

The Thinking Heart, The Loving Mind

THE APPLICATION OF PSYCHODRAMA IN THERAPEUTIC REUNIFICATION WORK WITH MALTREATED AND NEGLECTED INFANTS AND THEIR PARENTS

PATRICIA O'ROURKE

ABSTRACT

In this article, Patricia O'Rourke describes the way in which she applies psychodrama in her therapeutic reunification work with parents and babies in the child protection system in Australia. The paper was developed from a keynote address delivered to the Australian and Aotearoa New Zealand Psychodrama Association (AANZPA) Conference in Brisbane in January 2019.

KEY WORDS

babies, child protection, infant, Moreno, parents, psychodrama, therapeutic reunification

Introduction

The thinking heart, the loving mind... I love this image. It emerged as I was reflecting with a colleague on what it is that connects the various areas of my work. The first part, 'the thinking heart', is the title of not one but two books. The first is a book of delightful uncomplicated poems by a South Australian, Jenny Joseph, regarding her everyday life after the second world war, while the second is by child psychotherapist Anne Alvarez, whose work, mainly with autistic children, is exquisite and quietly revolutionary.

This image of a thinking heart and a loving mind shines a light on what I first warmed up to in psychodrama, that has since deepened and grown over time. Psychodrama is essentially an applied method. We all do this – integrate psychodrama into how we work in the various contexts where we work. This paper is about how I apply psychodrama when working in the area of parents and babies, where those babies have been harmed by their parents. And it is a thinking heart and a loving mind that I work to develop both in myself, and in my colleagues, when doing this work.

I began my professional work as a teacher, and then moved into the areas of child psychotherapy, counselling, psychotherapy and psychodrama.

Over this time, I worked out that whoever you are working with therapeutically, however old they are, at heart you are working relationally with the child or baby in them. In Morenian terms, this means relating in some form to their original social and cultural atom. I began to wonder about moving from this imagined baby to intervening early with the actual baby and the mother-baby relationship. For the last 20 years, I have focussed on working with parents and their babies, and with other professionals working in this area. Psychodrama underpins and profoundly informs this work.

The application of psychodrama with a thinking heart and a loving mind requires us to create relationships, nurture them and stay real in them. Relationship is not only what I work with, but also it is what has enabled me to do the work. Psychodrama is an embodied training where we learn to work within the tele of a relationship and with warm up. We do not just learn a method. We experience it in relationship with other real people having real experiences. 'Relationship' – creating relationship, being in relationship, sustaining relationship – is the heart of psychodrama and it is the heart of all my work.

This paper is a relationship – a relationship between me the writer and you the reader. I will write about what I do, and I am counting on this sparking your generous receptivity, your alive imagination as we encounter those elements we have in common – in your work and in my work – and as in any relationship, this will enlarge our experience and I hope create something more. We are certainly living in a world that needs more relationship, more connection. One in ten Australians are prescribed antidepressants. The World Health Organisation has recognised for years that depressed and anxious people are human beings with unmet needs for belonging, purpose, meaning and connection. They are not crazy, or machines with broken parts. This applies to my work with parents and infants in the child protection system.

There's no such thing as a baby, only a baby and someone...

Donald Winnicott (1964)

All children who enter the child protection system need a therapeutic response because they have all suffered harm. While harm is a disaster for any child, this is especially so for infants. Infants are heavily reliant on the relationship with their primary care-giver for the rapid structural development of their brains, which then affects all areas of their ongoing functioning and development (Zeanah & Zeanah, 2009). We wanted to create a service that could intervene early to make timely, long-term decisions for vulnerable babies who had already been harmed and were often

'bouncing' in and out of care¹. At this critical developmental period, babies need sensitive responsive consistent care because it is through repeated interactions that they learn to 'be in relationship'. In 2011, we received funding to set up the Infant Therapeutic Reunification Service, which is a partnership between state child protection and health services.

Working in the Infant Therapeutic Reunification Service

I co-ordinate the Infant Therapeutic Reunification Service (ITRS). We work with babies who have been removed from their parents because they have been maltreated, neglected or are at high risk of this occurring. We assess suitability for reunification with biological parents based on assessment of their parenting capacity. Where reunification may be possible within the infant's developmental timeframe, we provide intensive weekly therapy with parent and baby. Where timely reunification is not possible, we support long term planning and decision-making for the infant and sometimes provide therapeutic intervention with kinship and foster carers to help them understand and parent these disturbed babies. The ITRS also works intensively at a systems level to support child protection and other services to provide a wrap-around service for these at-risk families.

The greatest protection for a baby is to be held in the mind and heart of a sensitively attuned other...

John Bowlby (1988)

This is not easy work. Just being with these parents and their babies is hard. These are parents who have harmed their infants or allowed them to be harmed. They do not want to be there. They do not want to face up to what they have done or even think about it. They do not want to go anywhere near the psychic pain that it will throw up if they do think, let alone feel, about what has happened.

We know that intense emotional states in attachment relationships, whether they are related to passion, love or feeling threatened, can deactivate people's abilities to mentalise, that is, to understand their own and other peoples' mental states and so understand why other people behave in certain ways (Fonagy et al., 1991). Because of their own history, maltreating parents often struggle to recognise their own feelings, to read another person's intentions and/or make emotional sense of what is happening. They have usually developed maladaptive ways of thinking and feeling, especially when stressed. They find it stressful to be in relationship – with a

¹ Infant vulnerability arises from infants' physical fragility, dependence on others for survival, under developed verbal communication and their social invisibility. The first 1,000 days (conception to two years old) is a critical period in a child's development. Due to the critical nature of this development phase and the importance of interactions, experiences of abuse and neglect can have significant impacts upon the child's physical growth and psychological development (Moore et al., 2017)

partner, a baby or a therapist. Perhaps the most difficult factor is that although they crave relationship, they also fear it to the point of rejecting it whenever they sense it on the horizon. And they reject relationship in any number of ways, most of which are out of their awareness or control. They will lie, pretend, flatter, have a 'spit' and leave, rage, sneer, anything to try and 'throw the therapist off'.

And then there is also a baby in the room. The desperately loved baby who 'falls out' of the parent's mind when that parent has to think about something stressful or feels vaguely under threat of connection in a real relationship, of being seen or receiving empathy from the therapist. At these times, the infant feels the disturbance in the room, from the parent or the therapist or both, but cannot make sense of it and becomes agitated. The baby squirms, spits up, shrieks or cries to be picked up, only to wriggle to be put down. Having just seen their parent for the first time in days, some infants arrive only to fall immediately asleep. And they may simply sleep, session after session. Here are one therapist's brief descriptions of her first meeting with three babies arriving for therapy.

This baby does not look up. He stares at the floor, at the toy his mother has shoved towards him. He looks defeated.

At first it seemed that the pram was empty, but no, there was a small lump under the blanket attached to an even smaller scrunched up face dwarfed by a hot pink headband with a lacy flower on it.

This one has thin blondish hair, almost shoulder length, thin little arms like hollow tubes. Baggy little pants, always pink or purple, hanging off bony little hips. Hollow children, always small, pale, like fish you can see through, starved on every level.

As you can see, it is sometimes hard to even look at the infant. However, in our service we have learnt to keep our focus firmly on that infant. Sometimes we talk to the baby but more often we talk 'for the baby'. In psychodrama terms we double the baby, which shines a light on what is happening for them and provides them with the embodied experience of being seen, of 'being held in mind'. 'Good enough' (Winnicott, 1965) parents do this naturally. The parents in our service have never had 'good enough' parenting themselves. Sometimes they have been brought up in out-of-home-care and this, often coupled with the trifecta of homelessness, family violence and substance abuse, means that they are seriously compromised and at risk. Our job is to provide this parent, over and over again, with the experience they have not had: a loving mind and a thinking heart willing to be with them, to feel and think with them, to try and see the world as they see it, to

'hang in' and help them make sense of their own and other people's emotional states and behaviour. The aim is that they eventually provide this same experience for their infant, for at least enough of the time.

Attachment and intersubjectivity make up the double helix of psychological birth, it's how the baby grows a mind within the affective bond that develops between them and their primary care-giver...

Dan Hughes (2004)

We use the parent and infant relationship as the portal of entry to think about and provide social and cultural atom repair. We work to develop the beginnings of reflective function, to help our clients think and feel about their baby while at the same time experiencing their own thoughts and feelings. It is about the development of a new warm up, a new role system. These theories are helpful, but we also need to hold different perspectives, to look through multiple lenses. We are dealing with complexity and chaos, and not all parent infant reunification is successful.

We are in there with the baby, seeing them, talking for them, helping their parent see them and be with them in brief moments. This means that the baby will have a different parenting experience to the hopelessly inadequate experience of their parents. We give the parent a new experience to set up a new template for relationship. We warm up to being fully present with the parent and the baby in the moment, to provide a steady heartbeat that they can feel and respond to over time. Sometimes a parent will slowly, very slowly, begin to trust us, trust our intentions and maybe for the first time since they themselves were infants feel themselves again in their bodies, with their feelings and mind responding to us, momentarily, in relationship. At the heart of the work is relationship, creating relationship, nurturing relationship and staying real in relationship. It takes a long time and it is complex and difficult, as you will see in the following illustration with Sally and Jak.

Sally and Jak

Jak is three months old when his mother Sally first presents him at the hospital with an inflicted injury. His parents' lives are characterised by substance abuse and extreme domestic violence, and the denial, lying and terror that these encompass. Sally, now drug free for three years and separated from Jak's father, has her younger children living with her in her own home, with everyday contact with her older child. All of the children 'have had it rough' and for Sally, there is 'always a difficulty'.

During the last few months of therapy, Sally has focused on her relationship with Jak. He has been in multiple out-of-home-care placements for over a year and she is worried about his aggression and inability to share

her with the other children. She is afraid 'he's like his dad' and wants me to 'fix him'. I do not want to reinforce the idea to Jak that he is irreparably damaged. He is doing well at the childcare centre, where he is very protective of his little sister whom he bites viciously at home. The problem appears to be not so much in Jak, as in his relationship with his mother. I decide to meet with Sally on her own to focus on their relationship. Over a few sessions, we set out her social and cultural atom, and through concretisation, doubling and a little mirroring, Sally realises that, "Jak is just like me. He's going to have my life! Or his father's!"

Through previous doubling and mirroring and our reflecting together, Sally is aware that when she begins to feel intensely she yawns and becomes 'lost', in other words, she loses her capacity to mentalise. In this session, she remains present, warms up to her social and cultural atom and finally allows herself to feel intensely, not for long, but for long enough. We are both delighted. But the following week Sally phones to say that she is sick, and the next week she fails to keep her appointment. When I do not hear from her, small doubts creep in. Has she 'fallen off the wagon'? Is she 'back on the meth'? Has she taken up sex work again? I wait, then phone and leave a message for her. Still I hear nothing.

Then Sally phones the following week to tell me that she is, "getting ready for Christmas, doing the house" and cannot attend her appointment. Although I feel like shouting at her, "I can't keep seeing you forever! Jak can't wait!", I know that this would recreate her childhood experience of shame and blame. So, I say nothing. Sally says, "I saw my corrections officer for the last time last week. Four years I've been checking in. She told me that I'm one of her most successful clients in 15 years! Off the dope. Out of the DV. No more charges. All my kids (living with me)". I register Sally's pride. And then she says in a small voice, "You're not going to say you're not going to see me anymore?" The pain of it, because I had been thinking exactly that. I hear the despairing resignation in her voice. We make another appointment.

I saw Sally again weeks later. Over the Christmas break I had thought about her, role reversed with her and realised her sense of aloneness in a world that often does not make sense to her. It occurred to me that she may be presenting 'the problem of Jak' because she does not want to lose our relationship. I think of the spirit of psychodrama, its authenticity and abundance and generosity. I remember watching Max Clayton dive down into himself again, in a long drama with a protagonist who was just 'not getting it', searching within himself for a new response. I witnessed Max doing this over and over again, never giving up on himself or another. Although I feel cautious regarding the need for boundaries in therapeutic work, I decide to tell Sally that I am here for her, anytime. She is in my life now and has been since I accompanied her to court because she had no one else to be with her. If the court had sent her to prison, who would tell her

children why she had not returned home?

Sally arrives, not in her usual bouncy state but very distressed. All the hurt about her family of origin pours out, then the stories of 'getting drunk', becoming angry with her children and finally feeling terrible because she has enacted those old familiar roles learnt in her family of origin. However, she goes on to say, "At least Maggie was there for them and I went back the next day and I apologised to the kids. I said it was my fault. I was hurting and that's why I said those (angry) things". She explains that she had felt again the desperate abandonment that emerges every year at Christmas when, despite the huge changes she has made in her life, her family make no effort to see her or the children. Indeed, her mother cannot even remember where she lives. She cries and says, "It hurts so much". Later, Sally reflects that this is the third Christmas that her family has not acknowledged her and now, drug-free, she cannot 'medicate the pain away'. Finally, she laughs and says, "You know what? It was better when I didn't feel".

Sally had met Maggie in a pilot group that we ran at ITRS and they are now strong supports for each other. That group was one crazy ride – nine clients, eight women and one man – a naïve young man who learnt a lot in that group about women and life. All but one of those parents was successfully reunified with their baby, when we had not been very hopeful about most of them. In the group, they were able to share their experiences, including having their children removed from their care. They were able to have this experience normalised, to practise 'being in relationship' and to receive small doses of doubling and mirroring. However, there are times when reunification is not possible, as the following story of Alisha and Tarni illustrates. These situations, too, need a thinking heart and a loving mind.

Alisha and Tarni

Alisha presents with Tarni. Alisha is 17 and this is her second baby – both to the same father. Alisha has 8 half siblings – no full siblings. She has no relationship with either of her parents and cared for her mother's younger children from the time she could walk until she left home at 14 to live with her boyfriend and his family, although they too were troubled by domestic violence. Tarni was taken into care when she was born. She lives with a big-hearted foster-mother who also has Alisha's older baby. The foster-mother manages a boundaried, positive relationship with Alisha which is no small feat. Tarni is a bonny little four-month-old.

Alisha presents like the young teenager she is, with her black eyes and green hair. She fronted up to our first therapy session with a real black eye and bruised face. "I got jumped by two girls in the city", she tells me smiling. "It was sort of my fault." I am reeling. It is her brave cheerfulness that is so brittle that I feel if I breathe out too heavily she might shatter. Alisha teases Tarni gently and she responds smiling. Alisha allows herself to be besotted. I

remember thinking hopefully that at least we have a healthy baby going for us here.

It is not enough as it turns out. Over the next few months we can not manage Alisha's ambivalence – which is, tragically in this case, actually a small sign of health. I wonder if she always at some level knew she could not do it. This ambivalence meant that at critical moments, she reverted back to binge drinking and living dangerously on the street, finally waking up next to her drug-using friend, dead beside her. He had died overnight from an accidental overdose. From then on – the work was to keep Alisha alive.

Tarni could not wait any longer for a safe home, a secure base, the continuity of care provided by a long-term, good-enough, growing-up home that will allow her 'to go on being', growing into herself as she is doubled and mirrored and learns eventually to role reverse – a thing her birth mother, Alisha, never had.

Ongoing Challenges

Working in the reunification space is fraught with unknowns and complexities. We strive to keep a thinking heart and a loving mind. However, the level of vulnerability in us and in our clients is often intolerable. This is how one of our therapists describes it:

It's the feelings that arise, the thinking that is lost. It's the wide-eyed silence of unheld babies that invades the room. You have to be there, tolerate it. You can't run, though you want to. You need to know what it is, in you, and in them, that has you running. The unbearable presents itself over and over, asking to be held.

We use the encounter in the therapeutic relationship, the tele in the 'here and now', to help parents learn to be with their babies and the babies to be able to take them in. And our clients accept nothing less than a **real encounter**. If they get any sense that we are not being real and authentic with them they will walk out, and they won't come back. You cannot be anyone but yourself when you are with them.

The encounter is a telic phenomenon. The fundamental process of tele is reciprocity – reciprocity of attraction, reciprocity of rejection, reciprocity of excitation, reciprocity of inhibition, reciprocity of indifference, reciprocity of distortion... A meeting of two: eye to eye, face to face...

Jacob Moreno (1969)

The corner stone of our work at the Infant Therapeutic Reunification Service is a willingness to return and hold oneself in the encounter, those 'moments

of meeting' (Boston Change Process Study Group, 2010). 'Being with', providing the experience of relationship, being one's self in relationship, and developing the capacity to think and feel in relationship – this is what we work to create in ourselves and our clients. It is a thinking heart and a loving mind that helps us bear the 'unbearable' and make sense, in the moment, of our experience – the babies, the parents, and us.

REFERENCES

- Boston Change Process Study Group. (2010). *Change in Psychotherapy: A Unifying Paradigm*. W.W. Norton & Company, New York.
- Bowlby, J. (1988). *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Basic Books, New York.
- Fonagy, P., Steele, M., Steele, H., Moran, G. & Higgitt, A. (1991). The Capacity for Understanding Mental States: The Reflective Self in Parent and Child and its Significance for Security of Attachment. *Infant Mental Health Journal*, 12(3)201-218.
- Hughes, D.A. (2004). An Attachment-Based Treatment of Maltreated Children and Young People. *Attachment & Human Development*, 6:263-278.
- Moore, T.G., Arefadib, N., Deery, A. & West, S. (2017). The First Thousand Days: An Evidence Paper. Centre for Community Child Health, Murdoch Children's Research Institute, Parkville, Victoria.
- Moreno, J.L. (1969). *Psychodrama Third Volume: Action Therapy and Principles of Practice*. Beacon House, New York.
- Winnicott, D.W. (1964). *The Child, the Family and the Outside World*. Penguin Books, Middlesex, England.
- Winnicott, D.W. (1965). Ego Distortion in Terms of True and False Self. In Winnicott, D.W. (Ed.), *The Maturation Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. Hogarth Press, London.
- Zeanah, C.H. & Zeanah, P.D. (2009). The Scope of Infant Mental Health. In Zeanah, C.H. (Ed.), *The Handbook of Infant Mental Health* (pp.5-21). The Guildford Press, New York.



Patricia O'Rourke, PhD, is a psychodramatist, educator and child psychotherapist. She has a special interest in preventative work with infants and their families, child protection, reflective supervision and group work. She coordinates the Infant Therapeutic Reunification Service in the Women's and Children's Hospital in South Australia, is a Senior Lecturer in the Paediatric Mental Health Training Unit at Adelaide University, and provides supervision and training in private practice. Patricia can be contacted at <patriciaor@pxorourke.com>.