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JOURNAL ARTICLE

Original citation: Gustavus-Jones, Sarah (2007) *Negotiating time. The significance of timing in ending inpatient work.* Journal of Child Psychotherapy, 33 (3). pp. 325-344. ISSN 0075-417X

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Negotiating time: the significance of timing in ending inpatient work

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Abstract *This paper discusses work with young people during their stay on an NHS psychiatric inpatient unit, especially focusing on the end of treatment and the appropriate timing of discharge into the community. When approaching the end of an admission, various factors are considered that seem particularly relevant to the decision of when a young person may be ready to leave and cope with the transition back to life outside the unit. Indications of medical stability, in patients where this has been an issue, is a factor of prime importance. Other important factors include family functioning; the availability of adequate ongoing local CAMHS support for the child and family; suitable school provision; and the identity of the child within a peer group. The reality of NHS resources and the demand for inpatient beds is another pressing consideration. The young person's own motivation emerges as crucial at this stage – towards the end of treatment – not only in terms of what is said, and therefore evident verbally, but also through signs of internal shifts in the child that indicate a capacity to re-engage with life outside in a lasting way. Decisions about when to stop are taken with all this in mind and when the decision does not seem straightforward, it can provoke considerable anxiety in the multi-disciplinary team. Clinical material from psychotherapy with a young adolescent boy with anorexia nervosa is used to illustrate some of the dilemmas.*

Keywords Inpatient work; timing of discharge; internal shifts; external factors; somatic illness; Oedipal issues; time and space; psychic retreats; Unit as prison; Unit as retreat; Unit as therapeutic space; time-limited psychoanalytic psychotherapy.

Introduction

This paper discusses work with young people during their stay on a hospital inpatient unit, especially focusing on the end of treatment and the appropriate timing of discharge into the community. While some of the factors that are significant to the timing of discharge are external, others are more linked to internal change. Discussion of external and internal factors in this context leads to thoughts about disturbances in time and possible indicators of progress seen through the process of psychotherapy.

The detailed clinical material of a young adolescent boy called Peter is used to illustrate these issues.

Becoming ill and being admitted to hospital is invariably a traumatic experience. It takes the child outside the time continuum of ordinary, everyday life and locates them in hospital. Until they are well enough to leave, they cannot rejoin a normal living relationship to the world and until they do that, they cannot really be said to be in step with time along with their peers. In this sense, being in hospital takes them out of ordinary time.

The young people are admitted with various different problems. What seems to be the same for all of them, however, is that their stay involves them, to some extent, in negotiating the timing of their own developmental process as it is interrupted by their illness and hospital admission.

Joanne, for example, suffering from conversion disorder, was 13 when she arrived on the Unit – very sleepy, unresponsive and wheelchair bound – and she looked about 10 or 11. At first, she wanted to leave as quickly as possible but then kept changing her mind, and when her discharge date came she said it was too soon and the date was changed. When Joanne finally did leave, she looked much more like the teenager she was, and she had also managed to negotiate a further three months of individual psychotherapy post-discharge. Other patients, like Simon, who was 12, had a conversion disorder and arrived at the Unit in a fixed prone position and being tube fed. For a long time he took a pride in being the illest patient on the Unit who had been in hospital for the longest time. There always seems to be a certain amount of competition for this particular position amongst some of the patients. Simon did not like to hear anything about discharge or any possibility of making progress.

The Unit

The Unit is a Tier 4 NHS children's psychiatric inpatient unit for 7–14-year-olds. It takes referrals from around the country as well as those from the local Tier 4 Specialist CAMHS team of which it is a part. It is a nine-bed unit and costs the referrer approximately £2200 per week, per child.

The treatment programme and the multi-disciplinary team

The treatment programme, delivered by the multi-disciplinary team, is intensive. Within a framework of psycho-social nursing, each child is allocated two 'key workers'. The Nurses and Therapeutic Care Workers also run various therapeutic groups and community meetings, with the aim of giving the young people opportunities for working with peers. All the children go to the small school on the Unit and, in time, progress to the larger hospital school. The children and their families all attend regular family and individual work. The relationship between the different aspects of treatment in an inpatient setting is interwoven and there is a strong emphasis on combined efforts working together, where one area of work in the multi-disciplinary team is felt to be no more or less responsible for treatment outcome than another.

Liaison with local services

Regular six-weekly Review Meetings are held for each child. At the beginning of an admission, the Review Meeting is the place where the family sees the inpatient team and outpatient professionals all together discussing their child. The ongoing involvement with local CAMHS throughout an admission – their support and interest in the family and child – feels crucial, and the Review Meeting becomes the focus of contact. As the Review Meetings are repeated – and discharge becomes more of an issue – the atmosphere of meetings can shift and there seems to be a perpetual question hanging in the air: Who now ‘holds’ this child and family emotionally? An ongoing negotiation between inpatient team, family and outpatient services around this question is played out in the Review Meeting and the issue of time is gradually drawn into sharper focus. The question goes much deeper than medical and clinical responsibility. The child and family will eventually need a discharge date, but they cannot be discharged into nothing. On a very basic level, it would not feel helpful for the timing of discharge to coincide with the beginning of an unstructured school holiday and when CAMHS support is mainly unavailable due to annual leave. On a deeper level, the child and family need to feel supported and held in the mind of their local team.

If staying on the Unit is seen as a kind of ‘time out’ from life, leaving the Unit could be seen as re-engaging with time as part of a continuation of the developmental path that has been interrupted while the young person has been ill. While staying on the Unit may be necessary for them, they cannot afford to disassociate themselves from the time and space of the outside world too completely or for too long, as time and space are the basic co-ordinates of existence – a part of the reality of life. In order to develop, they need to re-engage with this reality, and for this they need strong, supportive footholds outside the Unit, particularly at the time of discharge.

The Unit as a retreat

When thinking about ending this kind of treatment, it may be helpful to think about what is being left behind. The average length of an admission is five months, although some patients with more severe conditions can sometimes stay for about a year. When a young person arrives in a particularly shut down state, I have often had the impression that the Unit symbolises for them a place of ultimate retreat – the final stop in a refusal to engage with life in ordinary ways. At the same time, there is often a strong resistance to a psychological approach and attempts to understand what may be causing so much pain in the mind. Wedded to the idea that their illness has an organic cause, the young people often do not want to be on the Unit one bit. Sometimes, on the other hand, the young people can feel worryingly settled and there is an eerie feeling that this is less to do with what the Unit is offering, and more to do with clutching ever more tightly to the identity of being the illest child in hospital. There is powerful feeling of ‘stuckness’ in this situation, very much along the lines of John Steiner’s descriptions of ‘psychic retreats’ (Steiner, 1993).

So, being ‘in’ hospital and not ‘out’ in the world seems, in this way, to reflect a state of mind where progress is limited. Historically the child has physically been born into

the world, located in time and space. This existence has been tried out, but something – at some stage – has gone wrong. The emotional and psychological conflict involved seems to have been experienced as completely overwhelming. What has not been possible to work through, psychically, spills over into a physical expression in the body. Using the body in this perverse way can put the young person in grave physical danger, painfully witnessed in somatic illnesses, including anorexia nervosa. When being in hospital represents being ‘inside’ in this unfruitful way, divorced from the reality of time and space, engaging a young person in treatment in a genuine way is an enormous challenge, let alone imagining a time when they may be genuinely ready to end. Ending in this context may, for the child, mean leaving an unprofitable, risky but more emotionally unchallenging and therefore ‘safe’ haven and being open to real-life experiences outside – that is, facing the monsters that felt sufficiently overwhelming to drive them ‘in’ in the first place.

I think there are some interesting parallels here with Jan Anderson’s research into risk-taking, dangerous behaviour in childhood, and the three different situations in which these occur, described as ‘no haven’, ‘illusory haven’ or ‘perilous haven’ (Anderson, 2003).

The Unit as a prison

Another patient perspective of the Unit that emerges regularly is that of being inside a prison. Then the staff may be seen along the lines of prison warders, depriving patients of their freedom and individuality. Getting ‘out’ and going home for the weekend feels a bit like parole, and the treatment programme is looked at askance as something cruel and controlling. The weekly Ward Round is described, for example, by 11-year-old Louise, as the place where the ‘fat cats’ meet, interested only in their own greedy power to make punitive decisions about a young person’s life. Sometimes one strand of the treatment programme is idealised and another denigrated, each time afresh challenging the team’s capacity for thoughtfulness rather than acting out in ways that lead to staff feeling fragmented and cut off from one another. This ‘prison’ Unit has retribution as its focus more than rehabilitation and, for the child, ending treatment has little to do with making progress. In this context, discharge simply means ‘release’.

The Unit as a therapeutic space

The aim of the treatment programme is to help the young person make progress and move forward. But the first task is to try and create a thinking space that redefines for the patient what it means to be staying on the Unit. If they get too far in, it becomes like a Meltzerian ‘claustrum’ (Meltzer, 1992), where thinking is not possible – at first more like a place to hide and then its deterioration to a place where one feels imprisoned. But being outside has proved itself too overwhelming and something else is urgently needed. If the Unit could be seen to function as a kind of transitional thinking space – on the boundary of inside and out – then some kind of therapeutic work may be possible. This kind of borderline position is perhaps particularly symbolised by the dynamics of the Review Meetings as the outpatient professionals are represented alongside the inpatient

team as an inevitable part of reality and development. Maintaining itself as a transitional thinking space therefore seems to involve the Unit facing in two directions at the same time: an equal focus not only on the therapeutic work as it happens on the Unit, but also on the progressive moves outward, where real life is – with all its opportunities for further growth. Full rehabilitation can only happen in the context of ordinary life.

Ending

There remains the question of how much therapeutic work is needed before discharging a patient back into the community. This question is asked bearing in mind that the Unit does not aim to ‘cure’ patients before discharge, but rather to discharge them when they are well enough to manage life outside, where the local CAMHS team can support their ongoing development and progress, in some way continuing the work started on the Unit. Although the work of the Unit is made up of different strands, which feel impossible to separate in terms of inpatient treatment outcome, it also seems helpful for each discipline to have a sense of what may be the necessary input in their particular area of work, and how this input may then interact with other strands of the inpatient treatment to good effect and a positive outcome for the patient. Judith Trowell’s outcome study on childhood depression (Trowell *et al.*, 2007) has shown that time-limited psychoanalytic psychotherapy is effective for lasting change, and this is particularly encouraging in the context of inpatient units where input often coincides with the minimum 30 sessions specified in Trowell’s research.

I shall now discuss a case in more detail to illustrate some of these issues.

Case illustration: Peter

At the time of his admission, Peter was 13. His older 19-year-old sister had Downs Syndrome, and he also had two younger brothers, eight and four years old. Peter’s parents were articulate, professional people, both Kenyan Asian and both working in responsible positions in the field of engineering. They came to Britain from Kenya in the early 1970s and now lived in a terraced house in a suburb of London.

Peter’s difficulties started after a bout of flu. He felt very nauseous and this put him off eating. He lost a significant amount of weight and needed a hospital admission for nasogastric tube feeding. At the same time, he was suffering from other physical symptoms, especially pain in his arms, and he had some unusual physical movements. It was unclear whether there were organic causes behind his symptoms and he had many tests. Peter was then assessed and given a diagnosis of anorexia nervosa. He arrived at the Unit a week later, having dramatically lost weight again – his weight for height now being just over 60% (the healthy range is between 95% and 105% weight for height). Peter looked close to death and his appearance panicked the other children on the Unit, who described him as a ghost. He was immediately transferred to a general paediatric ward and was felt stable enough to return to the Unit the following week.

When I first met Peter he was skeletal and in a wheelchair. His dark eyes looked huge and his cheekbones jutted out sharply. His black wavy hair fell across one side of his face in a striking way.

Session 1

Because of the very high level of anxiety in the room, I felt I needed to speak for a while, talking generally about once weekly individual psychotherapy on the Unit, and also trying to address some of Peter's possible concerns about it, not really knowing me, and so on. Peter jiggled his legs in a pronounced way, never taking his seemingly unblinking eyes off me for a second, and was not forthcoming. He eventually baldly said he had got flu and then couldn't eat – there was no build up. I said it must all feel very bewildering. Peter curtly nodded, his long hair now covering more of his face. When I asked more about his experience since arriving on the Unit, Peter was more communicative over medical issues. He highlighted some disagreements and hinted at possible mistakes over his medical investigations. I said perhaps there was a question in his mind about whether the Unit was in fact the right place for him, how strange it all felt, and could we even be trusted. Peter agreed with this. He was then able to tell me a bit about his family, the high professional status of his parents, how he looked out for his older sister, and also a few details of his hobbies and interests before becoming ill.

It seemed that Peter needed to let me know something about his previous way of functioning, when he was the one doing the important, 'high status' job of caring – looking out for his sister – and what a shock it was to find himself in this different place, in the Unit and in therapy, where he was now the one who seemed to be in need. It just did not feel right.

In Peter's third session, he talked about his family's involvement in their local church and how when Dad came to visit Peter on the Unit, he would read him a story from the Bible. Peter always asked for the same one, his favourite one since becoming ill. It was the story of Jonah and the Whale. I asked if he could tell me about it:

Session 3

Peter said that God wanted Jonah to go to Nineveh and lead the people there out of wrongdoing. But Jonah is scared and doesn't want to go. So he runs away to sea. He finds a boat going somewhere but God sends a storm. At first Jonah hides but then he feels guilty and tells the sailors to throw him out of the boat. He is swallowed by the whale and lives inside, where he praises God, and so the whale throws him up, back on to the beach. Peter smiles a bit at this point. I asked what happened to Jonah. Peter said he then went to Nineveh and did what God had wanted him to do in the first place.

The Prophet's Prayer is given in Jonah 2:

... Out of the belly of hell cried I,
 And thou heardest my voice.
 For thou hadst cast me into the deep, in the midst of the seas;
 And the floods compassed about:
 All thy billows and thy waves passed over me.
 Then I said, I am cast out of thy sight;

Yet I will look again toward thy holy temple;
 The waters compassed me about, even to the soul:
 The depth closed me round about,
 The weeds were wrapped about my head;
 I went down to the bottoms of the mountains;
 The earth with her bars was about me forever:
 Yet hast thou brought my life from corruption, O Lord my God;
 When my soul fainted within me, I remembered the Lord . . .
 And the Lord spake unto the fish, and it vomited out Jonah upon the dry land.

The imagery of the prayer graphically illustrates Jonah's claustrophobia inside the 'belly of hell', as weeds wrap themselves around his head and the underwater earth imprisons him 'with her bars'. In the weeks that followed, we returned to the story a number of times, mainly linking it with Peter's current experience of feeling trapped inside the Unit, as in some kind of prison, which Peter readily agreed with. His fascination with the story of Jonah and the Whale also seemed linked to it being a story between a father and a son. We talked about Peter's relationship with his own father, his concerns about him during a period of gastric illness three years ago (from which father subsequently made a full recovery). Peter's greatest fear, which he could not speak of and so wrote down on paper, was that his father's illness would come back and he could die. The piece of paper remained in Peter's box, which he then did not open for a long time.

In the story of Jonah and the Whale, the son defies the authority of his father. But the father's punishment is not straightforward, as the fish's 'belly of hell' also saves Jonah's life, perhaps this being more linked to the idea of a possible retreat. Peter also seemed to realise that the Unit had his best interests at heart but rather like God's provision of 'a great fish to swallow up Jonah' and save him from the raging seas, his current experience on the Unit felt like a different kind of punitive torture. He now felt imprisoned and he just wanted out. He became a model patient on the Unit, eating all his meal plan, contributing to groups, and so on. He wanted a discharge date and was doing many of the right things to get it.

Although Peter did use his individual sessions to talk, there were often occasions when I felt he seemed to be holding back. But while remaining adamant about not accepting the label of anorexia, he did tell me he sometimes felt flooded with thoughts about eating before and around mealtimes, particularly a voice in his head that said, over and over: 'Don't eat, don't eat'. What also began to emerge very clearly in both Peter's family and individual sessions, was his strong attachment to his mother and his feelings of powerful rivalry with his siblings and his father for her attention. This was also confirmed in the transference relationship with me as Peter seemed particularly competitive with other patients of mine on the Unit. I also felt very aware of how closely we seemed to walk together, up and down the stairs to his sessions, his step almost precisely in time with my own; it felt like he was almost inside me. However, my feeling about Peter 'holding back' remained and I began to wonder if discharge would be when work with Peter could really develop. He was slowly but steadily putting on weight and his thoughts about discharge now also generally seemed more realistic in the mind of the team.

Team discussion around discharge

When approaching the end of an admission, various factors are considered that seem particularly relevant to the decision of when a young person may be ready to leave and cope with the transition back to life outside the Unit.

Indications of medical stability, in patients where this has been an issue, is a factor of prime importance. Family functioning also emerges as an important factor, as does the availability of adequate, ongoing local CAMHS support for the child and family. Suitable school provision and the identity of the child within a peer group are also highly significant. The reality of NHS resources and the demand for inpatient beds is another pressing consideration. Similarly, the young person's own motivation emerges as crucial at this stage – towards the end of treatment – not only in terms of what is said and therefore evident verbally, but also through signs of internal shifts in the child that indicate a capacity to re-engage with life outside in a lasting way. Decisions about when to stop need to be taken with all this in mind and when the decision does not seem straightforward – as it rarely does – it can provoke anxiety and inevitable debate within the multi-disciplinary team. Peter's case was no exception.

There is always a certain amount of anxiety around discharge and endings, and discussions in the inpatient team tend to reflect this, with different members of the team speaking 'for' while others speak 'against'. While the process can often feel very uncomfortable, on reflection it can also be recognised as helpful if it enables us to be more in touch with the patient's and family's possible anxieties around ending. The team can then experience, work through, and try and emotionally contain this on the family's behalf. But, at the same time, is the patient really ready to end now? Would a few more weeks help to consolidate any progress that has been made?

Medical

Although still thin, Peter was now medically stable, and he was steadily gaining weight each week. It was reassuring that Peter would, when the time was right, be discharged to an outpatient CAMHS team experienced in eating disorders.

CAMHS provision

The outpatient CAMHS team felt confident about Peter and had experience of working with similar low weight patients on an outpatient basis. Peter's individual psychotherapy sessions could continue with me, and family sessions, a parents' support group and a young people's group could also be offered. The outpatient package was therefore substantial.

Family functioning

By now, Peter had been going home for weekends on a regular basis. There had been issues around anger and control at home, especially around mealtimes. More recently, Peter had been showing his anger particularly towards his father – with a number of episodes of shouting, biting, kicking and scratching. It felt significant that Peter's parents

were able to be very open and realistic about the difficulties they were experiencing. This then enabled them to work closely with the inpatient team during such times. They now felt more confident about managing Peter at home and they were keen for discharge.

Peer group and school

Peter was now regularly meeting old friends over the weekends at home. A gradual school reintegration programme looked feasible, and when this started Peter seemed to be managing well.

Motivation

Peter seemed highly motivated, looking forward to discharge, and keen to be back at school and at home with his family. He was also willing to work on his ongoing difficulties on an outpatient basis.

Internal shifts

My feeling was that it was still early days for Peter and the nursing team also expressed some concern about Peter's inpatient admission feeling somehow 'too easy'. On the other hand, he had used his individual sessions well in terms of talking about his difficulties – feelings of rivalry, anxiety about his father's health, worries about eating, and so on. I felt reassured that I could continue with Peter as an outpatient where further progress could be made. I also thought Peter's wish to leave hospital was more healthy than not wanting to leave.

External pressure

The reality of the NHS is that there can be some pressure on beds, with the team aware, through Referrals Meetings, of other potential patients waiting in urgent need. Patient turnover is also a factor that seems to identify inpatient Units as working well, so helping the Unit's profile in a generally pressurised climate of NHS cuts. As the discussions around possible discharge continued, Peter had now reached 85% weight for height.

Decision

On balance, it was felt that Peter was ready for discharge. At his third Review Meeting, a discharge date was set with the time and date of Peter's Leaving Drinks confirmed.

The reason I chose to discuss Peter's discharge in particular is that, very unusually, five months later he was readmitted to the Unit. His weight had dropped from 85% to 70% weight for height. Could there be a way to have predicted that Peter was not ready for discharge? Every situation contains its own complexities, and such situations are always opportunities for reflection. In hindsight and with some close retrospective consideration of Peter's case, it may be possible to identify what essential ingredient was missing in terms of his capacity to cope as an outpatient.

Peter's struggle as an outpatient

Initially Peter's family coped well and supported Peter through his difficulties with eating, which continued to be an ongoing and time-consuming struggle. However, the family was thrown into crisis by a series of very distressing and tragic events a few months later, including the sudden death of maternal grandmother. Apart from Peter's own feelings of loss, his grief-stricken parents were temporarily less able to make his eating difficulties the focus of their attention and he needed to fit in with the family more. Peter found this very difficult to accept and mealtimes became arenas of potentially explosive tension.

Around this time, when Peter began to lose weight again, I began to experience a growing sense of unpredictability in his outpatient sessions. I felt his eyes on me again in an unblinking way, and I felt he was looking at me with a kind of hatred. But it was confusing, as he also seemed to be clinging to me with his eyes. I felt very unsure how I could take this up with Peter.

To try and distract himself at home around this time, Peter began writing a story, which he brought to his sessions.

Session 28

Peter told me his story was about two characters who needed to escape an Evil King. They spent a long time burrowing through a tunnel before going on a raft and heading towards a beach. They thought at one point that the Evil King was dead but then discovered in fact he was alive again. The beach was a way out, but there was also danger there.

In his next session, Peter was listless, and told me everyone at home had given up. Everyone was 'flat'. He didn't think he'd contributed to this. I mentioned my hearing that he had been hiding food, which he hadn't told me about. Peter vaguely said he hadn't really thought about it. The session continued:

Session 29

I said I thought something was also happening here, between us, which may need talking about. Peter looked more interested. I said I thought he was, in one way, working in his sessions – talking about his story, etc. – but also that he left things out, and some things, particularly linked to his eating, remained hidden. Peter gave me a chilling look. I said I also thought that although he seemed to genuinely appreciate our time, there was a part of him that hated it, and hated me for bringing these things to the surface. Peter smiled and said he thought it was true. I said when he looked at me sometimes I could feel it very strongly, like just a moment ago. What seemed important was that I could know these things about him – the hidden secrets – and could be resilient enough to face the truth about it, not give up or be defeated. We needed to work with this in mind. The 'flatness' seemed like a way out for him too, but it felt dangerous, less engaged, less human.

Peter went on to describe more about his story. He said the slaves of the Evil King had gone after the two characters who escaped to the beach, but some slaves

stayed with the King. In the end, the King was killed and the two characters on the raft reached the beach, but a small black fish/snake slipped back into the water.

In the following two sessions, Peter remained listless. He talked about his anorexia as 'Chuck'. I found myself becoming more challenging, commenting that he often agreed with what I said, but nothing seemed to have any impact. I said I thought Chuck sounded too friendly – how about the black slippery fish/snake, a part of himself in league with the slaves that never really left the Evil King. Peter responded by struggling to try and explain something to me about muscle.

Session 32

I was shocked. Peter looked like a skeleton again. He said he'd had a bug and couldn't eat during part of the week. He said he knew he was coming back into hospital. He felt really disappointed. The atmosphere in the room was very heavy and Peter was struggling to speak. He drew a picture of himself on medication, smiling, but he said he couldn't think or feel anything. Then he drew a picture of himself off medication, with a blank face. When I commented on the blank face he said, 'I don't know something'. Peter quickly scribbled down lots of goals, the most striking being something about the need to develop physical strength, muscle... I wondered what he thought had happened. Was it something to do with the black slippery fish/snake? Peter said he didn't think it was exactly that, but something like that.

What these events seemed to confirm was that the changes seen in Peter while he was an inpatient on the Unit were essentially external changes and, when under pressure, they could not sustain him outside. The crises in the family then made the home structure more fragile than it may have been otherwise. To cope with life outside, a patient needs to have developed a certain level of internal capacity, which can then link with enough parental resilience to bear the strain of the child. During his inpatient stay, Peter had talked about important things, but there had been no significant internal shift, which indicated a new capacity in Peter to re-engage with life outside in a lasting way. This is what seemed to be missing. The nurses felt it was 'too easy' and internal shifts do not come so easily. Outside was a new world to him, and when he said 'I don't know something' it seemed that he really didn't know where he was in this new world.

From the perspective of psychoanalytic psychotherapy input as part of Peter's treatment programme, it is interesting that my last individual session with Peter as inpatient was session 15 – half the time recommended by Judith Trowell's study to support lasting change.

Second admission

On his second admission, Peter was again dangerously underweight. A few weeks into the admission, he asked for a second individual session, as he was finding the waiting particularly hard. We agreed this would be helpful, although for practical reasons it would not be possible for a while.

Peter talked about the second admission being different from the first and he didn't like it. I commented that he was not being the 'good boy' of the first admission. In fact, Peter was being very tricky with lots of spilling and smearing food at mealtimes. He also wanted to be in the kitchen when the nurses were preparing the food; it had been the same when he was at home with his mother. Now, on the Unit, the nurses were similarly being driven to distraction. When I tried to explore this with Peter he told me he thought the nurses were 'doing something' to his food. I asked if this was related to portion size? Peter said, 'No'. I asked what he thought they were doing then. 'Meddling with it,' he replied. I asked if he thought the nurses were trying to poison him. 'Yes,' he said. We clarified that he had had the same feelings at home and Peter agreed that he would find pre-meal support from nurses helpful, addressing this issue directly. This was subsequently arranged. I was also able to address Peter's suspicions about me and our work together. What was I up to?

Peter then told me about an upsetting incident at school, related to his current preoccupation with avoiding fat and developing muscle, which he said happened when he returned after his first hospital admission. Three boys in the playground had teased/bullied him saying, 'They sent you away to get fat, and now you're back,' implying that he had returned fattened up. Something about the story felt very humiliating. There was a feeling that Peter needed muscular support, both physically and emotionally.

Session 37

In Peter's session before the Easter break he arrived very tearful, saying he thought the nurses were angry with him and had given up on him, giving an example of an incident with a fruit smoothie at breakfast time. Reading between the lines, it sounded to me as though Peter was being tricky but the nurses were portrayed by him as cruel and at fault. The idea of the Unit as a prison emerged very strongly again, with the nurses as prison warders. When I suggested this Peter agreed that this is what it felt like. I said I was having another idea, that his anorexia was holding him prisoner, like a kind of hostage, pushing him to smear, hide food, water down his juice in the fridge, take advantage of any second a nurse's back was turned, any moment of human error on their part, like the example of the fruit smoothie. This was the world he was living in and it was a terrible one. Peter nodded. I said this world seemed to get muddled up in his mind with the Unit and the nurses, who were actually trying to pull him out of the anorexia prison he was in. There was a pause and I wondered how I might fit into all this. Perhaps in the anorexia world I was meant to be the one he could dupe, pull the wool over my eyes, play down the anorexia and all his behaviours around food. But it seemed helpful that I could, in fact, see the whole picture in a real way.

I wondered, also, with a two-week break coming up, whether it felt like I too was giving up on him. We had a few minutes left of the session and I wondered how he may feel able to hold onto our work together over the break. Peter said he didn't know how to do it and began to cry. I said it felt very difficult for him and after some moments I suggested that Peter may find it helpful to write something down in the break, perhaps a book in which he could write a little bit

every day, as if he was talking to me – he could see if it worked for him. Maybe he would find it helpful to try very hard and notice not only what he was thinking about but also what he did – there could be a separate column for each. Peter seemed to catch hold of this idea and nodded. I walked with Peter back up to the Unit and there was a noticeable firmness in the way we made eye contact and said goodbye.

At the end of a session and just before a break, Peter seemed to be dissolving into water as he cried and said he didn't know how to hold on to our work together. This may link to his earlier experience of being discharged before he had the internal capacity to cope more independently with life outside the Unit. With moments to go before the session was due to end, I was faced with a decision about technique and the introduction of an idea that is not necessarily common practice in psychoanalytic psychotherapy. I felt, at this point, however, that I needed to give Peter something rather physical, the idea of a book, to hold on to in his mind, perhaps a kind of external support which he seemed to need in order to (a) leave the session, and (b) to keep in touch with our work over the break. I wonder if this departure in terms of technique is particularly relevant to patients who tend to somatise their difficulties, and are not yet at the stage of having developed a more muscular support internally. Possibly the two columns I suggested – thinking and doing – gives some kind of acknowledgement to this stage of development, while also trying to encourage Peter to link these two distinct areas in his mind, and take responsibility for them both, which the somatising aspects of his illness seem so determined to avoid. These kinds of departures in technique are certainly subject to debate.

Meanwhile, something more robust seemed to be developing at home. Peter was now well enough to leave the Unit at weekends but at home was being very demanding of all his mother's time. Dad finally put his foot down and one morning insisted Peter stay with him while mother spent time with Peter's sister and brothers. Peter became furious and attacked Dad – shouting and hitting him. But Dad remained firm and the family were able to have a good afternoon in the end. In the same session, Peter complained about the attention the busy nurses gave all the other children on the Unit and we were able to link this with mother giving attention to his siblings and, to top it all, he was still having to wait for a second session with me.

Three dreams

In the weeks that followed, something seemed to change. Peter brought a series of dreams and I would like to describe this material in more detail:

Session 39

Peter began the session by telling me, with a hint of amusement, about a longstanding dispute his father was having with their neighbours on one side, about a boundary garden fence issue between the two properties.

Peter went on to talk about going home for the weekend, how he was looking forward to it, and it felt better as he was more in the routine of being on the Unit

and spending weekends at home now. I said that made me remember the previous weekend at home, when he'd had an argument with Dad. It made me think of his dad as the boundary keeper, not only of his land – as in the garden fence story – but also of his mum when Peter wanted to spend *all* the time with her, almost get right inside her – something we had talked about a lot together. Peter said it was like that.

I said it felt really hard for him when mum spent time with anyone else, Dad included – at one point there was an upset over his dad sleeping with his mum when Peter wanted her to sleep with him. It was very strong, this wish to have all of mum for himself. It also made me think of some difficulties he had with me seeing other patients on the Unit and the issue of our sessions having a boundary around them – a start and end time. And he was *still* needing to wait for a second session, until it was possible for me to arrange it – stay within that boundary, very frustrating.

A little later in the session, Peter told me the following dream:

Dream One

I was playing tennis with my friend Siddesh and some other people. We were playing this game – King, Queen, Jack, Peasant. Then Siddesh hit the ball to me and it went over the high net around the court. Because I missed it, the tennis coach said I was out and I got upset. Then on the way home in the car, Siddesh was saying how he had been King twice and I said how I had been King once.

We talked about Siddesh being his good friend and they liked to play football together now, although they used to play tennis when they were in primary school. Peter also explained about the tennis game: all the peasants go on one side of the net and the King, Queen and Jack go on the other. The peasants take it in turns to hit the ball and if the Jack misses, he swaps and becomes a peasant, going to the back of the queue; if the Queen misses, the Jack becomes the Queen and the Queen becomes a peasant, and so on. Peter confirmed he was the Queen in the dream when he missed the ball. I wondered how fair it was – Siddesh had hit the ball so high, over the surrounding net, so it seemed impossible to hit back, but Peter was still out. Peter agreed. I asked about the tennis coach and Peter said he had had two – the first, who he preferred, was more fun but the second was more serious about tennis.

I talked about how interesting Peter's dream was and how it made me think of the King and Queen on one side of the net, with their special child, the Jack, and all the other children peasants on the other side. The object of the game seemed to be to become King, a bit like the children trying to knock a dad-king out of his place and replace him alongside the Queen, like the younger part of Peter himself wanting to knock dad out and have his mum all to himself.

I said the theme of competition seemed to be strong in the dream, not only to be king but also amongst the peasants, and especially between him and Siddesh. Perhaps again it was something about competitiveness with his sister and brothers in the family for mum.

I then wondered about the link this may all have with his eating difficulties. I supposed that his anorexia seemed to give him a kind of special place alongside his mum and dad, particularly around meals, putting him in the place of Jack alongside the King and Queen, with the peasants on the other side. I wondered who would have had most attention before he got ill. 'Ruth,' said Peter, without a moment's hesitation. I agreed, probably because of her special needs. And then, when his younger brothers came along, babies needed lots of attention. Perhaps giving up anorexia may feel like a risk in terms of attention, looked at in that way. Perhaps here too, as he saw new patients coming in and taking up more attention on the Unit. Maybe it seemed harder for him to imagine that moving forward and making progress could establish a different kind of attention in his parents' and my mind, where he could be held and thought about but at the same time feel he could develop in a different direction and get on with his life.

The following session Peter arrived at my room with a face like thunder. Whatever I said was wrong, and he wasted no time telling me so.

Session 41

In his next session I tentatively mentioned the King, Queen, Jack, Peasant dream to Peter again and said I felt our discussion about it had put him in touch with his position as one of the children, or peasants, in a way that I thought made sense to him, but was also difficult for him to hear and come to terms with. Despite our previous discussions along the same lines, the dream seemed to confirm something for him on a different kind of emotional level – not just an intellectual idea – and it wasn't easy. I thought he appreciated my thinking with him about it but at the same time felt angry with me for seeming to make him see himself in a different light – it seemed like the end of an era in the way he viewed himself in relation to his parents, no longer the chosen Jack alongside the King and Queen, but in the queue with all the other children. At first, Peter said that what I just said didn't make sense, and when I repeated the same thing he said that now I had hit the nail on the head. I said he seemed to both agree and really want to disagree.

A little later, Peter then said he was now remembering a dream that he had when he was about eight, that was probably irrelevant. I encouraged him to tell it to me anyway.

Dream Two

Me and my friend Lewis were in school. We had a pack of cards. Inside the pack there was sometimes a gift. I opened the pack and the gift was a tazzar – a round disc; I've got a collection of them. The picture on the tazzar was of a hedgehog, upended with gas coming out, with fire. Then me and Lewis went into the green field.

When Peter had described the tazzar he seemed to hold it up to his face as he talked about the picture. I commented that he seemed to be describing a kind of fiery fart coming out of the hedgehog. He agreed. I said I thought Peter

mentioning the dream now was significant and wondered if it may confirm something of what we had just been talking about. The pack of cards seemed linked to the King, Queen, Jack, Peasant dream and although he had some understanding of his dilemma in relation to his parents before we discussed the dream, something did seem more real now, as we had said. I asked Peter what he thought about the green field? He said he didn't know. I said it was an outside space though, not stuck inside. He agreed. I said the prickly hedgehog did make me think of him last week when he had been rather cross and prickly with me in the session. I thought perhaps the fiery fart was one in the face for me, for putting him in touch with these things and now there was the half term break. Peter laughed and said he thought that sounded right.

Session 42

In the next session, and following a week's half term break, Peter first told me rather crossly how he felt excluded from the social life of the family while he was stuck on the Unit. He then told me the third dream:

Dream Three

I was in a field, the grass was like a football field. I was with some others and we were running around the edge of the field. The field was surrounded by a kind of hedge or bush and the way out, a small muddy path, was in the top right hand corner. Outside was another field with cabbages growing in it.

As I asked questions about the dream, Peter suggested he could draw it (Figure 1). He said the 'others' were his own age. The muddy path would be a bit difficult to get through because of the mud, not as easy as going around the field. The cabbages were neatly planted, with a square of earth around each one, but they were a funny colour, a bit brown at the base. Later he added that they were rotting into the earth. I asked and Peter confirmed that he didn't like cabbage at all and yes, it was on his list of 'hate foods'.

As we were talking Peter said he was now remembering the end of the dream:

On the outside of the cabbage field there was a tree with a muddy patch around it and bushes behind. Then the small muddy path opened out into a wider track. Beyond the field was something else, but he didn't know what this was – it wasn't like the cabbage field that he could see in the dream.

Peter turned the paper over and began to draw the second part of the dream (Figure 2). I asked about the tree. He said the leaves were colourful but not the fruit – they were a bit like black baubles on a Christmas tree, but not quite. It made him think of the Adam and Eve tree a bit. I tried to explore which way Peter went in the dream. He said the tree was a kind of choice. You could either go the way of the wider track, into the place he didn't know, but what would be worse would be to go behind the bushes, which were behind the tree.

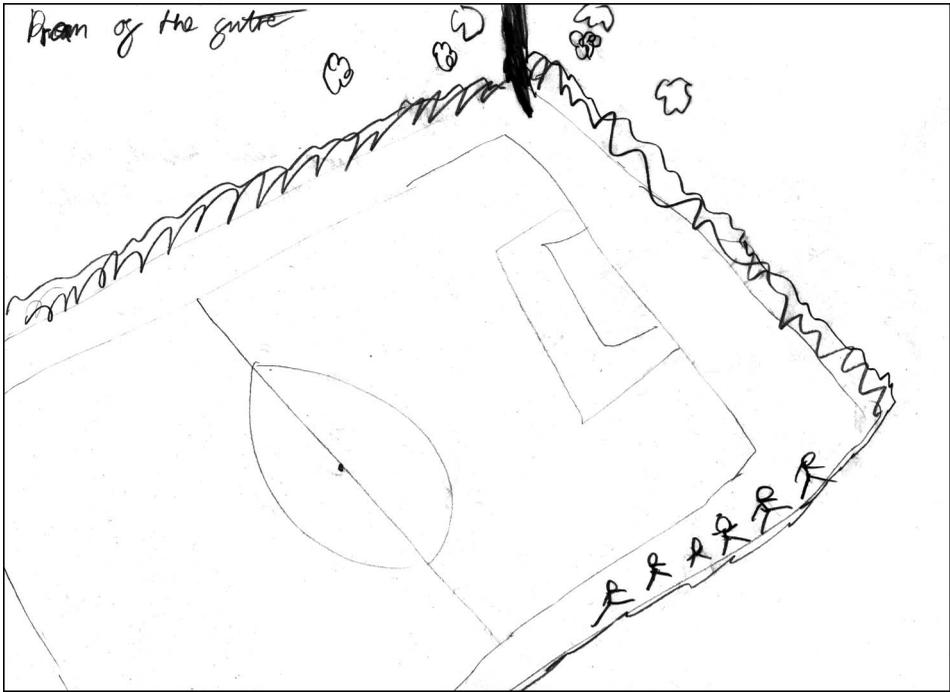


Figure 1.



Figure 2.

I said all this reminded me of the other Bible story he had told me when he first came to the Unit. Peter remembered it was the story of Jonah and the Whale. I talked about that being about a son going against the father – Jonah didn't do what God asked at first. Also Adam and Eve went against what God had asked and then hid behind the bushes in the garden, a bit like the bushes behind the tree in his dream. I linked the boundary of the football field in his picture to the boundary fence of his father's land – at the time we had talked about his father being the boundary keeper for his mother. The King, Queen, Jack, Peasant dream also showed a younger Peter trying to knock out the father King and take his place with mother. I wondered if this dream today was also somehow about that, a story about his movements from an inside place to outside, but then, on the boundary is the tree, which is like a temptation or choice, perhaps linked to the black slippery fish/snake part of himself in relation to the father in his mind.

At this point the atmosphere in the session became tense and I felt Peter became anxious. I said there seemed to be so much about punishment in the dream. I wondered if this was linked to the father in his mind, who was very different from his real father. His real father was interested in him getting better, not in punishment. Peter said he thought the dream was more a story about the future, not about a mother and father at all. I wondered if it could perhaps be linked to both. But I asked if what I had said had frightened him. Peter said it had a bit. The tension in session had now eased and I talked about the idea of interest, helping him to know more about himself, nothing to do with punishment, which was more in his mind.

We had five minutes to go and I talked about his writing on the picture: 'not having the time to look at the future in the dream'. I said next week I could confirm when a second session could start. Peter said he would like to have two sessions. We talked about how the gap between sessions made it much more difficult for him to stay linked with the work, especially when there was a break like the week before. He may be more inclined to retreat to a different kind of inside place then. Two sessions would be better.

The significance of reaching dream material

What is the significance of reaching dream material? Perhaps it is something to do with Peter's interest in the reality of his internal world – no longer just preoccupied with issues around weight/meal plans/targets or the 'too easy' process of the first admission, but rather a developing interest in what it means to have an experience, an interest in mental 'muscle'. In this context, it may be interesting to explore a contrast between 'fat' – as some kind of 'layer' – and 'muscle', more linked to the idea of food turned into strength through the digestion process. When Peter was discharged after his first admission, he said the boys at school said he was sent away to get 'fat' and now he was back. The question now was: Was something different happening in Peter's experience of the second admission? Does the movement seen in his dream material, and the experience of his second admission, indicate internal shifts that were sufficient to go

deep enough into Peter's mind to influence at the level of 'muscle' – both bodily and mental muscle?

Certainly, the balance of Peter's preoccupation with body and mind seemed to be changing. The working through of Oedipal issues seemed to have helped Peter recognise, at a deeper level, something of the 'essential facts of life' referred to by Money-Kyrle (1968), as he entered the new era of finding his place as one of the children, rather than, as Steiner puts it, 'turning a blind eye' (Steiner, 1985) and maintaining the 'Oedipal illusion', referred to by Britton, of being his mother's partner (Britton, 1989). As new concepts related to the Oedipal story build up, Peter's mind seemed to be developing, and there may be some movement towards the depressive position with the resolution of the Oedipus Complex, in the direction that Britton suggests (Britton, 1985).

The mind, where the imagination lies, was now centre stage in Peter's therapy. And there seemed to be a place in his dream world for living in time and space, located, as Money-Kyrle (1968) puts it, 'in a time-space system'. The places in Peter's dreams are all distinctively located in time and space. There is, in this sense, a kind of building up of a three dimensional space in his internal world. And all the dreams have movement in them. The dimensionality Peter seemed to be beginning to acquire, represented in the dreams, does, I think, seem to show some degree of internal shift that indicated Peter was now more ready than before to leave treatment as an inpatient, and go out and engage in time and space in a progressive developmental way. There the struggle will continue, with Peter either moving outwards towards the 'wider track' and the unknown future, or retreating back in the direction of the narrow muddy path. Despite it still being early days for Peter, his third dream seemed to illustrate some new and more positive options.

At this point in Peter's treatment, timing was again crucial, as a period of consolidation would be needed before discharge – a time to firm up and strengthen the internal muscle that showed signs of beginning to form. This period of consolidation should not be too short, but just as crucially, neither should it be too long and generally seems to be a matter of six weeks or so, usually coinciding with a planned school reintegration programme that progressively builds up days attended each week. In fact, time does not stand still and young people like Peter need to step back in with the flow, along the regular continuum of space and time, in order to exist in reality. This is where they can begin to grow and test their muscle. The Unit is a transitional space, not a place to live.

The Unit as a microcosm

I have sometimes thought about the Unit as a kind of microcosm of therapeutic experience, and that some of the themes around the timing of ending work here also resonate with the experience of ending psychoanalytic psychotherapy in more general outpatient settings. Essentially, for me, this involves the idea of the physical entity of the Unit being, in various ways, symbolic of 'inside states of mind', which can incarcerate or hide away inpatients and outpatients alike. The movement necessary to stimulate the patient's progress from states of projective identification may also be evidenced through

similar kinds of internal shifts. Whereas for the inpatient the ending generally needs to be the beginning of outpatient work, for the outpatient, ending is more conclusive in terms of treatment, but it is, perhaps, also the beginning of something else too – that is, the ongoing struggle to stay predominantly in the depressive position in the recognition that Bion's (1970) formulation of $PS \leftarrow \rightarrow D$ travels both ways. Along the lines of the challenge facing Peter, it seems that the timing of ending needs to coincide with development of the emotional muscle to experience being 'outside' the object in a more lasting way, in favour of real relationships in the world and with one's own internal parents.

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