mental health, education, Department of Human Services personnel, me and Dorothy. An atmosphere of sadness pervaded the room. I found myself reminding the group of how far he had come, of how this was a regression in the context of adolescent development. The decision was made for him to be seen by the mental health
adolescent team, in conjunction with a private adolescent boys group. In our final sessions, David and I took photographs of the therapeutic environment—the therapy room, his mother and me, and the turtle enclosure—to assist him in remembering our three years of work together. As he left the room on the last occasion, I watched him walking with his foster mother to their car. I considered him with immense gratitude for all that he had taught me. His trust in me and his dependence on my work with him was humbling. I sensed he knew that the work was becoming too dangerous, that in some ways I had truly failed him by not being able to survive his malevolent, sadistic attacks and abandoning him to his rage—the aspects of his abuse that he had internalised and identified with. This ending of the therapy leaves me feeling great sadness, mixed with granules of belief that David can use his intellect, his mathematical capacity, his devotion to his foster mother and his memory of the therapeutic encounter with me to truly see himself as the one whom he became, in my eyes and in the eyes of his foster mother—a frightened, creative, brave young boy who barracked for his beloved Australian Rules football team and dared to trust and hope.

References


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